**Safeguarding Exercise – Section 42 Case Study Exercise shared by the Yorkshire and the Humber region**

The exercise was developed through a regional task and finish group in Yorkshire and the Humber, who have been exploring the different interpretations of a Section 42 enquiry to understand the decision making that takes place when determining the pathway for a safeguarding concern. The sixteen scenarios below were provided by four local authorities across the Yorkshire and Humber region.

These case studies relate to a presentation by Dave Roddis, ADASS Yorkshire & Humber, Programme Director, offered at the November 2018 LGA/ADASS workshops and available on the LGA website.

The aim of the exercise is for each local authority to work with the relevant safeguarding practitioners in their local area to **assess each scenario and determine the decision they would have made on each one**, **explaining the rationale behind their decision** in the relevant boxes below.

Following the exercise taking place locally a regional workshop explored the collective answers, looking at themes and to examine the reasoning behind the decisions made. The aim is to further enhance practice and consistency both locally and regionally.

Importantly, this isn’t about right and wrong answers in this exercise, however it is critical to be clear about reasons behind decisions – this will allow for a generalised discussion to potentially reach some regional consensus about what triggers a Section 42 enquiry.

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| Case No. | Case Outline | Your Decision | Your Rationale |
| 1 | Referred by South Yorkshire Ambulance Service  **Detail** – Care home staff call ambulance for Mrs X, on arrival at hospital the ambulance crew inform the husband of Mrs X that they have concerns over care received in the care home and they will be referring to safeguarding. Concern is that care home staff have been aware of Mrs X being unwell and have not taken appropriate action, Mrs X had been leaning to one side and Mr X had noticed and reported to staff the previous day. Mrs X has Dementia and doesn’t fully understand what is happening. Mrs X also appears dehydrated. Potentially staff have been aware of Mrs X not feeling well for 3 days.  **Action -** Telephone call with care home manager.  Care home were aware that Mrs X became ill 3 days earlier (Thursday), no immediate concerns and staff were monitoring. No change in presentation on Friday, contact made with health professional who advised further monitoring. Fluids were being monitored and a UTI was queried.  Care home have a person centred plan for Mrs X and all observations including fluid intake were recorded. Mrs X deteriorated during Friday and the Care Home contacted emergency services.  Telephone call with Mr X husband/advocate  Mr X is upset that the hospital staff took him to one side to tell him they had concerns over his wife’s care, Mr X trusts the care home staff and was worried Mrs x would not be able to return to the care home. Mrs X was ready for discharge following antibiotics and the identification of a UTI. Mr X was aware he could report any concerns but did not want any further action. |  |  |
| 2 | Referred by Care home manager (Jackie).  **Detail** - Mrs Smith Suffers from dementia and requires hoisting for all transfers. Mrs Smith suffered an unwitnessed fall in the lounge on Sunday at 11.56. Was sat in the lounge in a comfy chair. Staff were in the lounge but was dealing with another resident who required the toilet. It was then noticed by staff that Mrs Smith was on the floor. The other residents who were in the lounge all require hoisting so they are not able to have been involved. Mrs Smith is not usually at risk of falls from the chair and Jackie does not know what prompted Mrs Smith to try to move as she is usually quite settled in her chair. There has never been the need to strap Mrs Smith (or any resident) into their chairs. Mrs Smith has a bump above her left eyebrow, and two black eyes. Was taken to Hospital. Was cleaned up and a dressing placed on her forehead. Staff were advised to maintain observations with her. Mrs Smith would not leave the dressing on her head - she removed it. Since then she has been fine- her usually self - Jackie has no concerns about her at all. No previous falls.  **Action -** One of the Nurses who was on duty on Sunday Sandra spoke to Mrs Smith's son Peter to inform him of what had happed. Peter thanked Sandra for informing him. Staff rang him again to inform him when Mrs Smith was back at the home.  Mrs Smith is still able to sit in the lounge - There is always a member of staff in the lounge but another staff member will be called on to watch Mrs Smith whenever she is in the lounge. Mrs Smith will be tried in the reclining chair to see if that is more suitable for her. There has never been the need to strap Mrs Smith (or any resident) into their chairs and the home feel the above measure will be enough to stop this happening again.  Mrs Smith lacks capacity to state her desired outcome of a SG . Jackie has spoken to Mrs Smith son Peter today and he has stated that he is satisfied with the outcome and does not want the matter investigated further. |  |  |
