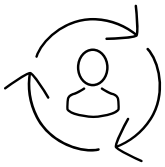
SAR Aidan Learning for Professionals

Safeguarding Adults Review

Aidan was a 61 year old white British man. He had a learning disability and lived at home with his brother. Aidan died due to oesophageal rupture and acute kidney injury/disease. There was an open safeguarding at the time of his death, there had been concerns for many years about Aidan's care at home and barriers to his access to health and social care. A SAR commenced in Sept and was published in August 2025. The full report is available here.

Key messages for professionals

Good practice identified



Person Centred Care
Strong sense of person centred care from all professionals

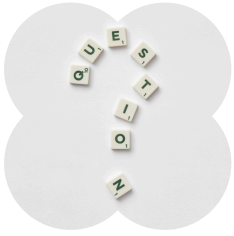
Covid
Aidan's day centre staff provided consistent support and communication through the pandemic

Aidan
Commitment to promote Aidan's choice in daily decisions

What were the worries?

Advocacy
Even though Aidan had his brothers, it would have been helpful to also have an independent advocate

Neglect
Identifying and naming neglect was challenging for practitioners

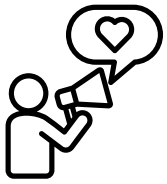


Curiosity
over-optimism and normalisation

Parity
Non-statutory partners felt they were not listened to. Lack of parity of esteem

- Aidan had complex needs and lacked mental capacity, yet his voice was not consistently sought or represented.
- Advocacy was inconsistently applied; there were missed opportunities for non-instructed advocacy to represent Aidan's voice.
- Aidan's brother was deeply committed but increasingly isolated and resistant to professional involvement.
- Professionals respected the family's role but did not sufficiently challenge or assess the sustainability and safety of care.
- Aidan missed out on key wellbeing outcomes and missed medical interventions due to unchallenged refusals by Aidan's brother.
- Professionals did not consistently apply the Mental Capacity Act best interests framework.
- Decisions were overly reliant on Aidan's brother's views, despite Aidan lacking capacity.
- Safeguarding concerns were raised but there wasn't evidence of escalation.
- Professionals struggled to name abuse/neglect, especially within familial relationships.
- Lack of multi-agency strategy and protection planning.
- Professionals lacked a clear understanding of Aidan's home environment.
- Isolation increased risks.
- Over-optimism and normalisation of risk led to missed opportunities for intervention.

What can we do differently?



Advocacy

All practitioners should know about when and how to access advocacy for an adult

Escalation

All practitioners should know when and how to escalate to resolve professional differences

Listening

Work in a collaborative way and listen to those who know the adult best whatever organisation they come from

Resources you can use

Advocacy	**Escalation**
In South Gloucestershire we use Voiceability as our advocacy provider More information is here Referral form is here Advocacy Leaflet for professionals	South Gloucestershire Safeguarding Adults Board has a multi-agency Resolution of Professional Differences Policy. This can and should be used by any professional when there is a need to escalate a decision. The policy is available here