



WEST DUNBARTONSHIRE LARGE SCALE INVESTIGATION GUIDANCE

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Introduction

1.1 What is a Large-Scale Investigation (LSI)?

A Large-Scale Investigation is a time-bound, multi-agency ASP investigation led by the Council (or delegated social work service) when there is reason to believe more than one adult may be at risk of harm from the same service, system, setting or alleged harmer. LSIs can apply across registered and unregistered services (e.g., care homes, supported accommodation, NHS wards, outreach/day services, care at home) and also to patterns of harm in the community. Risk may arise from people (e.g., staff, other residents, members of the public), deficits in management or care governance, or from the environment of the service. The purpose is to establish whether risk exists at scale, put protections in place, and secure necessary improvements. An LSI concludes when adults are no longer at current risk of harm at scale (individual ASP work may continue).

In West Dunbartonshire, LSIs are used instead of running many parallel individual ASP inquiries where coordinated oversight, consistent decisions and multi-agency action are required. The local approach emphasises standardised process, clearly defined roles, and a common set of tools to ensure a defensible and proportionate response.

1.2 Legal context

The Adult Support and Protection (Scotland) Act 2007 and its Code of Practice provide the primary statutory framework for LSIs, including the definition of an "adult at risk," the duty to inquire, information sharing expectations and the principles of benefit and least restriction. Depending on circumstances, related legislation may also apply, including the Adults with Incapacity (Scotland) Act 2000, and the Mental Health (Care and Treatment) (Scotland) Act 2003.

1.3 Who this guidance is for

This multi-agency guidance is for everyone who undertakes, contributes to, or is affected by LSIs, including:

- Council/HSCP: Council Officers (including delegated social work services), ASP Leads, senior managers, commissioning/contracts/quality assurance teams and legal services.
- Police Scotland: early notification, criminal investigation, advice on parallel processes and protection planning.
- Care Inspectorate / Health Improvement Scotland / NHS Board: regulator/scrutiny partners; clinical and care governance input; improvement oversight.
- Mental Welfare Commission / Office of the Public Guardian: where mental disorder, incapacity and proxy powers necessitate their involvement.

- Independent advocacy: to uphold participation, rights and voice of adults at risk and families/carers.

LSIs are complex. Many different organisations and individuals may be involved. This guidance seeks to clearly set out everyone's roles and responsibilities and promote the joint working that's not only a duty, but so important in making LSIs effective. When close joint working happens, the outcomes are better for everyone especially those adults who may be at risk of harm.

1.4 What this guidance seeks to achieve (purpose and scope)

Alignment and consistency. This document aligns WDHSCP practice to the National LSI Guidance (Oct 2025) so that decisions are proportionate, defensible and consistent across agencies. This guidance aims to provide clarity on thresholds and triggers for LSI. WDHSCP includes practical indicators such as "six reports of harm within six months" or "no ASP referrals in six months" as potential signals of systemic concern or under-reporting culture. These indicators do not replace national criteria but support professional judgement on when "more than one adult is at risk."

This guidance describes how to start, plan, conduct and conclude LSIs, with explicit role clarity, meeting sequences, and document standards. It embeds expectations offers a communications and advocacy plan, and sets out cross-boundary protocols and notifications. It ensures adults and families have timely access to independent advocacy, that consent/capacity/undue pressure are considered throughout, and that information-sharing follows the ASP Code.

It sets out the LSI closure test (no current risk of harm at scale), post LSI monitoring, and learning debrief arrangements, with WDHSCP reporting via SMT to Clinical & Care Governance then to APC/Chief Officers.

1.5 How this guidance was developed and locally adapted

The National LSI Guidance (Oct 2025) was produced collaboratively by a short life working group supported by Iris, drawing on the 2023 National LSI Framework, research evidence, professional feedback, and stakeholder engagement.

The West Dunbartonshire LSI guidance originated from the West of Scotland LSI Guidance (2019) and the WDHSCP March 2021 version, which established local criteria, roles, and templates. This integrated document maps WDHSCP content into the national structure, retaining local forms, letters, checklists and process charts so that staff can work with familiar tools while adhering to national expectations.

Section 2: Preventing the Need for a Large-Scale Investigation

Preventing the need for a Large-Scale Investigation (LSI) is not a statutory requirement, but it is recognised nationally as best practice.

Early, proactive partnership work can significantly reduce risks, support providers to recover early signs of deterioration, and protect adults from harm before systemic failure develops. WDHSCP adopts and enhances the national prevention approach by combining national indicators, local thresholds, and cross-agency quality assurance mechanisms.

Should preventative work be unsuccessful, and the service becomes subject to an LSI, earlier work can still have value. It provides important evidence to aid the LSI process; and can also help minimise the element of surprise when an LSI begins. Additionally, preventative work can inform future learning, since it supports all (including an organisation subject to an LSI) to better understand why the LSI commenced.

Good preventative practice, particularly in terms of health and social care providers, may include the following:

- Consider having a team, or worker(s), holding a specific responsibility for prevention of LSIs and leading on the practice detailed below. This may include collaboration with local independent advocacy services, in order to ensure adult and family views are represented.
- Regular analysis of the patterns of Adult Support and Protection referrals from local health and social care providers (an organisational chronology see Appendix 5 can help with this). Do referrals seem disproportionately high or low? If so, proactive working with the service in question to query the reasons for the excess or lack of ASP referrals, involving contracts and commissioning colleagues in these discussions, and providing any support identified, can help prevent an LSI in the future.
- Being transparent and proactive with local health and social care services about local ASP procedures (including what might trigger an LSI) and encouraging services and care providers to reach out at an early stage if they identify any patterns or issues of concern. Appendix 2: Frequently Asked Questions about LSIs may be helpful to share.
- Strengths based and relationship-based work with local services and care providers, sustained over time, in order to build trust. This can help with developing the soft intelligence needed for supportive work in the event of future ASP involvement.
- Proactive work when a new service or care provider sets up in the local area, building up relationships from the beginning.
- Using the Early Indicators of Concern in Care Services, which are specifically designed to help health and social care practitioners in Scotland intervene at an earlier stage to prevent the significant deterioration in service quality associated with abuse and neglect. They are particularly useful in services for people with learning disabilities, and care homes for older people.
- Ensuring a robust mechanism for addressing care that does not meet required standards is embedded in the contracts and commissioning processes.

- Consider how you can build up a picture of the service at times outside of regular office hours. This could include visits in the evenings or weekends, and/or sharing or receiving intelligence with the Care Inspectorate or others who know the adult(s) or the service which may include family and carers.

2.1 Purpose of Prevention Activity

Prevention work aims to:

- Identify patterns of concern early within care services or community settings before they escalate to harm, affecting multiple adults.
- Promote collaborative problem-solving with providers, regulators, health partners, advocacy, and commissioning teams.
- Support culture, capability and care-giving practice within services to reduce the likelihood of institutional harm.
- Inform proportional and evidence-based decision making about whether LSI criteria are met.

Prevention activity does not replace the legal duty to undertake ASP Inquiries where harm to an adult is suspected. Instead, it should enhance the quality of early response.

2.2 Early Indicators of Concern

The National Guidance (2025) highlights the importance of structured early warning systems. WDHSCP employs the national Early Indicators of Concern model, complemented by local intelligence sources.

[Supporting documents - Early Indicators of Concern in Care Services - gov.scot](#)

Indicators may include:

a. ASP Referral Patterns

- Sudden increase in referrals linked to a provider.
- Six harm reports in six months (a WDHSCP local trigger).
- No referrals in six months (possible under reporting culture).
- Frequent low-level concerns indicating unmet need for supervision or care planning.

b. Contract Monitoring & Commissioning Intelligence

- Provider instability (high turnover, vacancies, loss of leadership).
- Complaints or unresolved quality issues.
- Unmet improvement actions after contract visits.
- Indicators of failing governance or weak escalation processes.

c. Multi-Agency Practice Intelligence

- Concerns raised by GPs, District Nursing, Allied Health Professionals, Care at Home staff, mental health teams, or community addiction services.
- Acute hospital disclosures indicating possible systemic issues in commissioned care.
- Recurrent missed visits, medication errors, issues with nutrition/hydration or pressure care.

d. Regulatory Indicators

- Care Inspectorate downgrade in evaluations.
- Regulatory requirements unmet or repeated.
- Whistleblowing that raises concerns about culture, leadership or safety.

e. Environmental or Safety Indicators

- Unsafe, unhygienic, or unmonitored environments.
- Fire safety concerns identified by SFRS.
- Unresolved equipment failures (hoists, pressure equipment, alarms etc.).

These indicators do not automatically trigger an LSI, but they provide critical evidence to inform early planning.

