Appendix 2 - Adult At Risk Report:

Overview of concern raised.

This citizen was living in a nursing care home. Concerns were reported by the manager regarding an allegation of physical abuse (resident on resident). The citizen was kicked in the leg by the other resident. This was a one-off incident between the two residents, but this was the third report regarding alleged physical abuse within 6 months.

Neither resident had capacity to consent to nor understand the safeguarding process, the alleged victim was unable to provide her personal outcomes. Whilst there was no evidence to support that the citizen had suffered any emotional trauma as a result if this altercation, there was some evidence to support that she had suffered a minor injury. There was reasonable cause to determine that the alleged victim was an adult at risk as defined in the Social Services and Well Being Act (Wales) 2014, citizen was unable to protect herself from abuse, harm, neglect, nor the risk of it. Citizen had no insight into risks posed if she invades another person's space.

Action taken.

An Adult at Risk report was submitted to the LA and S126 enquiries commenced. All professionals consulted agreed with the decision to progress to Strategy Meeting, in line with the North Wales Protocol for the Management of Multiple reports of Incidents between Adults at Risk.

Police were involved during the S126 enquiries stage, they made decision not to take any action in regards to the allegation of assault, noting that both citizens were deemed to lack capacity in regards their actions. This was deemed to be a spontaneous incident, with no antecedence or warning to suggest that this incident could have been predicted and therefore could not have been prevented.

The care home consulted with the GP and Advanced Nurse Practitioner visited, examined the bruising, and prescribed analgesics for the pain.

To explore the personal outcomes regarding the safeguarding process, the citizens

family/advocate were consulted.

Strategy meeting was held, with the agreement of the multi-disciplinary team (MDT) that the citizen should be re-assessed to ensure that the current placement was able to meet her needs. It was established that her needs had changed, a new placement was required.

Further review of the alleged abuser was also undertaken, to ensure that the any wider safeguarding issue would also be addressed. An Adult Protection Conference was explored with the family/advocate, but this was declined. Appropriate actions and measures were in place for any wider safeguarding issues, no further meetings were held.

The difference/impact to the Citizen and or the service.

The outcome of these enquiries clearly identified that this citizen was an adult at risk and would be unable to protect herself from harm. An alternative placement was found where her needs will be more appropriately met.
The citizen was at the centre of this process, with further actions to ensure that any wider safeguarding issues for others in this care home were implemented. The Service reviewed current risk management strategies and amended specific risk assessments in relation to the alleged abuser.

Section 5 Referral

Overview of concern raised

Physical altercation between an Adult at Risk (AAR) and member of the public in fast food restaurant. This AAR required a 1 to 3 staff ratio when accessing the community, this was planned activity and the appropriate risk assessment were in place. Staff allegedly failed to follow the risk assessment and care plan to support this AAR. This resulted in a member of the public being horrendously attacked, hair pulled out, hit with a closed fist and was emotionally traumatised by the experience. The S5 referrals were submitted to the LA.

Action taken.

Strategy Discussion Meetings were held, it was agreed that due to the severity of the allegation and impact for both parties the AAR and the member of the public, these referrals needed to be progressed to formal strategy meetings. In line with the Section 5 procedures, the employees were sent a letter advising them individually that they were subject to the process as detailed within the Safeguarding Wales Procedures and was advised of the nature of the concerns/allegations.

At the initial Strategy meetings, the employer provided the accounts from the staff members, stating that the outburst came from nowhere and that they had been following the approved risk assessment. It was confirmed that the CCTV had been viewed by police, they advised that the accounts from the staff members were not accurate. Consent was given for the CCTV to be viewed by the members of the strategy meeting. It was clear that the staff had failed to follow the agreed risk managements strategies, they had not accessed a table by a window, they had failed to position themselves between members of the public, with one staff member in the queue for ordering food, before allowing time for the AAR being settled by a table. The police had considered the assault and determined that due to the AAR's capacity, they would not be taking any further action. This had caused some difficulties for the victim and her family due to managing their expectations following the incident which had proved to be problematic.

The staff initially gave their own accounts of the events, but they were vague and played down the incident when they returned to the care home. This raised several concerns around their professional practice and their reliability around professional conduct. The employer followed their HR process and concluded that all three staff members would be dismissed. All three employees were working under the Home Office Sponsorship Programme.i.e. working visas.

The employer has undertaken further actions under their own HR process and have referred through to the appropriate regulatory channels for Sponsorship employees and the termination of their employment status.

The difference/impact to Worker and /or the service

There is the personal impact for all three staff members regarding their current employment ending and the impact to their future careers in social care, depending on the outcome from the Home Office's action regarding their working visas.

The employer worked collaboratively with the police and the LA to support the implementation of the section 5 process - Person of Trust.

The conclusion of section 5 process determined on the balance of probabilities the allegation of neglect was substantiated for all three staff members. A letter from the Chair of the meeting was sent to each 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 were identified, and the case was then closed.