| 3 | Referred by Care home (Team Leaders)  **Detail** - As staff was supporting residents in to the dining room for tea, the care assistant noticed that another resident was pulling out a chair at the table for xxxxx as they sit together but the resident had pulled it out too far and xxxxx sat down and ended up on the floor, staff had seen what was going to happen but by the time they had made their resident safe and ran over it was to late one of the staff did shout to the resident but it was too late.  Team leaders called paramedics they took xxxxx to hospital to be checked over. She returned back the same day every thing was fine.  post falls observation put in place. Family informed. xxxxx said she just felt silly.    **Action -** Care home manager contacted. They explained that xxxxx has capacity and sits with the lady who had pulled her chair out to assist her on a daily basis. Xxxxx was not harmed by the fall, but staff did call a paramedic to check her over. The fall was witnessed by staff, they just couldn't reach her in time and did call over but it was too late and xxxxx misjudged the chair and missed. xxxxx herself has said that she felt fine and very silly about the whole thing. Agreed that this was an accident, xxxxx is not a known falls risk (does not meet criteria In falls protocol) and staff responded by doing appropriate checks and seeking outside medical support. |  |  |
| 4 | Referred by the Care Home Manager  **Detail** - Fred (service user 87 years with vascular dementia) was being visited by his son and walking down the corridor at a care home when he grabbed Bob (service user 82 years with alzheimers) by the throat. Fred’s son quickly asked Fred to let it go which he did. Bob then tried to took hold of the bottom of Frank's shirt and pulled it. Fred knocked away Bob's hand. Bill immediately took hold of the shirt again. At this point, Fred turned around and placed his right hand around Bobs throat with the thumb on one side and fingers on the other side. And pushed Bob against the wall. Fred's son stated that no pressure was applied by Fred. When Fred's son tapped his father's arm and said to let go, Fred let it go immediately. According to Fred's son, the whole incident took a couple of seconds only.  Staff attended to Bob immediately and did not find any signs of distress or any mark on his neck.  **Action -** The Care Home Manager was contacted and confirmed this was unprovoked attack and resulted in no harm to either of the residents. Both residents have dementia and are assessed as lacking capacity.  Staff have monitored both residents closely and none of them remember what happened later on. Risk assessment was implemented and behaviour care plan was put in place. |  |  |
| 5 | Referred by the Care Home  **Detail -** As yet no harm or abuse to xxxxx has occurred though he is at risk of verbal and possible physical abuse from members of the public, and also at risk of being reported to the Police.  xxxxx was observed by a member of care home staff urinating in public.  Nurse said that he had been out on an appointment with a worker and was now proceeding to go catch a bus to go town, when a member of staff saw him urinating near the bus stop. Nurse agreed that it could be that xxxxx had been caught out and just wanted to relieve himself before boarding a bus.  **Action -** Staff spoke with xxxxx regarding the incident and the need for a Safeguarding Alert. Staff advised xxxxx that urinating in public is both anti-social and against the law and could place him at risk of being reported to the Police and of verbal abuse by members of public who may observe this behaviour and that he must find a public toilet to use or return to the care home.  Person's View:-  xxxxx confirmed he understood what staff said to him and that he would not urinate in public again. He confirmed verbally that he consented to the Safeguarding.  He has capacity and once spoken to by staff he understood the possible risk implications of what he did. |  |  |
| 6 | Referred by Mental Health Service  Detail - Miss Y is a vulnerable adult due to a number of factors including the sexual abuse she has suffered as a child, she has now become vulnerable to further abuse. She has significant physical disabilities which impact on her ability to protect herself as well as PTSD symptoms including dissociation. Mr X has sexually assaulted her on more than one occasion and previous safeguarding has been put in place to keep him away for m her residence, this does not seem to be working.  **Action -** Referrer has reported incident to Police as well as safeguarding, advice has been sought from the Vulnerable Persons Team within the Police and from a clinical lead with the mental health series. Agreement that further work is needed to ensure the safety of Miss Y |  |  |
| 7 | Referred by the Care Home  **Detail** - The adult at risk is Peter, a 26 year old male with severe autism and LD disabilities who attends day care x3 days per week. The person alleged (Person A) is another service user; the allegation is one of physical abuse. At approx.10:30am today both services users were being transported to the day care and were sat together as usual Person A reached over to Peter and pinched him on the left arm.  **Action -** The bus was immediately stopped and staff separated both service users to different seats distraction techniques were used. Staff advised Person A their actions were not appropriate, they were brought back to base and were kept apart by their 1:1s. Peter was initially distressed but soon calmed down he was checked for injuries and he had a red bruise with the imprint of three fingers from contact this was body mapped  Peter’s mother has been informed of the incident, advised of actions taken to minimise risk eg being kept apart by 1:1s, she's happy with the measures implanted. Peter’s mother is consenting to the safeguarding and is likely to contribute where needed |  |  |