2.3 Building Relationships with Providers

Effective prevention requires trusting, transparent relationships. WDHSCP adopts a values based approach:

- Regular contact with service managers and workforce leads.
- Early discussion when concerns first emerge to support improvement.
- Joint visits with commissioning, CI inspectors, or health colleagues where appropriate.
- Sharing learning materials, including:
 - Early Indicators of Concern
 - National LSI FAQs
 - Advocacy information
 - Local improvement resources

Continual engagement reduces the likelihood of difficult escalations and strengthens provider capacity.

2.4 Proactive Intelligence Gathering

Both national and WDHSCP practice highlight the importance of multisource intelligence triangulation.

Prevention activity includes:

- Cross-agency risk discussions (Public Protection, Care Governance, Contracting).
- Pre-planned and unannounced visits (evenings/weekends where relevant).
- Sharing insights across nursing, AHP, social work, commissioning and police teams.
- Monitoring of:
 - staff disciplinary activity
 - sudden leadership changes
 - unexpected hospital admissions
 - increased falls, pressure ulcers or medication errors

This triangulation strengthens early decision making and helps distinguish poor care, declining practice, and potential harm.

2.5 When Prevention is Not Enough

Even effective prevention work will not stop all LSIs.

Where prevention activity has not mitigated emerging risks, or new concerns arise that reveal harm at scale, WDHSCP must:

1. Follow national ASP Principles be of benefit, least restrictive option and include participation.
2. Escalate using WDHSCP alert processes, including notification to senior managers, Legal Services, Police Concern Hub and Public Protection.
3. Arrange Multi-agency Initial LSI Discussion.

Prevention data strengthens the evidence base at this stage and makes it easier to demonstrate why escalation is necessary.

2.6 Value of Prevention for Future Learning

Prevention activity is not wasted even when an LSI is triggered as it:

- Provides a documented track record of concerns, actions and provider engagement.
- Reduces the “element of surprise” for providers.
- Supports fair, measured and evidence driven decisions.
- Informs future learning debriefs and improvements to commissioning, oversight and provider support.
- Strengthens the local system’s ability to self-correct and build safer care environments.

Strong prevention practices reduce risk, build resilient services, and support adults to remain safe without waiting for harm to escalate.

Section 3: Principles of a Large-Scale Investigation

Effective Large-Scale Investigations (LSIs) are grounded in a clear set of principles that ensure the process is lawful, proportionate, person-centred, and consistently applied across WDHSCP. These principles are drawn from the **Adult Support and Protection (Scotland) Act 2007**, and the **National LSI Guidance (2025)**. They apply throughout every phase of an LSI from initial concern, through to planning, investigation, closure, and learning.

The section below combines national expectations with explicit WDHSCP local requirements.

3.1 Adult Support and Protection (ASP) Principles

The ASP Act requires that any intervention in an adult's life:

a) Must provide benefit that could not reasonably be achieved without intervention

Every LSI decision must be clearly linked to improved safety, wellbeing or protection for adults. Any action taken whether initiating an LSI, imposing a moratorium, coordinating assessments, or establishing protection plans must add measurable value.

b) Must be the least restrictive option

The LSI process should never impose more disruption or restriction than is necessary to keep adults safe. For example, a full-service wide LSI should only commence when prevention and early corrective action cannot adequately mitigate risk at scale.

c) Must take account of the adult's rights, will and preferences

This includes:

- Exploring and recording adults' past and present wishes
- Ensuring communication needs are supported
- Recognising legal documents such as Advance Statements
- Involving advocacy early and consistently
- Ensuring adults understand the process and can contribute meaningfully

WDHSCP practice mandates that independent advocacy is offered at the earliest stage and reoffered throughout every significant stage of the LSI.

d) Must consider the views of relevant others

This may include:

- Nearest relatives
- Carers
- Guardians and attorneys
- Significant others who have an interest in the adult's wellbeing

LSIs often require group engagement through residents' meetings, family meetings or targeted communication, ensuring the perspectives of those affected are heard.

e) Must support adults to participate as fully as possible

LSIs must incorporate:

- Trauma-informed communication
- Accessible information
- Advocacy
- Flexible interview arrangements
- Consideration of cultural, linguistic and disability-related needs

Participation is not optional it is a legal obligation.

f) Must ensure adults are not treated less favourably

Adults at risk must not be disadvantaged due to disability, illness, mental disorder, age, or communication needs. LSIs must examine whether the care environment itself contributes to unequal treatment.

g) Must take account of the adult's background and characteristics

This includes:

- Cultural identity
- Language
- Gender
- Religion
- Sexual orientation
- Neurodiversity
- Trauma history
- Previous experiences with services

All must be considered in protection planning and communication.

The Large-Scale Investigation principles were originally created for the 2023 Adult Support and Protection National Large Scale Investigation Framework. These are values that inform the process of an LSI throughout. They have now been adapted for this guidance.

Principle 1 – Person-centred

An LSI must remain focused on the safety, rights and lived experiences of the adults at risk. While LSIs examine systems, the central question is always:

While an LSI will look at systemic and management issues, the wellbeing, safety, rights and experiences of the adults at risk of harm are always the central concern of all LSIs. An LSI begins when there is more than one adult at risk of harm and it ends when there are no adults at risk of harm.

Principle 2 – Supportive

LSIs can be distressing for adults, families, staff and providers. A supportive approach assumes:

Everyone wants to provide good care unless proven otherwise.

WDHSCP operationalises this through:

- Transparent communication with providers
- Opportunities for providers to share their perspective
- Attention to staff wellbeing (including LSI team wellbeing)

Principle 3 – Planned

Every LSI must have:

- A clear scope
- Time-bound milestones
- Evidence-based objectives
- A structured investigation plan
- A communication strategy
- Defined reporting routes

This ensures momentum and prevents drift.

WDHSCP reinforces this with:

- LSI recording documents
- Standardised templates (SBAR, impact assessment, media strategy)
- Clear governance through SMT, Care Governance and APC pathways

Principle 4 – Multi-agency

LSIs rely on collaboration, not parallel silo working. The Council leads, but all statutory partners have a legal duty to cooperate.

This includes:

- Police Scotland
- NHS GGC (including relevant clinical specialists)
- Care Inspectorate
- Advocacy
- Commissioning & Contracts
- MWC, OPG and HIS where relevant

WDHSCP integrates multi-agency roles early by:

- Contacting Legal Services and Police Concern Hub during initial inquiries
- Involving Quality Assurance and Commissioning from the first planning meeting
- Coordinating cross-boundary engagement for non-local authority residents

Principle 5 – Professionally curious

Professional curiosity is about changing information into intelligence. It involves thinking through different possibilities, being able to identify concerns, and to make connections between different types of information. It's also about being open-minded and being prepared to have difficult conversations

It involves:

- Questioning assumptions
- Investigating inconsistencies
- Seeking evidence for improvement claims
- Considering systemic, cultural or environmental contributors
- Looking beyond individual incidents to whole service patterns

WDHSCP uses tools such as:

- Chronologies
- Contract monitoring intelligence
- Regulatory inspection analysis
- Multi-agency information-sharing

Principle 6 – Lawful

While LSIs are not mentioned in law, the Adult Support and Protection (Scotland) Act 2007 Code of Practice sets out statutory powers and are the principal basis on which an LSI is carried out. As well as statutory

powers, the council may have contractual powers whereby the council is a purchaser of the service and has a contract with the provider where certain requirements have to be met.

LSIs must comply with:

- ASP (Scotland) Act 2007
- ASP Code of Practice (2014, updated)
- AWI Act 2000
- MH Act 2003
- Data protection legislation (UK GDPR)

WDHSCP ensures lawfulness by:

- Early engagement with Legal Services
- Recording decision making and rationales
- Ensuring capacity, consent and undue pressure considerations
- Following statutory notification routes (CI, MWC, OPG)

Principle 7 – Clearly communicated

Information must be:

- Accurate
- Timely
- Sensitive
- Trauma-informed
- Delivered to the right people at the right time

This applies to adults, families, providers, police, regulators, staff and elected members.

WDHSCP strengthens communication by:

- Using template letters for residents/families
- Maintaining secure and auditable record keeping

Section 4: Public Bodies and Key Roles in a Large-Scale Investigation

Large-Scale Investigations (LSIs) depend on strong multi-agency collaboration. While the Council (or delegated HSCP social work service) leads the LSI, the effectiveness of the process relies on coordinated activity across statutory partners, regulatory bodies, health services, advocacy organisations, and providers.

Every LSI is different; therefore, roles may vary slightly depending on the service type, scale of concern, and the nature of the risk. However, the responsibilities outlined below provide a consistent foundation for West Dunbartonshire HSCP (WDHSCP).

