Safeguarding Adult Review: 'Jason'

Presented to Oldham Safeguarding Adult Board on 17th January 2024

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1.0 Introduction and Review Methodology

1.1 A referral for consideration of a Safeguarding Adults Review (SAR) was made by the Principal Homelessness Strategy Officer from Housing Options at Oldham Council to the Oldham Safeguarding Adults Board (OSAB) via its Safeguarding Review, Audit and Quality Assurance Subgroup. A meeting of this subgroup considered the referral in January 2023. A timeline of multiagency involvement with service user was discussed at this meeting and as a result a unanimous decision concluded that the criteria for a SAR were met.

1.2 The Chair of the OSAB was informed of this decision and agreed that a SAR should be commissioned in response to the death of the service user in accordance with Section 44 of the Care Act 2014. The subject of this SAR will be known as 'Jason' to maintain their anonymity. Jason was an adult with complex care and support needs, there was concern that Jason had experienced harm and abuse, and there was cause for concern about how partner agencies had worked together to safeguard him.

1.3 Jason was only 45 when he died, he had experienced childhood trauma at a young age and became involved in criminality in his teens. He went on to become addicted to class A drugs and was reported as being both the victim and perpetrator of crime. He spent time in prison following a conviction for burglary in 2019, the review focusses on what agency support he received following his release from prison until his early death just over 2 years later.

1.4 The report has been authored by Michelle Grant who is an Independent Safeguarding Consultant. Michelle has a health background working in acute hospitals for 20 years and latterly for 10 years in a Clinical Commissioning Group (CCG) and an Integrated Care Board (ICB) as the Designated Nurse for Adult Safeguarding. She has previously authored several Safeguarding Adult Reviews across the Country. She is also the chair of the board of trustees at a charity in Derbyshire providing counselling services to survivors of sexual abuse and incest.

1.5 The independent author has no links to the Oldham Safeguarding Board or any of its partner agencies.

1.6 Following a meeting between the independent author, the OSAB business manager and the strategic safeguarding service manager, Adult Social Care, it was agreed that the review should focus upon the period from **July 2020** when Jason was released from prison until the end of **October 2022** when Jason sadly died.

1.7 Agencies that had engaged with Jason during this timeframe were asked to submit individual agency reports detailing their agencies work with Jason during this timeframe. They were also asked several questions aligned to the provisional terms of reference based on the discussions held at the initial screening meeting.

1.8 The panel agreed the Terms of Reference and panel membership at the first panel meeting held on 12th September 2023, additional information was requested from the agencies involved following initial reading of the individual agency reports by the Independent Author to support the review process.

Panel membership consisted of representatives from the following partner agencies:	
Adult Social Care Oldham Council (ASC)	Housing Options Oldham Council
Greater Manchester Police (GMP)	GM Housing First (Jigsaw Support)
Greater Manchester Probation Service	Howarth Housing Group

Northern Care Alliance NHS Foundation Trust (NCA)	Regenda Housing
Pennine Care NHS Foundation Trust	Domestic Abuse Service Oldham Council
Manchester University NHS Foundation Trust (MFT)	Oldham and Rochdale Active Recovery Turning Point
NHS Greater Manchester Integrated Care Board (ICB)	Business Manager OSAB

1.9 The panel met on 3 further occasions to discuss the information shared by agencies, identify any learning points and to agree the progress of the review. On **2nd November** a practitioner learning event was held which was attended by individuals from agencies who had worked directly with Jason. The contribution by the practitioners at this event was invaluable in the independent author and panel members understanding about what worked well in practice and where there were difficulties, which if overcome would improve multiagency working to support people with complex care and support needs in Oldham.

1.9 Additional communications with professionals who were either unable to attend the practitioner learning event or had minimal involvement in the team around Jason helped to clarify practice and shape the learning.

1.10 Panel members had the opportunity to review and approve the final draft report and the learning prior to presentation to the OSAB.

2.0 Family Engagement

2.1 The independent author on behalf of the panel members and Oldham Safeguarding Adults Board would like to express their sadness following the death of Jason. It is usual practice in SARs that the family of the person who is the subject of the SAR are asked to share their experiences of the care provided to their relative.