| 8 | Referral received from Hospital as follows:  **Detai**l- Nicola aged 43 has a learning disability and type 1 diabetes. Nicola attended a routine appointment at the outpatients department on 21.9.18 with her carer. On attending the appointment it was noticed that Nicola was very unkempt with dirty clothes.  In addition there were signs to indicate that Nicolas insulin was not being managed well. In particular it was identified that she has become diabetic ketoacidosis due to poor insulin management which is a life threatening disorder.  **Action -** There have been no previous safeguarding issues and there is no Mental Capacity Assessment on file  Adult at risk is under Learning Disability Team. She has a learning disability and has care and support needs which are currently being met in supported living accommodation. |  |  |
| 9 | Referred by the Care Home  **Detail** – x was found on the floor by her chair at approximately 22:40 hours by care staff. x was examined by the nurse in charge. No injuries were apparent, no pain or discomfort was voiced, no evidence of nonverbal signs of discomfort or pain observed. x did not present as being distressed by the incident. She was able to move her limbs independently she denied hitting her head, no evidence of this also found on examination.  Frase Risk assessment has been reviewed today she remains at a score of 20 indicating a HIGH risk of falls. Referral to the falls team sent today. x has had x 4 falls in the last 2 months.  x was examined by the nurse in charge for any possible signs of injury, none observed. x mobilises with assistance .  All staff are to be aware of x’s whereabouts at all times and to monitor closely.  x has had a similar falls where she had lost her balance.  Due to x having another fall her management plan will now be updated daily If no further falls this can then be reviewed monthly.  Currently awaiting feedback from the Falls prevention team.  Mobility Care plan and Risk assessment has been reviewed.  x lacks the capacity to understand retain and weigh up any information that is given to her due to her cognitive impairment associated with her diagnosis of dementia.  **Action** - T/C to Care Home Manager, Manager explained that x is a high falls risk and has been falling frequently, there is equipment in place and she stated that she has referred to the falls team today as this was not completed from the last safeguarding, manager has spoken with staff who had forgotten to do this and explained the importance of referring to falls to look at possible further preventative measures.  Manager has completed a risk management plan that she has evidenced to Safeguarding, along with mobility care plan and falls risk assessment. Manager previously was reviewing plans weekly, however due to the high number of falls she is reviewing risk daily for 7 days and if no further falls will drop this back to weekly to be proportionate to potential risk. No injury was sustained from this fall, steps are being taken by the home to manage the falls risk, family are aware of steps implemented by the home and satisfied that the home are trying to reduce risk for x. Manager thinks that the deterioration on x cognition is a massive contribution to this spike in falls. |  |  |
| 10 | Referred by Deputy Manager from supported living  **Detail** - Manager said that Mrs O moved into supported living in Jan . Mrs O has been seen by the memory clinic and her son brought in some tablets the carers were supposed to start giving Mrs O from 6 June 18. The tablet was called Memantine, she has dementia. She was supposed to have a low dose in the first week and then the carers were asked to increase this and monitor her to see how she was.  It has been brought to the manager’s attention that that the medication was never started and it's been 4 weeks now.   **Action** - The Manager is investigating the matter thoroughly to find out which staff were in and what has gone wrong. She thinks that all the staff will need supervision and possible medication re-training.  The manager has spoken with Mrs O’s son who did not want the matter reporting as he felt that as she has never been on the medication there has been no harm caused. The Area manager has advised her to make safeguarding aware. There has been no harm caused and there are no concerns about Mrs O’s immediate safety.  The manager has spoken to the Memory Clinic regarding starting up the treatment. The Manager said that she has not informed the CQC but will take advice from Area Manager about this. |  |  |
| 11 | Referred by Care home (Team Leaders)  **Detai**l **-** x medication had been changed from Madopar to Co Bendaloper. The madopar last dose should have been 14/08/2018 night.  The Co- Bendaloper should have commenced on the morning of 15/08/2018 however the Madopar had not been stopped on the MAR or removed from trolley. Team leader administering meds that morning gave both Madopar and Co Bendaloper and again at lunchtime,  On meds audit after lunch it was noted this had been done.  GP contacted and call back stated x should be fine as both meds are short acting and any complications would have arisen already but to monitor and continue with Co Bendaloper dose for rest of day, and contact if any concerns.  **Action** - T/C to care home Deputy Manager  Discussion had with manager regarding the error, she advised that this has been an oversight and due to the error she is in the process of doing a random audit to check that no further errors have been noted, at this stage there isn't. The error that occurred was in regards to a change in x Parkinson's medication. The error led to x getting his old medication as well as his new medication. The home immediately contacted the GP who advised that there should be no impact of doing this as it is a short impact medication and to continue the medication as prescribed going forward. x was asked how he felt; he said he felt no different and that his capabilities with his mobility/ balance had not been impacted. X agreed a safeguarding could be raised, but didn't want any fuss; he just wants the right medication to be given going forward. |  |  |
