

7 Minute Briefing: Valerie and Ian

Approved March 2021

<https://www.barnsley.gov.uk/media/18116/sar-valerie-and-ian-march-2021.pdf>



01

What is a Safeguarding Adults Review?

A Safeguarding Adults Review is held when an adult in the local authority area dies as a result of abuse or neglect whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult or when an adult in the area has not died, but the SAB knows or suspects that the adult has experienced significant abuse or neglect. The purpose of a Safeguarding Adults Review is to learn the lessons about how professionals and organisations work together and to consider how the learning can be used to improve practice for others in the future.

02

What happened?

Valerie and Ian came to attention of services in summer 2018, severe self-neglect and concerns about the condition of their home (owner occupier). Organisations were not able to access the house, couple claimed to have a big dog. Ian regularly attended GP, Valerie had not attended in many years. Ian (86) died in hospital April 2019 of intra-abdominal sepsis. Concerns noted about self-neglect, but no safeguarding concern raised. Valerie continued to live alone until she was brought to A&E by ambulance in December 2019. Her home was described as squalid, no heating, hygienic surfaces and no fresh food. She was described as filthy and unkempt. Valerie (75) died. The couple claimed that family delivered food weekly

03

First Finding

The SAR panel agreed that the author would be asked to look at the circumstance of this case and analyse the learning from two previous self-neglect and hoarding SARs – Jack and Clive. Valerie and Ian were noted to be very resistant to all interventions and were initially deemed to have capacity, this was questioned later for Ian (dementia) and Valerie (agoraphobia) A Self Neglect and Hoarding policy was in place but despite agreement that there were risks, no multi-agency response was coordinated under the policies. No attempt was made to reach out to Valerie following the death of Ian and attempts to secure family details proved unsuccessful. Family declined to be involved in the SAR and they shared limited information about Valerie and Ian

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What to do next?

As a worker

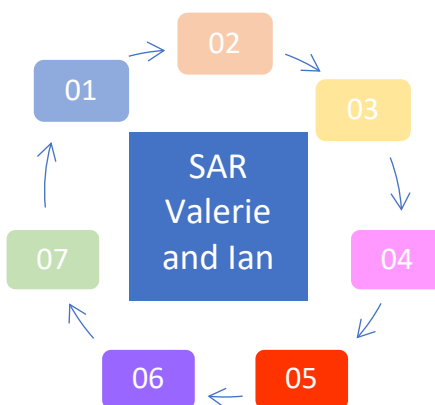
Do I know enough about this topic – if not access FREE training via POD -

<https://barnsley.learningpool.com/login/index.php>

Raise the issue in supervision or team meetings, do you get support from managers to be persistent.

Access the policy and summary guidance to assist you. -

<https://www.barnsley.gov.uk/services/children-families-and-education/safeguarding-families-in-barnsley/safeguarding-adults-in-barnsley/for-professionals-and-volunteers/>



04

Second Finding

Parallels with previous cases –

- ✓ Safeguarding concerns raised, failure to use self-neglect policy
- ✓ All appeared to have mental ill health, though not all had a diagnosis
- ✓ All had family contact but kept them at a distance. Workers did not use these as consent had not been given.
- ✓ All had experienced significant bereavements
- ✓ All had difficulties in engaging with services

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Fourth Finding

BSAB to consider commissioning hoarding services, possibly using money used for house clearances that are often repeated.

Managers to sign off on the closure of self-neglect and hoarding cases, especially when risks remain

Family group conferences should be considered.

Increase public confidence to identify adults at risk of self-neglect or hoarding by a media campaign

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Third Finding

Lack of persistence and curiosity by workers. There was limited evidence of “finding the person” and working with them despite their refusals

Lack of resources – bereavement services, hoarding support, psychological services to reach out to adults

We did not have a shared understanding of roles and responsibilities for managing self-neglect and hoarding cases, would training help?

Sharing success stories and developing relationships between workers and organisations key