

**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?

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

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

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



**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?
2. At any point should a Mental Capacity Act assessment have been considered? If yes, for what specific decision?
3. Does the new information change the concern at all? If yes, what is the concern?
4. What approaches could be made to gain engagement with J?
5. Who makes decisions and takes the lead in a case like this?
6. Should a referral to Adult Social Care have been made? If yes, what for?
7. When more than one agency is involved, who assesses the level of risk, and how?
8. What intervention could be considered at this stage?