4.1 Overview of Multi-Agency Responsibilities

The Adult Support and Protection (Scotland) Act 2007 places a duty on a range of public bodies to co-operate with ASP inquiries. An LSI is a specific type of ASP inquiry, so the same obligations apply. The Adult Support and Protection (Scotland) Act 2007 requires councils and a range of public bodies to work together to support and protect adults who are unable to safeguard themselves, their property and their rights. Section 5 of the Act provides that certain bodies and office holders must, so far as it is consistent with the proper exercise of their functions, co-operate with a council making inquiries under Section 4 of the Act and with each other where this is likely to enable or assist the council making the inquiries.

The Adult Support and Protection (Scotland) Act 2007 [Code of Practice](#) states LSIs "must" involve Care Inspectorate, the relevant local council, and the service provider responsible for the care of the adults. This, however, does not imply that other public bodies' involvement is not valuable and, in some circumstances, vital to an LSI's effectiveness.

Key expectations include:

- Timely information-sharing
- Attendance at planning, inquiry, review and outcome meetings
- Provision of evidence and records
- Active participation in analysis and decision-making
- Joint safety planning and improvement oversight

4.2 Health and Social Care Partnerships, Councils and Health Boards

Council / HSCP – Lead Agency

Under Adult Support and Protection legislation, councils have a statutory duty to investigate harm. In an LSI, the council (or social work service, where relevant to delegation arrangement) is the lead agency. This means

the council is responsible for decisions related to the start and the end of an LSI, and leading on the LSI throughout. The council is also responsible for keeping the LSI on track and for coordinating other agencies' involvement.

Under ASP legislation, the Council is the lead authority for all LSIs. In WDHSCP, this responsibility is formally delegated to the Integrated Operations Manager, Lead Officer Public Protection, Senior Managers, Chief Social Work Officer and Council Officers.

Core responsibilities include:

- Making the initial decision to commence an LSI
- Chairing Initial Inquiry, Planning, Review, and Outcome meetings
- Co-ordinating the LSI team and managing timelines
- Ensuring compliance with ASP Principles and Code of Practice
- Ensuring adults' views and rights remain central
- Overseeing cross-boundary notifications
- Leading risk management and protection planning
- Providing the documentation framework
- Consider linking with Children and Families where an individual is recently over the age of 18
- Ensuring governance escalation to:
 - Chief Social Work Officer
 - Senior Management Team
 - Clinical & Care Governance Group
 - Adult Protection Committee
 - Chief Officers Group

Health Boards / NHS GGC

NHS partners provide clinical leadership and contribute essential expertise. Their responsibilities include:

- Identifying and assessing clinical risk
- Providing relevant health records, care histories and assessments
- Supporting specialist reviews (e.g., tissue viability, medicines management, dietetics, speech and language therapy)
- Participating in adult protection planning
- Ensuring health services under investigation remain safe
- Liaising with HIS where regulatory scrutiny is required

WDHSCP relies on NHS GGC clinical managers, GP input, District Nursing, AHPs, and specialist clinicians throughout the LSI.

4.3 Police Scotland

Police Scotland has a statutory responsibility to detect, investigate and prevent crime. In LSIs, they:

Whilst criminality will not always be a factor in an LSI it is imperative that the police are notified about the LSI from the outset. This allows for both early identification of, and early elimination of, criminality.

The investigation of crime requires a high degree of cooperation between all stakeholders and partner agencies. Police are responsible for making quick-time decisions to protect the safety of vulnerable adults and also any other identified person within their family or the wider community. The need to gather information and evidence must always be balanced against the need to take any immediate protective action.

A criminal investigation is led by the police. The council will consult with police in LSIs where there is a criminal investigation, and the police will advise how these parallel investigations can progress.

Even if criminality is not suspected, Police Scotland can provide background checks, relevant local or national information, and advice on safety planning and/or risks to the community. Where the risk of harm is significant and immediate, the focus of the initial risk assessment is to ensure direct action is taken to mitigate risk and to provide appropriate safety measures to the adult(s).

Through early engagement with the police, and their inclusion throughout an LSI, vital evidence can be obtained, and plans put in place to ensure an efficient and effective parallel investigation is carried out alongside any intervention to safeguard any individual adults at risk. This joint working ensures that safety and welfare considerations are captured within the investigation strategy.

- Receive early notification
- Examine whether criminality is suspected
- Advise on the interface between ASP and criminal investigations
- Lead criminal inquiry work
- Maintain forensic opportunities and evidence integrity
- Participate in planning and risk assessment
- Advise whether provider involvement could compromise an investigation
- Assist with immediate safety planning

In WDHSCP, initial contact is made through the Police Concern Hub, with rapid escalation if an adult or multiple adults may be at immediate risk.

4.4 The Care Inspectorate (CI)

The Care Inspectorate is the national regulator for registered care services. The role of the Care Inspectorate is as a scrutiny body which supports improvement.

Their roles during an LSI include:

- Receiving formal notification when an LSI is initiated and concluded
- Sharing regulatory intelligence, inspections, complaints history and enforcement activity
- Participating in Initial Inquiry, Planning, and Oversight Groups
- Supporting the analysis of leadership, governance and workforce concerns
- Considering whether regulatory enforcement action is required
- Co-ordinating with WDHSCP Commissioning and Contract Monitoring

A CI representative should be invited to all multi-agency meetings where the LSI involves a registered service.

4.5 Healthcare Improvement Scotland (HIS)

HIS regulates and inspects independent hospitals and other healthcare providers.

They may become involved when:

- An LSI concerns an NHS ward or healthcare service
- There are concerns about clinical governance, patient safety or healthcare-associated harm
- Specialist assurance is required

In WDHSCP, HIS involvement is agreed on a case-by-case basis through the HSCP/NHS governance liaison.

4.6 Mental Welfare Commission for Scotland (MWC)

The MWC protects and promotes the rights of people with:

- Learning disabilities
- Mental illness
- Dementia
- Personality disorder
- Related conditions

MWC involvement is appropriate where:

- Adults at risk have mental disorder
- Compulsory measures are in place
- Concerns relate to mental health services or treatment environments
- Issues of rights, capacity or restrictive practice are identified

WDHSCP must notify the MWC when adults meet these criteria or where the nature of the concern indicates they may need to exercise their statutory functions.

4.7 Office of the Public Guardian (OPG)

The OPG oversees the financial/property affairs of adults lacking capacity.

Their role in LSIs includes:

- Receiving notifications where concerns involve financial harm
- Reviewing concerns about attorneys, guardians, or interveners
- Providing information on existing orders and powers
- Participating in investigations where financial safeguarding is required

WDHSCP must notify the OPG where financial governance or misuse of powers of attorney/guardianship is relevant.

4.8 Scottish Fire and Rescue Service (SFRS)

SFRS contributes specialist knowledge where:

- Fire safety concerns are identified
- Environmental risks emerge
- A moratorium or emergency closure impacts fire safety
- Prevention input is required during the improvement process

In WDHSCP, SFRS should be automatically notified when a moratorium is enacted.

4.9 Independent Advocacy

Independent advocacy ensures adults' voices are central.

Their roles:

- Supporting adults and families to express their views
- Assisting with decision making and participation
- Providing non-instructed advocacy where capacity is impaired
- Ensuring rights are upheld throughout the LSI
- Offering independent communication pathways

WDHSCP mandates early referral to Lomond & Argyll Advocacy for all LSIs.

4.10 Adults, Families, and Support Networks

Adults and families contribute essential evidence.

Their involvement includes:

- Sharing experiences of care
- Highlighting concerns or strengths
- Participating in reviews
- Receiving accessible, trauma-informed communication
- Attending meetings where appropriate

WDHSCP uses structured letters, and templates to ensure consistent communication.

4.11 Providers or Agencies Subject to an LSI

The service under investigation must:

- Cooperate fully
- Share records promptly
- Enable interviews and environmental access
- Participate in meetings where appropriate
- Support staff welfare during the LSI
- Develop and implement improvement plans

WDHSCP sets clear expectations around communication, liaison leads, and transparency.

4.12 Commissioning, Contracts & Quality Assurance

These teams are core contributors to LSIs because they:

- Hold key intelligence on provider performance
- Lead contract compliance and improvement monitoring
- Support improvement actions
- Advise on moratoria or enforcement
- Lead on market stability considerations

Their involvement is embedded from the initial inquiry stage onward.

Section 5: Instigating a Large-Scale Investigation

Instigating an LSI is a proportionate, time-bound decision taken when there is evidence (or a well-founded belief) that more than one adult may be at risk of harm from the same service, system, setting, or alleged harmer. The steps below combine the national process with WDHSCP specific requirements so that escalation is lawful, consistent, and defensible.

5.1 Responding to the Initial Referral

Screen quickly, protect immediately, and gather the right people.