2.2 The independent author and panel members were aware of the involvement of some of the male members of Jason's family in relation to allegations he made against them, and allegations they made in against him. Being aware of some of the wider family struggles with substance misuse and mental health issues it was felt that it would be appropriate to check with the support worker of one of Jason's brothers who he never made allegations about to see if he felt able to share his views of how services worked to support his brother.

2.3 The support worker managed to confirm that the brother Jason named as his next of kin (NOK) when attending hospital would speak over the telephone with the independent author. Having had the opportunity to speak with this family member it has allowed the report to reflect on 'family perspective' and the author is very grateful to Jason's brother for taking the time to speak with her.

3.0 Parallel Processes

3.1 There has been a Coroner’s inquest into the death of. Jason which concluded in 2023 citing the cause of death as a long-standing medical condition There are therefore no parallel processes that would influence the findings or learning being shared because of this review.

4.0 Lived Experiences of 'Jason'

4.1 Jason had what we would now term 'adverse childhood experiences'[1] (ACEs) he had no contact with his own father from birth, he lived with his mother, stepfather and 3 half-siblings. From the age of Jason was seen by a child psychiatrist due to having developed fire setting behaviours causing damage to the family home. Records from childhood show that Jason was not brought to all his hospital appointments; and show that he started school with a degree of learning difficulties. Following an improvement in behaviour at home Jason was discharged from psychiatry while still at primary school.

4.2 In **1984** when Jason was 7 years old his mother asked children's services at the Local Authority to accommodate the 3 children as she was struggling to cope, she was admitted to a psychiatric unit at this time. She sadly went on take her own life when Jason was 9 years old.

4.3 In the following 4 years Jason then spent time living with 2 different female family members as well as in a foster placement and a short-term respite placement. By **1993** Jason was reported to be stealing, drinking, driving cars and using cannabis. He was then accommodated in a residential unit following breakdown of placements within his own extended family.

4.4 Jason was known to the Police from a being a youth, his offending history dated from **1993** when he was only 16 years old. His pattern of offending was predominantly acquisitive his motivation being offending providing a source of income to fund substance misuse and addiction over many years. He was also known to have a history of rough sleeping and homelessness for periods of time in adulthood.

4.5 For the purposes of this review Jason's treatment for substance misuse was transferred to Turning Point[2] on the **1st April 2018**, he initially failed to engage with the service and his file was closed. There were 2 further treatment episodes outside the scope of this review, during one in **2019** at which he self-referred; Jason reported to his recovery worker that he was homeless and was using both heroin and crack cocaine daily, with frequent accidental overdoses. He disclosed that he was experiencing anxiety and depression and had ongoing back, neck and head issues. The recovery worker continued to support Jason until he received a custodial sentence in **June 2019.**

4.6 Jason was again supported with treating his substance misuse by Turning Point from **July 2020** following his release from prison. He was prescribed 20mls of Methadone daily whilst in custody which gradually increased to 50mls at the time of his death. His engagement with the service was poor, often not answering telephone calls or attending planned appointments. He also often did not collect his prescription and therefore had to be re-started on a substitute prescription to stabilise his illicit drug use. At the time of his death Jason was recorded as misusing heroin, crack cocaine, pregabalin and diazepam several times per week.

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[1] Common ACE's include physical abuse, verbal abuse, physical neglect, emotional neglect, a family member who is depressed or diagnosed with other mental illness and a family member who is addicted to alcohol or other substance misuse https://www.cdc.gov June 29 2023

[2] Turning Point - Rochdale and Oldham active recovery is a substance use service that provides an integrated drug and alcohol service https://www.turning-point.co.uk/services/rochdale-oldham

4.7 On release from prison in **July 2020** Jason presented to Housing Options[3] at Oldham Council as homeless and was placed into temporary accommodation. He was supported by Housing First and was later rehoused into a Regenda tenancy.

4.8 He spent some time begging at a local supermarket and relied on food parcels despite being in receipt of benefits, he also appeared physically frail.

4.9 Jason was registered with the same GP throughout the period of this review. Following Jason's release from prison the GP recorded that he was taking regular medication for mental health issues and was experiencing chronic pain. North West Ambulance Service NHS Trust (NWAS) responded to Jason 12 times over several locations during the same time period, he was transported to hospital on 6 occasions and refused to attend on 5 occasions, there was one emergency call that was responded to.

