Learning from OSAB SARs: John

Background

A Safeguarding Adult Review (SAR) was commissioned under the Care Act 2014 because it was recognised that there were missed opportunities to manage and monitor John's needs more effectively and suspected that self-neglect and neglect may have been contributing factors to his death. John lived in a 'House in Multiple Occupation' (HMO) and appeared to have limited family contact. John did have friends but over time his friendship group became smaller. Covid-19 lockdowns had a negative impact, he did not want to spend time with those he lived with and spent more time alone. Poor mobility limited his ability to go food shopping. The communal bathroom and kitchen were in poor condition with no functioning cooker or microwave. John was admitted to hospital following a decline in physical and mental health. He was malnourished, had a pressure ulcer, and was treated for a urinary tract infection. He was found not to have a mental health condition that required treatment.

What Happened?

A safeguarding referral was made by staff as John disclosed that the five people he lived with were 'intravenous drug users and alcoholics', and he felt unsafe to return due to ongoing health issues. He was able to communicate the support he felt he needed to a mental health practitioner - rehousing and a package of care. Staff informed John his rehousing request was unlikely to be accepted. Possibly as a result, he agreed to return home with support from Age UK Oldham and declined a stairs assessment and equipment including a commode. The risks of returning to the HMO were explained; it was felt he had the mental capacity to make the decision to return to home with limited support. No agency saw him following his discharge until he was readmitted with several pressure ulcers and maggots in leg wounds; he was covered in faeces, significantly malnourished, and had been unable to mobilise resulting in double incontinence. John sadly died two days later, aged 69.

Resources & Information

The SAR report in relation to John is available online. Practitioners can also access further guidance related to the SAR findings including: Professional Curiosity Guidance; Partner Agency Safeguarding Roles and Responsibilities Profiles; Self-Neglect Policy, Procedures and Guidance; and the TRAM Protocol. OSAB offers regular multi-agency training about Self-Neglect, Professional Curiosity, and Risk Management. Find the latest training dates and book places via the OSAB website.

Response

Four referrals to Adult Social Care (ASC) did not result in safeguarding responses or needs assessments. There was no consideration of asking John for consent to contact health agencies to establish what his needs were and no capacity assessments undertaken. ASC opted for alternative routes including referrals to Mind and Age UK Oldham. When John refused to see ASC whilst in hospital, this was respected and no further attempt was made to try and engage John to explore the reason why.

Awareness of Housing Support Services

When John made disclosures about the issues with the condition of his property he was experiencing, there was potentially a missed opportunity to involve the Oldham Council Tenancy Relations Service in addressing whether the landlord who owned the property could have been made to address the poor living conditions. Poor living conditions can sometimes result in feelings of shame about someone's circumstances; John may have experienced this. Practitioners knocking on the front door, attempting to visit John, might have made relationships with others in the property 'difficult'.

Prior to hospital admission, John was referred to Age UK Oldham for support with rehousing, however they do not provide this. A referral to the Oldham Council Housing Options team would have been more appropriate as it is their role to support with applications for social housing. Age UK Oldham posted relevant information and contact details when they could not reach John, but it was unclear if the information reached him.

Take a look at a separate OSAB 7-Minute Briefing about HMOs and Safeguarding.

Hospital Discharge

Information mental health and social care staff held about the poor living conditions and the potential for John to continue to be at risk of self-neglect did not appear to be revisited as part of discharge planning, There was a missed opportunity to revisit with John his decision about discharge given the risks. When an adult is making a series of high-risk decisions, practitioners should consider undertaking a mental capacity assessment and/or developing a risk management plan under the Tiered Risk Assessment and Management (TRAM) Protocol. There was a heavy reliance on John to say if he did not agree with or would be unable to attend appointments after his discharge due to his mobility; the option of contact via phone was also relied upon but John's phone often did not work. Greater professional curiosity could have been applied to check how he would attend and that he had access to a phone.

Interagency Referrals

A referral made to Age UK Oldham at discharge did not reflect the level of detail about John's vulnerabilities that if known, might have prompted escalation when they could not contact him. Including adequate information in interagency referrals is critical to ensuring timely, coordinated, and effective support for individuals at risk. When referrals lack essential details, particularly around medical history, safeguarding concerns, and risk factors, receiving agencies may be unable to assess urgency, allocate appropriate resources, or understand the full context of a person's needs. Clear, comprehensive referrals help prevent duplication, missed opportunities, and delays in care. They also foster shared accountability and enable professionals to make informed decisions, especially in complex cases involving self-neglect, mental health, or housing instability. In safeguarding, **every detail matters**.

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