| 12 | Referred in by Daughter  **Detail** - Father 90 showing signs of early dementia, lives with wife at home. They are both now in a position where they are unable to look after themselves due to being frail and struggling with mobility. Father is adamant that he is fine and there is nothing wrong with him but I can assure you that he is definitely not the same man as I knew as my father. Wife tells me that he shouts at her and I am getting more and more worried that his temper may turn physical. He refuses to attend a memory clinic appointment which was made for him a few months ago and the clinic say they cannot do anything until he gives his consent. Last week he purchased a bed from people calling around the house - this bed cost him nearly £5,000 - they did not need a new bed as they have not long purchased a new mattress for their existing bed and it is out of character for him to spend a large amount of money. This has made the wife very poorly and she is finding day to day life pretty unbearable. Daughter lives two and a half hours drive away but tries to get to see them at least once a month.  Daughter has contacted the bed company and they have promised to get back but have not yet. In the meanwhile the bed has been delivered and the old bed taken away. The daughter has rang the bank and the cheque has been cancelled but there are still concerns around her father being bullied into buying it.  **Action**  Care act assessment referral  Action - reported to the Police |  |  |
| 13 | Referred by Hospital Staff/District Nurse  **Detail** - District nurse has visited Mrs C to dress long standing wound. The following day when the district nurse visited she was informed by care agency staff that the air mattress being used by Mrs C had completely deflated and was found to have been turned off at the pump. Mrs C had developed a large purple non blanching area to her sacrum.  **Action -** District nurse through the Health Trust reported the safeguarding concern. Social Worker requested further screening. Conversation with manager of care provider and has asked them to carry out further investigation into carers involved in Mrs C’s care and observations while in MRs C ‘s home |  |  |
| 14 | Referred by Care Home manger   **Detail** - The adult at risk Sam, is a 77 year old female who is a permanent resident at a care home. The person alleged to have caused harm (Person A) is also a resident at the care home. The allegation is one of physical abuse.   Person A was previously seen walking with purpose on the corridor Sam was sat near the nurses' station (not close in close proximity to the corridor), two staff members were assisting another resident to the toilet when they heard shouting from the corridor and attended. Both residents were observed being physically verbally abusive towards one another - contact made on the face. The Team Leader stood between both residents to break contact, Sam was diverted back to the Nurses' Station and Person A was diverted away to their room to ensure they were not in view of each other.   **Actions** – Both residents were reassured to reduce agitation, both residents were checked for injuries and a body map completed. Sam sustained a cut to her lower lip with minimal bleeding and Person A sustained a scratch to their chin cleaned with sterile wipes. As Sam lacks capacity views of family member has been sough on her behalf.  The care home has made a referral for support from care home liaison team, increase observations. The family member was happy with this and also asked for Sam to be checked for a UTI. |  |  |
| 15 | Referred by Daughter  **Detail** - The Daughter reported to the safeguarding hub that the care home staff were not passing on messages to each other about her mothers care needs and family requests. On visiting her mother she noticed her nails were soiled and she was scratching her wounds under the bandages. Despite family informing staff her nails were not cleaned and bandages not replaced even over 24hrs causing her legs to become infected. The daughter also said that medications were not being administered and her co-codamol had not been taken.  **Action** - On further fact finding it was established that the mother has now been admitted to hospital and lacks capacity and is 89 years of age with dementia frailty. |  |  |
| 16 | Referred by Care home  **Detail** – Care home manager called with a concern that two residents on the dementia unit had been involved in a sexual incident. One resident had been witness by a staff member inappropriately touching the other resident, both residents were in the corridor and neither seemed distressed by the incident. Both residents lack capacity.  **Action -** Telephone call to Care Home  There is no evidence to suggest that either resident is aware of the incident and there has been no reaction from either resident, resident 1 (perpetrator) is unaware of what he did or that it was sexually motivated. The unit hold four residents and is staffed by two workers. |  |  |