Appendix 2 – Case examples

Case 1

Over view of concern raised

93 year old lady in community hospital, concerns raised by health around potential financial abuse by a family member. These concerns related to ongoing issues and disagreements between relatives. The individual's Nephew and God-daughter were in conflict regarding future placement and management of finances. The ward staff reported that Nephew was encouraging the Aunt to sign legal documentation in relation to a Lasting Power of Attorney (LPA), it was deemed that the patient had fluctuating capacity at the time of this action.

The patient was deemed to have capacity to decide where she wanted to live, although there had been some doubt about this during this hospital stay. An independent advocate became involved to offer support around these safeguarding concerns.
God-daughter contacted Denbighshire safeguarding team to express her concerns regarding possible coercion by her Nephew, which she believed would jeopardise discharge from hospital. Counter allegation was then raised by Nephew regarding concerns about the God-daughter 'not acting in his aunt's best interest', this did delay discharge by a further day.
Advocate supported the patient to return to her own home, with a package of care and with additional support from God-daughter**.** It was felt that the situation between the two relatives was getting in the way of this lady's smooth discharge from hospital.

Action taken

Denbighshire safeguarding undertook initial enquiries in relation to determining if the lady was an adult at risk, was experiencing or at risk of abuse and as result unable to protect herself against abuse.

Designated Lead Manager (DLM) established the individual's capacity, to support gaining her wishes and views into the action she wanted. It was established quickly with the engagement of the advocate that this lady wished to return home. She was able to express herself clearly and was not wanting to reside in a care setting at this time.

The lady was requesting that both relatives were involved in supporting with managing her finances and did not want to pass the responsibility exclusively to her Nephew.

The Multi-disciplinary Team (MDT) concluded that there is reasonable cause to suspect that this lady was an adult at risk. However the threshold was not met to proceed to a strategy meeting under adult safeguarding procedures. There was no evidence of loss of material/processions or finances, the individual was not wanting any action other than that discussed with her advocate, She did not think she was at risk and was happy to have been allocated an advocate to help manage the conflict in her family. It was agreed the on-going support from advocacy would offer this lady the opportunity to make her own decisions and also inform her relatives of her wishes and views moving forward.

The difference/impact to the Citizen and or the service

This approach was person-centred, there was clear understanding of the personal outcomes that the adult wished to achieve 'what mattered' to this individual. Her outcomes were at the centre of the system to support the right solution could be found.
This 93 year old lady returned to her own home and was enabled to participate in the relevant decision- making with the support of an independent advocate. The family were clear about the wishes and views of their relative and of the on-going support - *Rights to safety need to be balanced with other rights, such as rights to liberty and autonomy, and right to family life.*

Case 2

Overview of concern raised

In-patient in Glan Clwyd Hospital (YGC)- Patient developed a Grade 3 Pressure Area. Allegation of neglect via Tissue Viability Nurse (TVN) as per reporting protocol.
Threshold met as the MDT felt that the concern required further enquiry to establish the circumstances on how the pressure area had developed in what is considered to be a safe environment.
The police were consulted and advised that this concern had not met their threshold and were content to proceed through the safeguarding process.
The Citizen was assessed as having capacity to consent and supported the decision to proceed.

Action Taken

Initial strategy meeting was convened but this was deferred to a later date to facilitate the attendance of the manager of concerned ward.
Appropriate safeguarding actions were taken by ward staff including a Datix report highlighting the concern. Citizen was subsequently transferred to a local hospital where a further Datix Report was submitted. The MDT agreed that as the Citizen was no longer a patient in YGC, the risks were reduced.
Final strategy meeting convened where the MDT agreed that with information and evidence shared, there was no requirement to proceed to a non-criminal investigation and that an outcome could be reached.
The MDT determined that there was sufficient evidence to confirm that staff took all appropriate actions to minimise the risks of the Citizen developing pressure areas and therefore neglect by staff was not considered. It was established, however, that the quality of the documentation was poor and needed addressing as a matter of urgency.
The recommendations from the meeting included- the ward manager will undertake quality monitoring of all staff, introduce further training supporting the importance of high quality documentation, the revision of polices in relation to managing and reporting safeguarding concerns. TVNs will provide guidance and advice to ward staff to ensure quality documentation is provided in relation to pressure area management and reporting.

The difference/ impact to the Citizen and or the service

The Citizen had given consent for the safeguarding process to be taken forward with the expected outcome that by raising the concern the process will minimise the risk of similar incidents occurring to other patients. The Citizen was advised of the outcome of the process and offered the opportunity of a case conference. The Citizen declined this stating they are satisfied with the outcome.

The additional training, revised policies and support from the TVNs should assist in reducing the risks of further similar incidents and will address the wider safeguards of patients on the ward.