- Screen within local ASP procedures and undertake inquiries. If immediate risks are present, put protections in place without delay (e.g., urgent visits, safety planning, clinical checks, interim staffing within a 24-hour period).
- If indicators suggest risk at scale (e.g., repeated incidents, institutional practices, multiple victims, serious whistleblowing), consider LSI and collect early evidence (inspection history, complaints, contract monitoring intelligence, health data).
- Notify Legal Services and consult the Police Concern Hub at the outset for criminality advice and to preserve evidence.
- Use LSI1 Part A to record the referral and all initial actions; start the Impact Assessment and Media Strategy if indicated.
- Offer independent advocacy early (and re offer regularly).

5.2 Convening the Multi-Agency Initial LSI Discussion

- Convene quickly (after initial screening) with senior manager chairing and authority to set direction and commit resources to commence LSI. Invite those holding key evidence and decision-making responsibilities (Police Scotland, NHS/clinical leads, Care Inspectorate where a registered service is involved, Commissioning/Contracts, Legal).
- Consider whether the provider can join part of the meeting without compromising any criminal or regulatory processes (Appendix 2).

5.3 Collating and Discussing Initial Evidence

Bringing the right evidence.

- ASP history: prior referrals, any previous LSI activity or “near-miss” discussions, patterns across time; relevant organisational chronology entries.

- Prevention work and Early Indicators of Concern: what was attempted, what changed, what failed to sustain.
- Contract/commissioning intelligence: visit reports, unmet actions, workforce/leadership stability, moratorium considerations.
- Regulatory information: CI inspection findings, complaints/enforcement; HIS input for healthcare contexts.
- Police intelligence: criminality, public protection concerns, advice on provider participation and evidence preservation.
- Health/clinical evidence: admissions, pressure damage, medicines management, nutrition/hydration, falls patterns, specialist assessments.
- Advocacy/adult/family views: experiences indicating risk at scale, participation needs, communication adjustments (trauma-informed).

Focus the discussion on the core question: Is more than one adult at risk of harm? Balance poor care indicators against harm thresholds; consider trauma-informed impacts on adults and families; record any immediate actions.

5.4 Making a Decision (Proceed / Not proceed / Time limited improvement)

Council/HSCP makes the decision, collaboratively, with partners.

- Proceed to LSI when evidence and professional judgement indicate risk at scale. Apply ASP principles (benefit, least restriction) recognising that precise benefits may only be fully understood after commencement.
- Not proceed when standards are poor but harm at scale is not evidenced. In that case, mandate robust improvement and monitoring via commissioning/regulatory routes, with review points and re-escalation criteria if risks persist or recur.
- Conditional approach: in unclear cases, agree time limited improvements (with named leads and dates) and set a review meeting to confirm if LSI is then required.
- Document the decision and rationale with actions, owners, and deadlines; circulate the minute.
- If the decision is to proceed, schedule the LSI Planning Meeting and start the notification plan.

5.5 Disagreements or No Decision Scenarios (Escalation and dissent)

If consensus cannot be reached, or a key partner disagrees:

- Escalate to a senior decision-making group (e.g., CSWO) to apply the same evidence-based criteria. If still unresolved (or conflicts of interest exist), escalate to the Chief Officers Group (COG) for a final decision.
- Record the challenge and outcome in the minute and update APC/COG summary logs as per local governance.

5.6 WDHSCP Practical Checklist (at the point of instigation)

- Immediate safety addressed (adults, staff, environment).
- Legal / Police consulted; evidence preservation actions agreed.
- Advocacy offered and re-offered; accessibility needs identified.
- LSI1 Part A/B completed; minute and distribution standards met.
- Impact Assessment and Media Strategy initiated where relevant.
- Cross-boundary residents/services identified; host/placing roles clarified.
- Planning Meeting scheduled; notification plan prepared.

Section 6: Commencing a Large-Scale Investigation

Once the decision has been taken to initiate a Large-Scale Investigation (LSI), the investigation must begin in a planned, transparent, and well-structured manner. This section outlines the national requirements for commencing an LSI, strengthened with WDHSCP's local processes, forms, escalation expectations, and governance pathways.

Commencing an LSI involves three core tasks previously mentioned:

1. Notifying all relevant bodies and stakeholders
2. Holding an LSI Planning Meeting
3. Establishing clear leadership, roles, and oversight

6.1 Notifications Process

Notifications are both a formal procedural requirement and a mechanism for ensuring that all partners understand their responsibilities and the level of risk. Clear, early communication helps reduce fear, uncertainty, and misinformation for all involved adults, families, providers, staff, and partner agencies.

WDHSCP Notification Requirements

As soon as an LSI is authorised, WDHSCP will:

- Notify the Chief Social Work Officer (CSWO)
- Notify the Senior Management Team (SMT)
- Notify the Clinical and Care Governance Group
- Notify the Adult Protection Committee (APC)
- Engage the Police Concern Hub for criminality screening
- Inform Legal Services
- Inform Commissioning and Contracts teams
- Begin cross-boundary notifications (for externally placed residents)

Notifications are recorded in and included in the Planning Meeting minute.

Nationally Required Notifications

Depending on the type of service:

- Care Inspectorate — for any registered provider
- Healthcare Improvement Scotland (HIS) — for NHS/independent clinical settings
- Mental Welfare Commission (MWC) — where adults have mental disorder or capacity concerns
- Office of the Public Guardian (OPG) — where proxies or financial concerns exist

- GPs — for every adult affected
- Other local authorities — where they fund or place adults in the service
- Disclosure Scotland — when harm involves a staff member and dismissal or misconduct is known or suspected

6.2 Notifying the Service or Organisation Subject to the LSI

Working with the provider (unless this would compromise a police investigation) is essential for:

- Minimising distress
- Supporting staff and residents
- Gathering accurate information
- Preventing defensiveness
- Reducing uncertainty

WDHSCP will:

- Provide clear, trauma-informed written notification using the standard Notification Letter to Provider (Appendix 3)
- Offer a single Liaison Lead for communication
- Share information explaining what an LSI is, why it is being undertaken, and what to expect
- Provide information on advocacy and rights
- Schedule meetings at times that minimise disruption to the service
- Encourage providers to create their own internal communication/update plan

If police advise that provider involvement would compromise evidence or risk safety, communication will be phased or restricted, and any such restriction recorded.

6.3 Notifying Adults, Families and Supporters

Adults using the service and their families are central to the LSI. Communication must be:

- Clear and non-alarming
- Accurate
- Accessible
- Trauma-informed
- Supported by advocacy
- Sensitive to health, disability, trauma history, literacy, culture and communication needs

WDHSCP uses:

- Standardised letters for residents and families (Appendix 4)
- Meeting invitations where appropriate (individual meetings or group/“open” meetings)
- Advocacy signposting via Lomond & Argyll Advocacy
- Accessible formats (Easy Read versions designed on request)

Residents and families must be reassured that:

- No assumptions have been made about the service
- Participation is voluntary but valued
- Advocacy is available
- Safety is the overriding priority

6.4 Notifying Other Councils (Including Cross-Border Cases)

If adults from outside the WDHSCP area use the service, the placing authority must be notified promptly. This includes:

- Local authorities elsewhere in Scotland
- Local authorities in England, Wales or Northern Ireland (if relevant)
- Self-funding individuals whose home authority may hold key information

The notification must include (Appendix 5):

- A summary of concerns
- The decision to initiate an LSI
- Expectations for information-sharing and involvement in reviews
- Named contacts for both host (WDHSCP) and placing authorities

Where a provider operates across multiple jurisdictions, WDHSCP will coordinate with other councils/partners to ensure consistent messaging.

6.5 Notifying GPs

In many cases, GPs hold important medical or wellbeing information about adults at risk. When an LSI is commenced, WDHSCP will:

- Notify every GP practice for each resident
- Request relevant information (subject to ASP and data-protection frameworks)
- Invite appropriate clinical participation in meetings
- Ensure GPs are informed of any changes to risk or care plans

GPs' input is critical for:

- HOLISTIC risk assessment
- Medication safety
- Reviewing admissions from the care setting
- Identifying missed harm
- Understanding presentation changes that may indicate abuse or neglect

6.6 Other Notifications

Depending on circumstances, WDHSCP may notify:

- SSSC, NMC, GMC, HCPC (for workforce misconduct or safety concerns)
- Housing providers
- Fire and Rescue (especially when environmental safety is a concern or a moratorium is enacted)
- Advocacy providers

Each notification must be recorded, time-stamped, and stored securely in the LSI file.

6.7 LSI Planning Meeting

It must take place within 5 working days of the decision to proceed (or sooner if risks require) (Appendix 6).

