

Introduction

A Safeguarding Adult Review (SAR) was undertaken in line with the [Care Act 2014](#) as Ruth sadly died by suspected intentional overdose at age 47; it was acknowledged that there were acts of omission by involved agencies and weaknesses in the system around care coordination, medication management and collaborative support of people with complex mental and physical health needs, that contributed towards Ruth's death. The [SAR Report](#) is available online. Professionals reported that Ruth was funny, generous and able to strike up conversation with people wherever she went. Ruth's friend, described her as a very caring, loving person who liked helping people, although this also made her vulnerable.

Next Steps and Resources

Oldham Safeguarding Adults Board's priority is to ensure the learning from this SAR leads to meaningful improvements and support for agencies to work together more effectively. Resources related to the SAR findings include [TRAM Protocol](#), [Partner Agency Safeguarding Roles & Responsibilities Profiles](#), [Trauma Informed Practice Guidance](#), and [Mental Capacity Act Policy](#). There are also [OSAB Gab Podcast](#) episodes about Practice Informed by Trauma and the TRAM Protocol.

Mental Health Pathways, Advice & Support

The SAR highlights a gap in mental health pathway clarity and clinical escalation for adults with complex mental health needs who are deteriorating in the community but are not open to a mental health team or service. Active care coordination was effective when in place however there was insufficient clarity regarding responsibility for ongoing mental health oversight and clinical advice following an inpatient discharge, leaving partners uncertain about who to contact when relapse indicators, overdose risk, high levels of trauma, relational distress, and care package instability emerged. Trauma-informed and relational practice was better developed in agencies with specialist mental health training, but less consistently available to the carers and workers providing daily support. The SAR identifies an opportunity to build on existing strength by considering how specialist mental health advice, formulation and reflective support can be made available, including to support domiciliary care and third sector partners working with shared cases, to help them understand behaviour and distress, maintain boundaries and sustain care safely.

Ruth had a history of physical health needs, mental health difficulties, substance use, vulnerability to exploitation, and repeated episodes of self-harm by overdose. These factors sat alongside a history of domestic abuse.

Ruth's mental and physical health fluctuated during the review period. She struggled with chronic pain but was determined to maintain her home and her independence. A central feature of Ruth's care was the risk associated with prescribed medication. Ruth had a significant medication regime, and medication arrangements were intended to reduce a known overdose risk, but over time they became a complex multi-agency risk management issue. Concerns about prescribing, administration, storage, access to a medication safe, stockpiling, missed or unsupervised doses, changes in mental state and pharmacy arrangements, were not consistently drawn together. Ruth had five domiciliary care providers during the review period. Care was further complicated by the absence of a clearly identified lead professional. Day-to-day liaison took place between third sector floating support and private care agencies.

Oversight

The SAR highlights the need for stronger commissioning oversight of complex care packages, and that repeated changes in care provision should trigger consideration of whether care packages are realistic for people with a complex combination of needs such as mental and physical health needs, relational distress, trauma history, and medication risk; whether providers have the required training and are adequately supported; and if additional support or specialist input is needed.

Medication Management

Changes in medication management risk did not consistently lead to review, escalation or revision of the medication safety plan. Practitioners recognised the difficulty of balancing Ruth's mental capacity, autonomy and human rights with the known risk of suicide. 'Having capacity' risks being interpreted as limiting the scope for intervention instead of prompting careful consideration of what proportionate, lawful, and least restrictive steps could still be taken to reduce risk. The SAR highlights the importance of clear oversight, accountability, escalation processes and strong coordination. Medication safety arrangements should be regularly reviewed to ensure safeguards remain effective, with clear triggers for multi-agency reassessment when risks change or controls become compromised so that concerns are identified early and addressed.

Multi-Agency Working

The SAR found that the Tiered Risk Assessment and Management (TRAM) Protocol provides a useful structure for coordinating complex multi-agency risk, and highlights that use of a Team Around the Adult (TAA) in Ruth's case demonstrated how this approach can support effective information sharing, planning and collective risk management. However, it was also determined that a safeguarding enquiry and TAA meetings ended without expected closure discussions, and awareness of the TRAM Protocol was inconsistent. A practical barrier to initiating TAA was identified when it is unclear which other services are involved. The SAR recommends development of a clearer mechanism to support practitioners with this and to reduce the risk of key agencies being omitted. The SAR also recommends that assurance is sought that the process is understood by statutory, voluntary, and commissioned provider agencies.

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