4.10 Following his release from prison until his death Jason reported a number of crimes against himself to the Police, not all of which were investigated further as he did not wish to support this or the suspects were unidentified. He was known by the Police to be the victim of domestic abuse on 4 occasions 3 of these being linked to male family members during the review period. In **November 2020** Jason reported that he was the victim of criminal damage following a brick being thrown through the window of his home by persons unknown.

4.11 In the same month he presented in the Emergency Department (ED) at Manchester University hospital following being stabbed in the buttocks, a practice known as 'bagging'[4]. He had also fractured his knee which required surgical intervention.

4.12 In **December 2020** his home was known to be targeted by local youths, at this time Jason was living with his brother following discharge from hospital following a heart attack earlier in the month.

4.13 In **February 2021** Jason was the victim of aggravated burglary, several unknown males attended his address, smashed his windows, entered the property brandishing weapons and once inside they stole his television and used drugs. In the same month Jason reported to his housing provider that his property was being used by drug gangs, this disclosure was supported by the amount of evidence of drug use at his property and the presence of several unknown males who may also have used the property for drug dealing. Jason expressed to professionals supporting him that he owed money to people and was fearful for his safety.

4.14 During the timeframe of the review Jason was recorded as having attended Royal Oldham hospital ED on a total of 27 occasions mainly requiring treatment for overdoses, assaults, and ongoing infections to his knee injury. In **March 2021** Jason was admitted to hospital following an alleged attack by some of the male members of his family. He was found to have been under the influence of drugs with evidence of a facial bone injury and bilateral epistaxis[5] There was concern that Jason had suffered a bleed on his brain following this assault, following investigations and medication to reverse the effect of substance misuse Jason took his own discharge against medical advice. He presented to the ED again the following day with worsening headaches, blurred vision, left ear pain and unsteady gait. He was found to have drug paraphernalia on his person and street bought drugs.

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[3] The Housing options Team sits within Oldham Council and offers support with housing advice, homelessness, applications for social housing, tenancy relations service and as a central access point for supported housing. https://www.oldham.gov.uk>directory_record>housing

[4] Bagging - Criminal gangs have devised a new tactic of stabbing their victims in the rectum with the intention of them having to use colostomy bags for the rest of their lives https:// www.standard.co.uk 22.12.2014

[5] Epistaxis is the medical term for a nose bleed

4.15 In **September 2021** a further referral was sent to Housing Options due to Jason's increasing vulnerabilities and escalation of risk to himself and others. During this time he spent periods of time in and out of hospital and deciding whether to leave the tenancy. One of these hospital admissions was a result of him being attacked by 2 males not known to him who inflicted a knife wound from his jawline to forehead. He was eventually placed into further temporary accommodation in **January 2022.**

4.16 Jason was seen by a mental health liaison practitioner in **April 2022** due to expressing suicidal thoughts when he was an inpatient in an acute hospital. He did not require admission for assessment under the Mental Health Act at this time. In the same month he was given a diagnosis of post-concussion syndrome[6] following the assault of him in **March**.

4.17 In the same month Jason disclosed to staff that he was sleeping rough in Manchester for 3 days to earn money to repay a debt he had acquired from buying street drugs.

4.18 In **August 2022** Jason was admitted to hospital with further problems with his right knee. He went into respiratory arrest thought to be because of taking an overdose and was transferred to the ICU. During this inpatient episode Jason was seen by the spiritual care team at his request who offered prayers with him. Repeated attempts by the DNs to treat his's knee wound were made after hospital discharge but he frequently did not attend or could not be located

4.19 On the **26th October 2022** GMP received reports of suspicious activity behind a property used by a housing provider. Jason was arrested for being in possession of an offensive weapon. Whilst in custody he was seen on CCTV believed to be concealing something. Following an authorised strip search no items were recovered. Later the same evening Jason was noted to be lying on the cell floor and 'drowsy'. He was assessed by a health practitioner and disclosed that he had taken 4 times the prescribed dose of his methadone the previous day. Jason was taken to hospital where he was treated for a probable overdose in ICU. The possibility of Jason having concealed drugs on his person was discussed, medical staff recovered a small plastic bag containing white and brown powder from his rectum; a further crime report was submitted. Whilst in hospital Jason was released from Police custody he later discharged himself from hospital, staff felt he had the mental capacity to make this decision and there was no legal framework that could have been used to detain him.

