Appendix

1 Allegations of abuse in care home settings

1.1 There were 42 cases where the alleged abuse occurred within a Nursing and Residential care home setting. 9 of these were within care homes registered for the EMI client group. The majority of these settings had only 1 or 2 referrals recorded against their service. However there was a small number of providers who had more than 2 referrals during this period. None of these providers with 2 or more referrals were registered as providing EMI placements.

1.2 Provider A had 6 referrals recorded with allegations against staff members. The concerns raised were in the form of allegations of neglect (1) and physical, emotional and psychological abuse (5). The overall outcome for 5 of these referrals were 'proven/upheld', and one being 'unlikely on the balance of probability'.

The outcomes for these victims were that the risks were removed. The alleged perpetrators were taken through the provider's disciplinary process and dismissed. Additional training for the remainder of the staff was implemented. This Provider made changes to their policy and procedures to improve safeguarding measures. This care home has subsequently closed, however this was not due to safeguarding concerns. The home was in administration and the decision to close was on the grounds that is was no longer a viable business.

1.3 Provider B has a number of homes across Denbighshire and had 5 referrals recorded: an allegation of neglect by staff which was found to be likely; 1 allegation of sexual abuse by another service user was found to be inconclusive; 3 allegations of physical abuse - 1 by another service user and found to be unlikely to have caused abuse and 2 against staff members, the outcome of one was inconclusive i.e. insufficient evidence to support that abuse had or had not taken place and the other being unlikely on the balance of probability.

The outcomes for the alleged victims were that the risk were reduced or removed, and Individual Protection Plans put in place. The outcome for the alleged perpetrators were extra training for staff members and extra supervision for the service user. The sexual abuse case required the service user to be recalled back to hospital under the Mental Health Act. The provider made amendments to their current polices/procedures relating to staff manual handling etc.

1.4 Provider C had 4 referrals recorded, 3 involved allegations of service users abusing other service users, and 1 was an allegation against staff. Two of the allegations against another service user were categorised as sexual abuse. The outcome for the victim in one case was that the risks were removed due to change of placement and the other the risks were reduced with the implementation of an individual protection plan being. The overall outcome of the allegation was that 1 was inconclusive and 1 was likely on the balance of probability to have caused abuse.

The third referral was an allegation of physical abuse by another service user and was found to be proven/upheld. This resulted in risk reducing strategies being implemented in the form of an individual protection plan and a general protection plan being implemented to support the wider safeguarding concerns to other residents.

1.5 The referral relating to an allegation against a member of staff fell into the category of physical, emotional and psychological abuse, with an outcome of likely to have caused abuse. The risks were reduced for the victim and there was extra training and supervision for the staff member. The Provider made amendments to their current polices/procedures and were also subject to the escalating concern process at the time which resulted in increased monitoring from all agencies.

1.6 In summary the care homes where the alleged abuse had occurred showed that these allegations related to 25 staff being recorded as the alleged perpetrator. There were 5 referrals where it was not possible to identify an individual staff member – for example in one instance the alleged victim walked out of nursing home unnoticed by staff and was returned by police. Although the individual concerned had suffered no actual harm, the potential for harm was high for this individual and other residents – allegation of neglect in this instance was not targeted at a particular member of staff.

We received 5 referrals where the allegation was against another service user. A further 7 reported that a family or friend had been the alleged perpetrator, these referrals related to 6 financial abuse and 1 case of neglect and sexual abuse.

2 Allegations of abuse in individuals' own homes

2.1 The total number of referrals which occurred within a vulnerable adults own home where 14. These referrals related to allegations against care/support providers, family/friends and other service users.

2.2 The referrals relating to allegations against care/support staff came from 6 different care/support providers, with 1 provider having 2 separate referrals recorded against staff members. 4 cases related to neglect, 2 being disproved, 1 recorded as inconclusive and 1 being admitted. This staff member was taken through the employee's disciplinary process and redeployed.

2.3 The care/support provider with the 2 referrals involved the same vulnerable adult, naming 2 different staff members. The first allegation reported was neglect and related to medication error by staff. Following an investigation the outcome was inconclusive. There was additional training provided to the staff member. The provider reviewed their policies and an individual protection plan was put in place to improve safeguarding measures for the individual.

2.4 The second referral alleged emotional/psychological abuse when it was alleged that the staff member had spoken in an inappropriate manner with the alleged victim. The outcome of the investigation was disproved but the staff member was dismissed following other concerns relating to practice and a referral to DBS completed.