Purpose

- Confirm LSI commencement
- Define scope, risks, and boundaries
- Assign roles and responsibilities
- Agree a full Investigation Plan
- Establish milestones (SMART)
- Agree immediate protective actions
- Coordinate parallel processes (e.g., police, CI enforcement, HR processes)
- Identify adults to be reviewed and required professional input
- Confirm communication and advocacy arrangements
- Identify any out-of-hours or contingency needs
- Establish data-sharing methods
- Set expectations for reporting to governance groups

A discussion on the needs of the adults who use the service is likely to include:

- Identifying any users of the service who may need their care and support packages reviewed, in order to ensure their care and support needs are being met now, and in the immediate future, while the LSI is being conducted. If it appears that these needs are not being met, then alternative arrangements should be identified.
- Identifying which users of the service may have been assessed as lacking capacity and whether there are appropriate proxy powers in place. Where there are no powers in place, the early provision of non-instructed advocacy should be considered.
- Identifying which users of the service should initially be the subject of the LSI
- Plans for a clear notification and engagement strategy with users of the service, their families and supporters, including direction to independent advocacy services as soon as possible.

Attendees may include:

- Senior HSCP Chair (Head of Service or IOM level)
- Lead Investigation Officer (LIO)
- Adult Protection Lead Officer
- Council Officers (allocated to individual ASP inquiries)
- Police Scotland
- Care Inspectorate
- NHS GGC (clinical leads, District Nursing, AHPs, relevant specialists)
- Contract Monitoring & Commissioning
- Legal Services
- Fire and Rescue (if applicable)
- Advocacy
- Representatives of other placing authorities
- Provider (if appropriate and agreed with police)

Actions from meeting

- Agreed Action Plan
- Named LIO and team
- Schedule of review meetings
- Immediate risk-management tasks
- Chronology requirements
- Data management arrangements
- Media strategy activation if required

6.8 Lead Investigation Officer (LIO) and the LSI Team

Lead Investigation Officer

The LIO provides day-to-day leadership.

They must be:

- An experienced senior social work/HSCP practitioner
- Skilled in ASP, complex assessment, and multi-agency coordination
- Able to manage evidence, analysis and risk
- Confident managing provider engagement and parallel processes
- Supported by Legal Services where required

The LIO:

- Coordinates the investigation team
- Oversees information gathering
- Allocates tasks
- Ensures milestones are met
- Provides updates to the Oversight Group
- Ensures ASP Principles remain central
- Maintains secure records
- Leads quality of analysis
- Supports interviews with adults, families and staff
- Leads multi agency triangulation of evidence

LSI Team

The LSI Team may include:

- Council Officers (for individual ASP inquiries)
- Nurses, AHPs and other health professionals
- Quality Assurance/Contract Monitoring staff
- Commissioning
- Clinical nurse specialists (e.g., tissue viability)
- Medicines Management
- Mental Health Officer(s)
- Case-holding social workers
- Advocacy leads
- Administrative support (critical for minute taking, file organisation and document control)

6.9 LSI Oversight Group

The Oversight Group ensures:

- Strategic leadership
- Accountability
- Pace and progress
- Problem-solving where barriers arise
- Adherence to legal duties and ASP Principles

- Clear communication to senior governance (APC, COG, SMT, Care Governance)

Membership:

- Independent senior chair (HSCP)
- Chief Social Work Officer
- Senior Manager(s) from HSCP
- Police Scotland
- NHS GGC
- Care Inspectorate
- Commissioning / Contracts
- Legal Services
- MWC / HIS / OPG where relevant
- Representatives of placing authorities
- Advocacy (where required)

Oversight Group Duties

- Receive and analyse updates from LIO
- Monitor milestones
- Escalate system level concerns
- Coordinate media handling with Communications
- Provide governance assurance
- Decide when conditions for closure may be met

Meeting frequency is proportionate to risk — weekly at the outset for high-risk LSIs, then reducing when safe.

Section 7: Conducting the Large-Scale Investigation

Conducting an LSI is a time bound, evidence led, multi-agency process that balances immediate protection with fair, thorough inquiry. This section sets out the standard national workflow.

7.1 Establishing milestones and pace

Set clear, time bound milestones at the outset and review them routinely to prevent drift. Milestones should cover evidence requests, interviews/focus groups, clinical reviews, risk actions, provider meetings, reporting checkpoints, and the draft/issue of the Outcome Report. Pace is proportionate to risk and overseen by the LSI Oversight Group.

7.2 Initial investigation activity

The Lead Investigation Officer (LIO) convenes the team promptly after the Planning Meeting to confirm objectives, allocate tasks, agree the data/evidence pack, and plan the schedule of interviews, observations, record reviews and provider engagement. Early actions typically include:

- Requests for clinical and care records, incident/complaint logs, rota/skill-mix, training/competence records, and governance minutes.
- Confirmation of parallel processes (police, regulatory, HR/disciplinary, adverse events, clinical governance).
- Activation of communications & advocacy offers; accessible information arrangements; and any immediate protections required by risk assessment.

7.3 Individual ASP inquiries and possible learning reviews

Where specific adults are identified as at risk, conduct individual ASP inquiries/investigations in parallel with the LSI and enact protection plans without delay. Consider whether the circumstances meet criteria for ASP Learning Reviews and escalate via local procedures and the Oversight Group if indicated.

7.4 Duty of Candour and openness

Where criteria are met, the organisational Duty of Candour applies (transparency, apology, learning). This may require notifiable incident handling for regulated providers, alongside the wider ASP process. The LIO and Oversight Group ensure alignment with regulatory expectations and local clinical/care

governance frameworks. A crucial part of the duty of candour is the apology. Apologising is not an admission of liability. This is the case, regardless of whether the organisation is in health or social care, or public or private sectors. This statutory duty of candour was brought into law in 2014 for NHS Trusts and 2015 for all other providers and is now seen as a crucial, underpinning aspect of a safe, open and transparent culture. It is so fundamentally linked to concepts of openness and transparency.

A notifiable safety incident (notifiable to the Care Inspectorate) is a specific term defined as the duty of candour regulation. It must meet all three of the following criteria:

1. It must have been unintended or unexpected
2. It must have occurred during the provision of an activity regulated by the Care Inspectorate
3. In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care. This element varies slightly depending on the type of provider.

If any of these three criteria are not met, it is not a notifiable safety incident (but the overarching duty of candour, to be open and transparent, always applies).

7.5 Meeting with the agency/service subject to the LSI

Unless restricted by police advice, maintain planned, respectful engagement with the provider: explain scope and milestones, agree a Liaison Lead, request evidence, arrange access to people/places/records, and set expectations for immediate risk controls. If police advise limited engagement, document the rationale and phase provider contact to avoid prejudicing any criminal inquiry.

7.6 Interviews, focus groups and lived experience evidence

Plan interviews/focus groups with adults, families and staff using trauma-informed, rights-based methods. Provide independent advocacy and communication support and minimise duplication by sharing information appropriately among partners. Attend to timing, setting, accessibility (Easy Read, interpreters, communication aids) and consent/capacity/undue-pressure considerations. Offer Lomond & Argyll Advocacy proactively from the start; use standard letters/telephone scripts for invitations/updates; capture participation preferences and adjustments in the case file. Supported decision making allows adults to express their will and preferences within the context of substitute decision-making. The purpose of supported decision-making is to ensure that the individual's will and preferences are central to and fully respected in decisions that concern them. There are briefings available on supported decision-making from [Iriss](#) and from the [Mental Welfare Commission](#).

7.7 Information sharing, records and data governance

Partners must share necessary, relevant and proportionate information to progress the LSI and protect adults, consistent with the ASP Code and data-protection law. Create and maintain a secure multi-agency record set for the LSI and manage retention per local archive/records schedules (e.g., SCARRS).

7.8 Organisational chronologies

Develop an organisational chronology to reveal patterns, triggers and deterioration or improvement over time. Populate it with ASP referrals, inspection and contract findings, staffing/leadership changes, enforcement, clinical indicators (e.g., pressure damage, falls, and medicines incidents) and adult/family feedback (Appendix 7).

7.9 Professional curiosity

Promote a culture of professional curiosity within practice across the LSI team: check inconsistencies between narratives and records; look for systemic contributors (workforce, supervision, training, culture, leadership, environment); and visit outside office hours where relevant to validate the lived reality of care.

7.10 Communications and media handling

Adopt a single, coordinated media line agreed via HSCP Communications; update as the LSI progresses; and brief local elected members where appropriate. Where there is parallel police investigation or potential for one, agree media handling with the police SIO to protect evidential integrity and safety. The Media Strategy template can be used to support this; instruct staff that all media queries are directed to Communications; maintain a log of public statements/FAQs.

7.11 LSI team welfare

LSIs are intensive and can be emotionally demanding. The Oversight Group and LIO should ensure:

- Protected time and workload adjustments for LSI team members;
- Reflective supervision/peer support and opportunities to debrief;
- Access to wellbeing resources, and escalation if staff are overwhelmed.

