Appendix 2 – Practice examples

1. Adult at Risk

Overview of concern raised.

A was a student at a residential college, he was an overseas student originating from a former British colony and entered the UK on a student visa.

His studies commenced in 2021 and during this time his country closed their borders restricting people leaving or entering, due to the pandemic. As a part of his studies and the requirements of the college, all overseas students required a named person/paid guardian to ensure that they have access to someone here in the UK. This citizen was also required to have a host family to support in non-term time.

Moving to a new college in September 2022, this citizen made an allegation of 'punishment beatings' by his father and of being fearful of further assaults if he were to displease his father.

Action taken.

An Adult at Risk report was submitted to the Local Authority and S126 enquiries were commenced. The necessary enquiries were undertaken involving key professionals in order to understand A's wishes and views in regards to these concerns i.e. personal outcomes.

Further checks were completed with other Local Authorities as A had resided outside of Wales, in other residential placements. There were no immediate risks as A had not had face to face contact with his family in 2 years.

A Strategy meeting was convened attended by Police, College safeguarding lead, social worker, DCC Solicitor, Care Inspectorate Wales (CIW) and Independent Mental Capacity Advocate (IMCA). The concern was complex as the allegation of abuse had allegedly occurred back in his home country when A had been a child.

A capacity assessment was completed regarding A's capacity to consent to the adult at risk report and his understanding to reporting this allegation to the Police. A was deemed to lack capacity around making these decisions. There was further discussion around A's capacity to make decisions about where he was living and his current care and support needs.

Police advised that as the allegation had allegedly taken place outside of the UK, it was outside their jurisdiction and were unable to do anything from a criminal investigation perspective. International checks and local checks were completed by Police, nothing had been reported to police during A's time here, until this disclosure in 2022.

Safeguarding actions were required as family were planning on visiting the UK to meet with their son. Adult Protection Plan (APP) was drafted and involved another Local Authority safeguarding team in England, as A would be residing with his host family, during the planned trip by his parent.

Reconvened strategy meeting was held after planned contact with family. The APP was reviewed and there was no further information or evidence to suggest that A had suffered any harm and the checks and monitoring had supported keeping him safe.

Other areas of care management were also being progressed in regards to 'deprivation of liberty'. There were new plans for A to return to his homeland over the Christmas period. The APP was further reviewed, the appropriate changes made to monitor and review, to support if any new disclosures of abuse were made following the trip back home.

A further reconvened strategy meeting was held, there was no new evidence to suggest that the A had suffered any harm. The checks and monitoring strategies are supporting keeping him safe, whilst

maintaining contact with family. The IMCA and social worker continue to work with A, while assessments are progressed around deprivation of liberty via the Court of Protection (DiDS).

The difference/impact to the citizen and or the service

The outcome of these enquiries clearly identified that A was an adult at risk and would be unable to protect himself from harm. These concerns were first raised while he was living in England, but there was limited information on how this progressed at that time. The disclosure was taken seriously; protective measures were undertaken to reduce the risk of harm. i.e. to make safe.

A was at the centre of this process, with further actions still ongoing in regards to his future plans. There is the need to ensure that his human rights are considered and acted upon to preserve these rights now and in the future.

2. Section 5 - 'Person in a Position of Trust'

Overview of concern raised.

Anonymous whistle blower made a report to Care Inspectorate Wales (CIW), raising concerns regarding a person in a position of trust. The reporter claimed that a member of staff working in a Care Home was abusive towards the residents.

The allegation stated that the carer would ridicule the residents by being offensive regarding their naked bodies when undertaking personal care and would swear at residents. The reporter stated that if challenged by other carers, this member of staff would respond with the statement 'that he was friends with the manager and if anyone said anything he would get them dismissed'. The reporter identified themselves as a person who worked at the home, but no other information regarding their identity was shared.

Action taken

A Strategy Discussion Meeting took place but observing the reference to possible friendship between the manager and the named carer, another manager from the service attended, including Police, CIW and Denbighshire Contracts team.

At the Strategy Meeting it was agreed an investigation was required under the Section 5: Person of Trust process. Safeguarding measures were implemented and the neutral act of suspension from work was executed.

In line with the Section 5 procedures the employee was sent a letter advising him that he was subject to the process as detailed within the Safeguarding Wales Procedures and was advised of the nature of the concerns/allegations.

During the investigation discrete checks were made with those residents with capacity to explore their experiences in being supported and cared for by this member of staff. Comments and feedback were extremely positive with residents stating that 'he was lovely'. They all knew that he was not in work, many said how much they missed him as he made them laugh. Members of staff were interviewed, none had any concerns and enjoyed working with him. The home manager was interviewed and confirmed that there was no personal friendship or any familial connection and had no previous concerns relating to this staff member. The carer was also interviewed and was extremely upset and tearful when he was made aware of the allegations and stated that he would never hurt or upset a resident.

The outcome of the investigation found no evidence to support the allegations and no additional actions were identified following the investigation.

The difference/impact to Worker and /or the service

There was personal impact for this carer as the allegation affected his own mental health and wellbeing, he was supported throughout the process by his employer and GP. The home manager acknowledged that there were ongoing challenges, knowing that there is someone working within the home who raised this unfounded allegation.

The conclusion of section 5 process determined on the balance of probabilities the concern was deliberately invented or malicious, there was clear evidence to prove there had been a deliberate act to deceive, as the allegations were deemed to be false.

A letter from the Chair of the meeting was sent to the individual informing of the outcome, explaining the reason for the outcome and the closure of this process. There were no additional safeguarding actions required, no further risks identified the case was then closed.