

**TRAINER’S VERSION**

**It is for attendees to answer the questions, following discussion in groups, but for you to guide them if they are completely on the wrong track.**

**The notes given underneath the answers are a guide only. You may come up with more detailed/different explanations/viewpoints.**

**Case Study – Part 1**

**Initial Information / Concern Arising**

J is male, in his 30’s, has an alcohol addiction and has some mobility difficulties that effect his ability to manage daily tasks, after suffering significant burns to his body from a previous incident. He has a partner, B, who is female and in her 30’s. J and B live separate from each other. J has lived in Oxfordshire for the past six months, previously living in a neighbouring county.

Various professionals have attempted to engage with J whilst he’s lived in Oxfordshire. During this time, he has been seen by 4 different GP’s, 2 Physiotherapists in Outpatients, referred to and offered appointments by the local drug and alcohol treatment service, and attended A&E on 7 separate occasions (each time in an intoxicated state with cuts and abrasions to his head, arms, legs).

J has not always fully co-operated with the treatment offered by health professionals, for example, on occasions walking out of A&E before treatment could be offered.

1. If J does not want to co-operate with interventions offered, do professionals have the right to force it on him? If no, why? If yes, why and how?

No to ‘force’.

Considerations need to be given to an adult’s self-determination (control over their own life) -vs- Is the person able to make their own decision in this respect?

2. Is this simply a case of an adult making unwise decisions?

Possibly. But what about capacity to make specific decisions when under the influence of alcohol (fluctuating capacity)? Can the decision wait?

3. What, if any, appear to be the current concerns and risks?

Possible self-neglect. Not acknowledging the possible benefits of intervention from drug & alcohol treatment service. Why is he walking out of A&E? What implications could this be having on his health/wellbeing?

4. Could J’s alcohol addiction impact on the actions and decision making of health care professionals involved with him?

Possibly. It may be easier for professionals to state he is making his own decisions not to engage with medical/health interventions, rather than giving consideration to the fact that alcohol intoxication may mean his is incapacious at that point in time.

**Case Study – Part 2**

**Formal safeguarding concern raised, and a Section 42 enquiry commenced**

A safeguarding concern is raised by J’s GP. J has not given consent to the GP for this. The type of abuse highlighted in the concern is ‘self-neglect’.

The safeguarding concern is received by the Safeguarding Adults Service who attempt to contact J on several occasions, to no avail.

During initial communication, information gained from J’s GP states she referred J to the local drug and alcohol treatment service for support, but J did not attend any appointments offered. Also, that J has had several A&E attendances for which his injuries have been stated to be “symptomatic of an intoxicated state”. The GP is concerned that J is self-neglecting to a point where his lack of self-care result in significant deterioration in health/wellbeing.

Information is also gained from the hospital authority who inform that notes show J has always appeared intoxicated when attending A&E, and his partner B has always answered questions on each occasion due to this and did not want anyone to speak with J alone.

The Safeguarding Adult Service open a formal Section 42 enquiry and call a strategy meeting for professionals to discuss the perceived/actual risks posed, and any interventions that may be used.

During the strategy meeting, J’s GP informs that his medical history states the significant burns he sustained were alleged to have been caused by his current partner, but J would not agree to proceedings against her, and he has not discussed the matter further, so the facts were still unknown. His GP states J has an ex-partner and child who live in a different county, having infrequent contact with his child which always takes place with his ex-partner present.

1. If J has not consented to the GP raising a concern, what justification could the GP give for raising it without his consent?

Holistic assessment of circumstances/use of professional judgement. Assessment may include (but not limited to) personal presentation e.g. J’s presentation (physically, mentally, practically (clothing etc.)), delays or evidence of obstacles in seeking or receiving treatment, evidence of frequent attendances to health services or repeated failure to attend (DNA).

“The GP is concerned that J is self-neglecting to a point where his lack of self-care result in significant deterioration in health/wellbeing”

1. At any point should a Mental Capacity Act assessment have been considered? If yes, for what specific decision?

Was J able to make a decision around consent to a safeguarding concern being raised? Was he intoxicated at the time?

What about A&E attendances? Did J require any interventions when he was medically assessed? Was his partner’s word taken, rather than J’s? Could any decisions have waited?

1. Does the new information change the concern at all? If yes, what is the concern?

Yes. There appear to be indicators of domestic abuse. Coercion and control need to be considered as it could be affecting J’s ability to make decisions about his situation.

1. What approaches could be made to gain engagement with J?

If J attends GP surgery, a joint meeting could be held there with the GP.

Information held at hospital in terms of J being a ‘regular’ to highlight if he attends again the concerns and for staff to attempt to engage him.

Does J have any regular daily routines? Could he be approached in his local community?

1. Who makes decisions and takes the lead in a case like this?

The Local Authority have duties to make enquiries under Section 42 of the Care Act 2014, “or cause others to do so” if they have reasonable cause to suspect an adult in its area (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. So the Local Authority would take the lead.

Also consider ‘team around the adult’, where the most appropriate agency takes the lead role in coordinating support. By most appropriate, we mean the agency whose staff are most likely to be successful in building a trusted relationship with the person.

In terms of any decisions, J should be at the centre of any enquiries and safety planning. His views, wishes and thoughts about his situation are central to any work undertaken by multi-agency staff.

1. Should a referral to Adult Social Care have been made? If yes, what for?

A referral to Adult Social Care should have been made as J was known to have significant burns to his body which affected his daily life and ability to carry out certain tasks (Care and support needs).

1. When more than one agency is involved, who assesses the level of risk, and how?

What are the actual risks?

What agency is best placed to oversee such risks and potentially offer interventions?

For example, with regards to domestic abuse (DASH risk assessment) this could be carried out by Safeguarding Adults Service, GP, A&E staff. The important point here is that a DASH is completed, and the outcome considered in terms of support available.

1. What intervention could be considered at this stage?

Information about/referral to domestic abuse services.

Information about/referral to drug & alcohol services.

Anything applicable could be offered to J at this stage, but he may say no. If his response is a “no” this should be investigated further. Why is he saying no? Is he making an informed choice? Is he experiencing coercion and control from his partner? Was he under the influence of alcohol at the time? When is the best time to speak with him about support that may be available etc.