7.12 Oversight during the investigation

Hold regular Oversight Group meetings at a cadence proportionate to risk (often weekly at outset). The LIO's update should include status vs. milestones, new/emerging risks, barriers requiring senior intervention, proposed scope/timeline changes, and impact on adults/safety. Ensure onward governance reporting to APC/COG/SMT/Care Governance as locally agreed.

However, updates are likely to include:

- Overall current status of the LSI
- Any new or emerging risks identified
- Completion of milestones
- Any challenges or difficulties
- Positive progress and good practice by the LSI Team
- The impact on the adults using the service subject to an LSI
- Any proposed changes to the original plan or timescales, and why

The LSI Oversight Group holds responsibility for updating other key stakeholders who are not part of the group. This may include (but is not limited to) other Heads of Service, the Chief Social Work Officer, the Adult Protection Committee (APC), the Chief Officers Group (COG) and other senior managers.

7.13 Concluding investigation activity

When evidence indicates adults are no longer at current risk of harm at scale, the LIO drafts the LSI Outcome Report for an Outcome Meeting. That meeting confirms closure or continuation (with defined next steps) and agrees improvement/assurance hand-over, post LSI progress reviews, and a learning debrief.

Section 8: Closing a Large-Scale Investigation

Closing a Large-Scale Investigation (LSI) is a formal, evidence-based decision confirming that adults are no longer at current risk of harm at scale. Closure is not the end of safeguarding: actions may continue (e.g., individual ASP plans, regulatory/contract oversight, improvement monitoring). This section sets out the national expectations and embeds the WDHSCP local requirements for outcome reporting, the outcome meeting, notifications, progress reviews, and the learning debrief.

8.1 General circumstances when an LSI should end

An LSI should end when the service/setting no longer places adults at current risk of harm at scale. Evidence reviewed by the LIO and multi-agency team should demonstrate that:

- Immediate and systemic risks have been removed or sufficiently reduced, and reasonable assurance exists that risks will not re-emerge in the near term.
- Any remaining issues can be managed effectively through other mechanisms (e.g., individual ASP plans, provider improvement plans, regulatory/contract monitoring, clinical governance).
- Partners agree that the objectives are met and any further actions have named owners, milestones and oversight outside the LSI.
- Where evidence remains ambiguous, the Oversight Group should extend the LSI with time-bound tasks and a defined re review date, or if risks are now person specific close the LSI and continue with individual ASP and commissioning/regulatory follow-up.

8.2 Large Scale Investigation Outcome Report (prepared by the LIO)

This report should provide a defensible account of: (1) why the LSI began; (2) what was done; (3) what was found; (4) what changed; and (5) what will sustain improvement post closure. The report supports the Outcome Meeting decision.

Minimum content – National Report template should be used (appendix 8):

1. Scope & rationale for LSI (triggers/criteria, adults/services affected, timelines).
2. Methods (records review, interviews/focus groups, observations, organisational chronology, specialist clinical input, triangulation with police/regulatory data).
3. Findings (themes on leadership/governance, workforce, care quality, environments, risk indicators, culture).
4. Risk position (what has improved; residual risks; protection arrangements for any individuals, contingency planning).
5. Assurance (who will do what after closure provider, commissioning/QA, CI/HIS, NHS clinical governance, advocacy involvement).

6. Recommendations & hand-over actions (SMART, owners, review cadence).
7. Communications & participation (how adults/families/advocacy were engaged; equality/trauma-informed adjustments; how closure will be communicated).
8. Data / Records (summary of evidence sources; secure retention arrangements per local schedules).

8.3 Large Scale Investigation Outcome Meeting (multi-agency)

This will decide on the basis of the Outcome Report and professional judgment whether:

- a) the risk is reduced
- b) the LSI should continue with defined next steps, or
- c) the LSI should transition to other oversight routes (e.g., commissioning/CI) with no further LSI activity.

Chairing & participation. Wherever possible, the meeting is chaired by the same senior officer who chaired the initial LSI discussion; invitees mirror those at instigation, plus any new stakeholders needed for assurance. Where appropriate the provider may attend parts of the meeting.

Core agenda (Appendix 9):

1. Confirmation of attendees, apologies, and purpose.
2. LIO summary of the Outcome Report and evidence.
3. Risk position and closure test are adults no longer at current risk of harm at scale?
4. If closing:
 - Provider improvement plan elements that remain; success measures and timeframes.
 - Contingency plan
 - Commissioning/QA monitoring plan (moratorium status; enforcement linkage).
 - Regulatory coordination (CI/HIS requirements, schedules).
 - Clinical & care governance follow-up
 - Communications plan (adults/families/advocacy; staff; elected members; media line).
5. If continuing; scope, milestones, evidence gaps, new timelines and resources.

8.4 Notifications on conclusion of an LSI

On closure, everyone notified at commencement should be informed of the outcome and the arrangements replacing LSI oversight. Depending on the setting, this includes:

- Care Inspectorate (registered services) via their notifications route. Health Improvement Scotland where clinical services are concerned.
- Other local authorities (placing councils) with details of review expectations. GPs for affected adults.
- MWC/OPG where capacity, mental disorder or proxy powers were relevant.

- Provider formal closure letter and improvement/assurance hand-over.
- Adults and families receive a plain-language closure letter (with advocacy signposting), prepared with the HSCP Communications lead and aligned to the media strategy; staff are instructed to direct media queries to Communications.

8.5 Progress reviews (post LSI monitoring)

To ensure that improvements are sustained and that risks do not re-emerge especially important given national evidence that LSI volumes and settings fluctuate over time.

Design. Reviews should be time-bound and proportionate to risk, focusing on:

- Whether provider actions are completed and embedded (not just planned).
- Outcome measures (e.g., falls/pressure damage/medication incidents; workforce stability; supervision quality; resident/family feedback; advocacy reports).
- Regulatory/contract assurance updates and any enforcement outcomes.
- Escalation criteria, clear triggers for reconvening an initial LSI discussion if risks recur.

8.6 Future Learning Debrief

This captures learning for system improvement and prevention locally and, where relevant, nationally. The debrief should consider:

- Were the right people with the right skills involved at the right times?
- Did milestones and communications work for adults/families/staff?
- How well did we integrate police/regulatory/clinical processes?
- What prevention signals (early indicators) did we miss or use well?
- What should change in local procedures (e.g., thresholds, templates, intelligence flows)?

Actions from this may include

- A short Learning Note for the APC and care governance forums (shareable with CI/HIS/Police Scotland partners as appropriate).
- Updates to local guidance, templates, and briefing materials (including the 7-Minute Briefing), and staff development offers (e.g., on professional curiosity, chronology, trauma-informed practice).

Section 9: Appendices

Appendix 1: Frequently asked questions about LSIs

What is a Large-Scale Investigation (LSI)?

A Large-Scale Investigation or LSI is a specific type of Adult Support and Protection investigation. It applies to services provided by agencies and/or organisations, and can include day services, outreach facilities, NHS or other health facilities, care homes, supported accommodation, or when someone is receiving services in their own home. It can also apply when there is an alleged harmer, unconnected with a service, placing more than one adult at risk of harm. It may be required when there is a belief that a particular service, or an alleged harmer, may be placing more than one adult at risk of harm.

Who are 'adults at risk'?

An 'adult at risk' is a legal term from the Adult Support and Protection Act 2007 (Scotland). It means someone who is 16 years and over, and who has been assessed as meeting all three of the following criteria: 1. They are unable to safeguard their own well-being, property, rights or other interests; 2. They are at risk of harm; and 3. That because they are affected by disability, mental disorder, illness or physical or mental infirmity they are more vulnerable to being harmed than adults who are not so affected. The presence of a particular condition does not automatically mean an adult is an 'adult at risk'. It is important to stress that all three elements of this definition must be met. It is the whole of an adult's particular circumstances which can combine to make them more susceptible to harm than others. In terms of an LSI, it means that if more than one adult is assessed as being 'at risk' in relation to a service or organisation, or a common alleged harmer, an LSI may apply.

What causes an LSI?

This can vary. In some cases, it may be that a perpetrator, or several perpetrators, are purposefully causing harm to people. In other cases, there may be a poor standard of care in a service that has caused adults to be at risk of harm. Part of the reason for an LSI is to understand, and take action to address, the reasons why people are at risk of harm.

What does an LSI aim to achieve?

An LSI is an Adult Support and Protection intervention, and it aims to keep adults at risk of harm safe. Many professionals from different agencies and disciplines work together to investigate the reasons for the risk of harm. Then, collaboratively and in a coordinated way, the LSI then takes action to stop it. It's important to understand that an LSI is about Adult Support and Protection and is time limited. It is not an ongoing process for addressing poor standards of care in a service.

How long does an LSI take?

