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Learning from SARs – Adult V

What is a SAR?

A Safeguarding Adults Review (SAR) is a statutory duty which Oxfordshire Adults Safeguarding Board must undertake when an adult with care and support needs dies or suffers serious harm as a result of abuse or neglect.

Including, if there are concerns that the partnership agencies could have worked more effectively to safeguard the adult/s.

What is the aim of a SAR?

The aim of a SAR is to offer learning, understanding and insight.

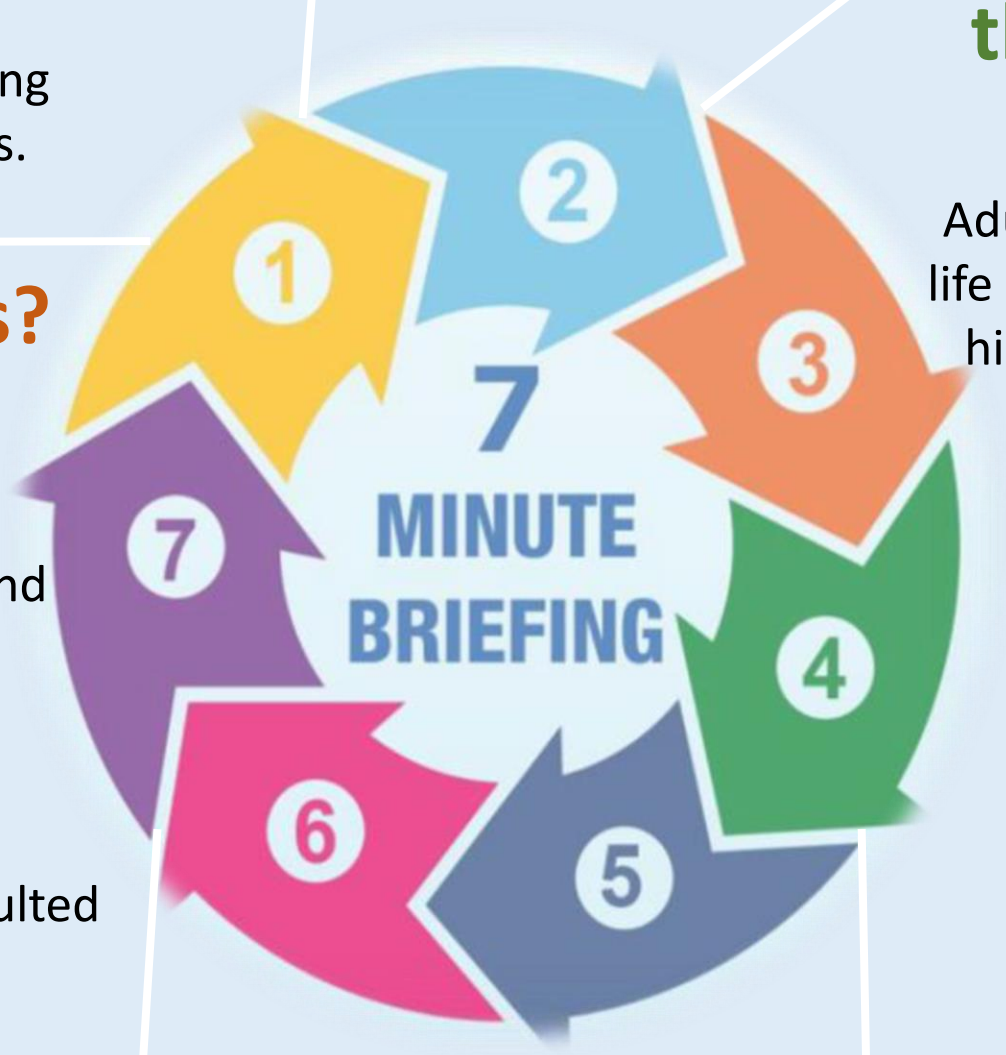
For example:

- To learn from cases where the agencies involved could have worked more effectively together in order to protect a vulnerable adult/s
- To ascertain whether serious harm or death could have been predicted and prevented.
- To develop learning that enables partnership agencies to improve their services to prevent any future abuse or neglect.

- To identify any issues in multi or single agency policies.
- To agree how this learning will be undertaken.

4 Key Themes were Identified for future learning:

- Professional curiosity, overreliance & judgment
- Mental Capacity, how &when to assess.
- Self-neglect, identifying & reporting.
- Multi-agency Working & Understanding Professional Roles and responsibilities.



What happened in the case of Adult V?

Adult V had periods of time in his life when he struggled to maintain his health and well-being to an acceptable standard.

Adult V informed a professional on one occasion that he found it hard to "keep on top of things" and in October 2014 a referral to Adult Social Care highlighted concerns in relation to self-neglect.

On the 8th April 2020 ASC (Oxfordshire Adult Social Care) contacted TVP (Thames Valley Police) as they were concerned for V's welfare after the last contact with him on 18th March via phone, he stated he only had one tin of food in the house.

Contact over the phone with V failed and due to COVID professionals were unable to carry out a home visit for a welfare check.
TVP attended V's address and sadly found V deceased with the suspicion that he had been for some time.

What were the findings?

1.Professional curiosity – There were missed opportunities to explore V's lifestyle choices, lack of interaction and his home condition.

2.Professional Overreliance- Professional's reliance of V to give feedback on his current situation resulted in him not receiving an immediate service.

3.Assumed Capacity- The further exploration of the reason and purpose of V's choices may have led to a different outcome.

4.Professional Judgment- Professional judgement across agencies did not result in holistic information sharing that may have led to a different outcome for V.

5.Self- Neglect- There was a lack of identification that V was self- neglecting, and the professional judgement was that he lived this way by choice.

What were the key questions for the review?

- What specific issues or questions does this case raise?
- Are there any unusual factors in this case? What are they?
- Are there any failings which appear obvious at this stage?
- Do there appear to be any gaps in multi–agency working?

Contact details:
OSAB@oxfordshire.gov.uk
Worried about an adult?
How to report concerns - Oxford Safeguarding Adults Board (osab.co.uk)

The key learning from SAR Adult V can be found in the additional 7 Minute Briefings available on the OSAB website.