

## Background

A Safeguarding Adult Review (SAR) was undertaken in line with [the Care Act 2014](#) as Joe sadly died by hanging in 2024, at the age of 27; it was suspected that abuse in the form of cuckooing, financial abuse, and self-neglect may have contributed to his death; and there was reasonable cause for concern about how agencies worked together to safeguard him. The [SAR Report](#) is available online. His family described Joe as a lovely, pleasant, and caring boy. Joe lived with his mother and two brothers until his early 20s. In 2020, Joe survived a serious stabbing incident when males armed with knives entered the family home. In

2021, he began sleeping rough after domestic abuse incidents in the family home where he was the alleged perpetrator. He began using drugs and alcohol and frequently presented as angry and aggressive to practitioners attempting to engage with him.

**Resources** Formal mental capacity assessments must be considered when a person refuses essential support or disengages, especially where there is evidence of impaired executive functioning. For more details see the [Mental Capacity Act Policy](#), [Practical Guide to Assessing Capacity](#), and [Executive Functioning Guidance](#) as well as [Guidance Where the Individual is Not Engaging with Services](#). OSAB offer regular 'How to Make a Safeguarding Adult Referral' training; book your place via the [OSAB website](#). [Trauma Informed Practice Guidance for Practitioners](#) is also available.

**Trauma Informed Practice** Joe's family take the view that the defining event in his life was the 2020 incident in which he sustained serious stabbing injuries. They felt that he appeared "tortured" by the experience and that the lack of psychological support led to a deterioration in his mental health and a change in his behaviour. NHS England recognises that many people treated for knife injuries will need long-lasting care for both the mental and physical aspects of their trauma. The SAR found that the response appeared to consist of a focus on treatment and care to enable Joe to make a physical recovery and a criminal justice response to try and bring the perpetrators to justice. The missing element was any consideration of the trauma experienced. At the time of Joe's admission to Manchester Royal Infirmary (MRI), the country was responding to Covid-19 pandemic and hospitals had adopted an approach which entailed discharging patients as soon as they were medically optimised. The expectation was that any assessment of ongoing needs would take place in the community. Joe was not referred to the MRI LMHT. Many practitioners who subsequently supported Joe became aware of the incident and appeared to have insight into the potential trauma Joe experienced as a result.

**Safeguarding Referrals Learning** With hindsight, the risks to Joe appeared to have been escalating but this was not recognised by the various agencies with which he came into contact in the months before he died. The SAR found that opportunities to make safeguarding referrals were overlooked by various agencies and highlighted missed opportunities to recognise he was becoming increasingly isolated from services and when there were indications that he was being financially exploited. The SAR states that it may be worthy of note that possible cuckooing was documented in the request for support as "people in his flat that he can't get rid of". Whilst this may have been an accurate description of what Joe had reported, it may also have been language which inadvertently minimised the issue. The SAR acknowledges that the quality of adult safeguarding referrals in Oldham remains a live issue.

**What Happened?** In September 2023, Joe was imprisoned for assault and obstructing police whilst affected by drugs and alcohol. Joe was diagnosed with a first episode of psychosis. Joe's presentation was complex. His fluctuating suicidal ideation occurred in the context of substance misuse, emotional dysregulation, past trauma, possible neurodivergence, and a challenging interpersonal style that may have masked underlying distress and limited opportunities for deeper exploration of intent, planning and any protective factors. Joe frequently attended hospital in distress. He displayed many antecedents of suicide including financial worries, isolation from family, and disengagement from services. Suicidal ideation tended to be recorded by agencies to which he disclosed it and was generally not the subject of multi-agency discussion. A more holistic, person-centred approach collaboratively exploring risks, understanding changeable safety factors, and co-producing safety plans would have been appropriate.

**Capacity** Joe's presentation could have led practitioners to question his capacity; he was assumed to have capacity even though decisions, such as his decision to decline support placed him at risk. Ongoing trauma-informed consideration and review of capacity in individuals who disengage from support whilst experiencing cumulative harm was not evident. Nor was there any consideration of whether his prior trauma, substance misuse and emotional dysregulation may have obscured indications of executive functioning.

**Learning - Assessment Request** Following a multi-agency meeting in April 2024, a Care Act Needs Assessment request was made to Adult Social Care; a decision was made to close this based on the information provided and information already held by the agency - Joe had previously been assessed as not having Care Act eligible needs in November 2022. With hindsight, the SAR identified that Joe did have care and support needs in respect of his mental health, and his ability to maintain a habitable home and to access community services and that relying on an assessment from 18 months earlier appeared to overlook the possibility that a person's needs may have changed. In addition, the request did not include all concerns shared at the meeting including 'no gas or electric' and 'poor engagement with services'. Reasons for the omissions are unclear. It is also unknown why a safeguarding referral was not made given indications of self-neglect and implications Joe may be at risk from cuckooing.



Access a second briefing concerning further learning from the Safeguarding Adult Review in relation to Joe.