It varies. Each LSI is unique and may involve many adults at risk of harm, or only a few. The circumstances involved in an LSI may be particularly complicated and this may mean an LSI takes a longer time. On average, LSIs take between two and four months to complete, but it is not unusual for LSIs to take longer than this. It is important for everyone involved, especially the adults at risk, that LSIs are timebound. This means that the team leading the LSI agree milestones and targets with their partners and clearly communicate these to all involved in an LSI. Sometimes these may change during the course of an LSI, but clear timescales will help prevent drift and delay during an LSI.

Do LSIs only take place in care homes?

No. While care homes are common places for LSIs to take place – because they usually have many residents who may meet all three of the criteria for an ‘adult at risk’ – they are not the only settings. For instance, a hospital ward is also likely to have many adults who could meet all three criteria for an ‘adult at risk’. LSIs can also take place in the community. There may be, for example, a service that provides care in people’s own homes that is subject to an LSI.

Can an LSI take place in NHS services?

Yes. For instance, an LSI may take place on a hospital ward, or in NHS services being provided in the community. Private health services, including private hospitals, could also be involved in an LSI.

Can an LSI take place in a service that’s ‘unregistered’, as in not registered with a regulatory body such as the Care Inspectorate, or in services unconnected with the NHS or Councils?

Yes. For instance, organisations such as charities and community groups, which are not registered with regulation bodies, may be subject to an LSI. Organisations do not have to provide health and social care services to be subject to an LSI. In these cases, awareness of the LSI process is likely to be lower than in health and social care settings. This usually means the team conducting the LSI may need to spend more time explaining the purpose and process of an LSI.

Do LSIs take place in children’s services?

No. LSIs are Adult Support and Protection interventions and do not apply to services or circumstances related to children under the age of 16. It does however apply to those aged 16 and over who may be supported by a children’s service. It is unlikely - but not impossible.

Do LSIs take place outside of Scotland?

No. They are an approach to Adult Support and Protection in Scotland. This is underpinned by Scottish Adult Support and Protection legislation. In some cases, a service or organisation subject to an LSI may have a head office outside of Scotland. But as long as the service itself is provided in Scotland, the Scottish Adult Support

and Protection legislation applies. Should the service or organisation also operate outside Scotland, and there are similar concerns outside Scotland to those which gave rise to the LSI, then the relevant legislation in that jurisdiction applies. However, it will obviously be important for co-ordination and information sharing between any investigations into the same organisation, regardless of where they take place.

Does an LSI mean that a service will close?

Not necessarily. In fact, it is rare that when a service undergoes an LSI it means a service will shut completely, although it can happen. The aim of an LSI is to end the risk of harm and mitigate the risk of future harm. As long as there are other ways to achieve this, the service is unlikely to close completely.

When does an LSI end?

An LSI ends when the adults who were at risk of harm no longer face these risks (although individual Adult Support and Protection investigations may still be ongoing). This is because an LSI is about Adult Support and Protection (and is not about supporting services to improve). If an LSI ends, it does not mean that a service or organisation has no ongoing issues. (There is likely to be an action plan that addresses these.) But it does mean that adults who were previously at risk of harm when the LSI started are now either not at risk of harm, or any inquiries/investigative activity required is being progressed on an individual – rather than large-scale – basis.

Can LSIs happen to a service more than once?

Yes. After the LSI has finished, there will be reviews of the service to ensure that the improvements needed to keep adults safe have been maintained. If they have not and adults are once again at risk of harm, or if new risks emerge to adults, there may have to be another LSI.

How is an LSI recorded in the Minimum Dataset?

Currently, the ASP minimum dataset collects information, quarterly, on the number of LSIs commenced in that quarter by service type. Other indicators may develop in the future. All ASPCs are required to accurately record the number and service type of LSIs as part of their ASP minimum dataset reporting responsibilities.

Appendix 2: Sample agenda template for multi-agency initial LSI discussion

This agenda template can be used at the multi-agency initial LSI discussion to ensure that all essential elements of discussion are covered.

1. Introduction and apologies
 - Confidentiality reminder
2. Summary of concerns and current information
3. Immediate considerations of harm identified and assurance that they have been addressed
4. Evidence presentation by attendees
 - Following all evidence presentation, analysis of the themes of harm together and discussion of any gaps in the evidence.
5. Discussion of whether, based on the evidence, there is **more than one adult at risk of harm**, as defined in the Adult Support and Protection (Scotland) Act 2007
6. Decision: is an LSI required?
 - If yes, continue the meeting to item 7.
 - If no, attendees to suggest alternative action (if any) and how this decision will be reviewed.
 - If a decision cannot be reached, discuss how to escalate the decision-making process.
7. Initial LSI planning
 - Determine any immediate actions that need to occur to safeguard individuals, for example protection plan, protection orders, moratorium on placements, health interventions.
 - Determine whether liaison with Police Scotland is needed, for any suspected criminality.
 - Allocate responsibility for notifying relevant public bodies that an LSI is to commence
 - Ensure all involved organisations are clear about expectations.
 - Consider gaps in information identified and ascribe actions to address these gaps.
 - Identify Lead Investigation Officer.
 - Identify appropriate lead to communicate with the organisation subject to an LSI.

- Identify appropriate lead to communicate with the adults who use the service, their families and supporters. This to include pro-active work ensuring access to independent advocacy.
 - Identify appropriate lead(s) for any other notification tasks and agree timescales for completion of these.
 - Agree membership of the LSI Oversight Group.
8. Consider if a media strategy is required at this stage. This should be inclusive of, and agreed by, all agencies. The police should also be consulted.
9. Agree any initial milestones with timescales, including date of the LSI Planning Meeting.

This meeting is to be minuted and minutes should be circulated within five working days.

Appendix 3: Sample letter notifying an organisation that they are now subject to a Large-Scale Investigation

We are writing to inform you that [insert name of organisation] is now subject to a Large-Scale Investigation.

A Large-Scale Investigation (or LSI) is undertaken as per Adult Support and Protection legislation in Scotland. It applies to services provided by agencies and/or organisations and may be required when there is a belief that a particular service, or an alleged harmer, may be placing more than one adult at risk of harm. There is more information about Large Scale Investigations in the enclosed leaflet.

We would like to stress that Large Scale Investigations are an Adult Support and Protection intervention under the Adult Support and Protection (Scotland) Act 2007. Our primary concern is assessing and addressing the risk of harm to adults who use your service. This means that, during the Large-Scale Investigation, we will work with you to make sure adults are no longer at risk.

We understand that the news of a Large-Scale Investigation may cause anxiety for your organisation, including your staff and the adults who use your service. Please be assured that we seek to make Large Scale Investigations as supportive as possible. We start from the position that all services wish to provide a good standard of care and not cause harm.

[Specific information about this particular LSI can be inserted here].

You have a named contact, [insert name and job title], who will work with your organisation, keep you informed about the progress of the Large-Scale Investigation, make clear any actions or information we need from you, and schedule regular meetings with you. [Name] can be contacted on [contact details] and will be in touch shortly. We would also appreciate a named contact at your end to ensure clear channels of communication.

[Specific information about any immediate action]

We have also notified [insert who else has been notified] about this Large-Scale Investigation, as per our duties.

Appendix 4: Sample letter notifying adults at risk and/or their families that a Large-Scale Investigation is taking place in a service they use

We are writing to inform you that [insert name of organisation] is now subject to a Large-Scale Investigation. A Large-Scale Investigation (or LSI) is undertaken as per Adult Support and Protection legislation in Scotland. It happens when we have learned that a particular service, or an alleged harmer, may be putting more than one adult at risk of harm. There is more information about Large Scale Investigations in the enclosed leaflet.

Firstly, we would like to reassure you that we will keep you fully informed throughout about the progress of the Large-Scale Investigation. We understand learning that a service that you use is subject to a Large-Scale Investigation might be upsetting. Please be assured that we seek to make Large Scale Investigations as supportive as possible and we will always seek to minimise any disruption to your life.

The reason [name of organisation] is subject to a Large-Scale Investigation is [insert reason]. This means [further information can be inserted here].

We will uphold your rights throughout the Large-Scale Investigation. We will treat all information you share with us legally and sensitively. We are always interested in your views and experiences of [insert name of organisation] and value any observations that you may have.

Independent advocacy is available to you during a Large-Scale Investigation. Independent advocacy is a way to make sure your rights are recognised, respected, and secured. An advocacy worker is independent of the Large-Scale Investigation process and can help make sure your voice is heard. The service is free to you, and we recommend you speak to a local advocacy worker at [insert details here].

You have a named contact, [insert name and job title], who will work with you and anyone, such as a family member, you would also like us to contact. [Insert name] will keep you informed about the progress of the Large-Scale Investigation and make clear any actions or information we would like to request from you. [Name] can be contacted on [contact details] and will be in touch shortly. You can also contact [name] and they will respond as soon as possible.

If you would like any further information at this stage, please do get in touch.

Appendix 5: Sample letter notifying placing councils of a Large-Scale Investigation

We are writing to inform you that [insert name of organisation] is now subject to a Large-Scale Investigation. We have identified that [insert names of adult(s) at risk] [is/are a user/users of the service and has/have] been placed there by your council.

[Specific information about this particular LSI can be inserted here, and any immediate action taken].

[If the Council is outside Scotland] Please note, a Large-Scale Investigation is part of Scottish Adult Support and Protection legislation. If you wish to know more, please read the enclosed leaflet.

You have a named contact, [insert name and job title]. [Name] can be contacted on [contact details] and will be in touch shortly. We would also appreciate a named contact at your end to ensure clear channels of communication.

Appendix 6: Sample agenda template for LSI Planning Meeting

1. Introduction and apologies
 - Confidentiality reminder

2. Confirmation that an LSI will be initiated in the named organisation
 - Confirmation of Lead Investigating Officer and team conducting the LSI
 - Confirmation of Chair of the LSI Oversight Group
 - Confirmation that required notifications have taken place, including to the Care Inspectorate (when in a service registered with them)

3. Discussion of evidence so far, including any updates since the multi-agency LSI discussion
 - Clarification of any parallel investigations
 - Clarification of any cross-boundary issues and how these will be managed

4. Agreement of LSI objectives (as SMART as possible).
 - Agreement and recording of these objectives

5. Agreement of initial risk management plan, including immediate actions to protect adults at risk

6. Discussion of the adults' needs who use the service, including any reviews to care and support packages and planning for an engagement strategy

7. Resource allocation and workload issues

8. Agree an action plan, priorities, and timescales to meet LSI objectives

9. Agree date of next meeting

This meeting is to be minuted and the minutes, along with the action plan, should be circulated within five working days.

Appendix 7: Organisational chronology template for use in Large Scale Investigations

Chronologies provide a key link in the chain of understanding needs and risks, including the need for protection from harm. When used with an individual in Adult Support and Protection, they set out key events in sequential date order and give a summary timeline of that person's circumstances, patterns of behaviour and trends in lifestyle that may greatly assist any assessment and analysis. Chronologies written in this way also give more insight into trauma and its impact, supporting a trauma-informed method of practice.

Chronologies are a logical, methodical and systematic means of organising, merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration, investigation and assessment.

An organisational chronology can be used in prevention work for LSIs, as well as when an LSI is underway. It works to the same principles as individual ASP chronologies, but in this case the focus is on the agency, service or organisation subject to an LSI. All agencies involved with an LSI should be invited to contribute their knowledge in order to create a comprehensive timeline, which can be added to as more background information becomes known and/or the LSI progresses.

Good organisation chronologies contain comprehensive yet succinct entries, with enough detail to make them easily understood. There is no definitive list of what to include in an organisational chronology, but the following should be considered for inclusion:

- Previous LSI activity (including when a potential LSI was under discussion, but the decision was taken not to proceed)
- Current and previous individual ASP referrals
- identification and analysis of patterns of ASP activity in the organisation (for instance, repeated instances of financial harm) and action taken to address these
- any relevant ASP activity in other services from the same provider or provided by the same organisation
- significant changes in the management or organisation of the service
- outcomes of inspection activities, including outstanding or completed recommendations or requirements
- analysis of the risk in the organisation, including strengths and protective factors in the organisation
- views of multi-agency partners, including information on criminal investigations
- a person-centred approach that reflects the views of adults that use the service.

- intelligence from any prevention activity (including Early Indicators of Concern indicators)

Whilst forming the chronology, and to support greater analysis, it is important to give thought to the level of risk arising from significant events experienced by the individuals who use the service.

Chronology template	
Organisation name:	
Chronology compiled by:	
Date last compiled: (dd/mm/yyyy)	

Date or date range (dd/mm/yyyy- dd/mm/yyyy)	Significant event(s) in the organisation	Outcome (What happened in the organisation as a result of the event, including any action taken)	Multi-agency analysis and level of risk	Source: Name (and agency where applicable). May be anonymised in the interests of safety

Analysing the chronology

Once completed, it is important that the information in the chronology is analysed for patterns and gaps. Questions for reflection might include:

- What patterns of risk are identified?
- What does this mean for the adults who use the service?
- What has been tried in the past, with what success, and for whom?
- Are there any gaps in information or further questions that need to be asked?

- Is there evidence of when things have been different? How is this accounted for (for instance management, staffing, training?)
- What are the organisation's strengths and resiliencies?

Appendix 8: Large Scale Investigation Outcome Report

The Lead Investigation Officer should prepare a Large-Scale Investigation Outcome Report when all actions agreed on at the Large-Scale Investigation Planning Meeting have been completed, and the milestones agreed locally have been achieved. This template can be used to structure that report.

Outcome report	
Name and address of service, agency or organisation subject to LSI	
Type of organisation and registering body (if any)	
Areas of harm/indicators of concern being investigated	
Investigative Officers and other agencies involved	<p>(Start with Lead Investigating Officer)</p> <p>Include here details of all public bodies involved and their role in the LSI</p>

Section 1: Introduction and Background

Introduction and background report	
Introduction	<p>The decision to proceed with this LSI was made at the [name of meeting] on [date], chaired by [name]</p> <p>The purpose of this LSI is to explore and report on relevant factors relating to adult protection concerns raised by [name of referrer(s)] and relate to [number of adults at risk] within [name of service].</p> <p>Attach chronology of events as an appendix</p> <p>Include consideration of an impact statement upon the service, including the impact on those adults who use the service.</p> <p>Also include information shared with the families of those who use the service.</p>
Background and summary of incident(s)	<p>Provide an account of the lead up to the LSI, the organisation involved, number of adults involved in the investigation and potentially the wider impact upon others not directly involved.</p> <p>Record any immediate action taken e.g. suspensions, internal investigation / disciplinary action</p>
Outline of investigation process	<p>Indicate dates of planning meeting, milestones agreed during the process, dates of LSI Oversight Group meetings and any disagreements during the LSI.</p>

Findings	Finding 1 – include adult’s name, reference or initials, as necessary, any action taken already, and outcome Finding 2 – Finding 3- [Repeat as necessary]
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Section 2: Analysis and Findings

Analysis and Findings	
<p>Analysis: Pull together the salient points of the LSI in a clear and concise manner, in order to understand the LSI's significance. Use of headings may provide clarity e.g. medication, falls, financial harm, assessment & care management, mental health, communication, etc.</p> <p>Indicate any themes identified and how they came to light.</p> <p>Include consideration of risk and how it is proposed this be managed, if not already in place.</p> <p>Include the views of adults who use/have used the service.</p> <p>Include details of any learning reviews (or other relevant reviews, such as Significant Adverse Event Review or Fatal Accident Inquiry) related to this LSI. Include the rationale why any of these were progressed. Also include, if relevant, the rationale not to progress a review.</p>	
<p>Conclusions: This may include wider considerations e.g. need for service / staff improvement, change in policy / procedures, escalation of concerns, preventing future LSIs, etc.</p>	

Date	
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Name of person completing report	

Appendix 9: Sample agenda template for LSI Outcome meeting

1. Introduction and apologies
 - Confidentiality reminder
2. Presentation and discussion of LSI Outcome Report
3. Ascertaining any outstanding concerns at the service, and assessment of their severity
4. Clarifying any individual ongoing ASP cases
5. Decision: Is the LSI to end?
 - If yes, continue the meeting.
 - If no, attendees to give reasons for not ending the LSI, what is to be gained by its continuance, and how this decision will be reviewed.
 - If a decision cannot be reached, discuss how to escalate the decision-making process.
6. Next steps planning
 - Creating an improvement plan (if needed). This should be done in close collaboration with any other agencies who also require improvement planning.
 - Assigning responsibilities for notifying all stakeholders that the LSI is concluded
 - Assigning responsibilities for notifying the Care Inspectorate (if the LSI was in a service registered with them) and/or any other relevant public bodies that the LSI is concluded
 - To decide if the media need to be notified, how this will be coordinated, and who has responsibility for this
 - Ensuring all appropriate risk assessments have been completed, and that protection or care management plans are in place
 - Discussion on how any improvements can be sustained in order to prevent recurring LSIs
 - Agreement on how progress will be reviewed

7. Reflections

- Any themes that may be relevant to future learning
- How feedback on the process will be gathered (if it hasn't been already)
- The experiences of the adults at risk, including their access to advocacy
- Staff welfare during the LSI and any actions/learning arising from this
- Agreeing a date for a Future Learning debrief.

This meeting is to be minuted and minutes should be circulated within five working days.