4.20 Jason was last seen by housing staff on review of CCTV footage in the early hours of the **29th October 2022** when he was seen talking to another resident. He was not seen again over the weekend and did not respond to knocks on his door, there was no reason for staff to access his property or have concern for his safety. On the **31st October 2022** Jason's brother and a previous resident asked staff to check on him because they had not heard from him over the weekend. Jason was sadly found to have died when his property was accessed on this date.

5.0 Review and Analysis of Multi-agency Working through the Lens of 'Safeguarding'

The following sections of the report refer to Multi-Disciplinary Team (MDT) and Team Around the Adult (TAA) meetings. Both can be used interchangeably, the purpose of them is to bring agencies together to share information about, and to fully understand the concerns of

[6] Post concussion syndrome occurs when symptoms of a mild traumatic head injury last longer than expected after an injury. These symptoms may include headaches, dizziness and problems with concentration and memory. They can last weeks to months. https://www.southtees.nhs.uk>post-concussion-syndrome/

different staff groups working with adults at risk of abuse or neglect. TAA is terminology used particularly in the Tiered Risk Assessment and Management (TRAM) protocol introduced in Oldham in January 2022.

5.1 The first safeguarding referral was submitted on the 20th August 2020

5.1.1 This referral was made by NWAS following their contact with Jason six weeks after he had been released from prison. He was feeling suicidal and expressed an intent to end his own life that day. He felt he wasn't receiving enough support and the accommodation he had been released to was full of drug users which had made him fall back into his old cycle of substance misuse. He also reported having money stolen.

5.1.2 As a result of this contact Jason was taken to hospital for an assessment of his mental health. ASC received the referral the following day and it was recorded on their system as a 'first contact' document. Following 3 attempted telephone calls to Jason which he did not respond to a letter was sent to him asking him to contact them if he felt he needed their support. No response was received back, and the case was closed as 'no further action'. The referral states that Jason 'does not know how to use a mobile phone' which would make the 3 attempts at telephone contact questionable.

5.1.3 This referral was dealt with during the first COVID-19 lockdown which restricted the face-to-face contact professionals had with people to limit their exposure to spreading/catching the virus which may have had a bearing on the method of approach in contacting Jason as described above.

5.1.4 The potential cuckooing aspect and financial abuse in respect of theft of money do not appear to have been considered in any greater depth before the decision was taken to close the safeguarding episode down. [Recommendation 7]

5.2 The second safeguarding referral was submitted on 20th March 2021

5.2.1 This referral was made by hospital staff following Jason presenting in ED following a witnessed assault by some of the male members of his family causing significant injuries. A DASH[7] risk assessment was completed by ED staff in line with their safeguarding procedures.

5.2.2 A social worker met with Jason face to face on the **24th March** as a result of the safeguarding referral being made. When the assault was discussed with him he presented as capacitous to the social worker and declined to proceed further with the safeguarding process stating his family members 'were under a lot of pressure'. This referral is associated with a safeguarding referral submitted by NWAS at the same time highlighting similar concerns about the same incident. Both referrals were dealt with as 'one referral'. A social worker again closed this referral.

5.2.3 Jason refused to give a statement to the Police, the safeguarding episode was closed under making safeguarding personal guidance noting that the Police were aware and that housing were supporting him, it was recorded as a 'first contact' document rather than a safeguarding referral.

5.2.4 There is no evidence that the earlier safeguarding referral for Jason was reviewed against the new referral. There was a missed opportunity to see a pattern of risk and

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[7] DASH risk assessment – The DASH tool (Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment) is an assessment tool that helps work out the risk level for the victim. https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face

vulnerability for Jason, had this occurred it would have been beneficial to arrange an MDT meeting to share information with the agencies that were currently supporting him.

5.3 The third safeguarding referral was submitted on 26th April 2021

5.3.1 This referral was submitted by a housing first worker from Jigsaw Support following concerns about his physical self-neglect, his continuing misuse of drugs and his safety at the property.

5.3.2 The Adult Safeguarding Concern (ASafeC)[8] record clearly sets out that Jason's physical health was significantly compromised due to his ongoing misuse of drugs, and the risk of infections due to his injecting into his veins. He had suffered a broken knee and a heart attack in **2020.** It expands on the risk to Jason from some of his family and associates and how this has escalated because of him allowing siblings to stay at his property. The documentation also records his lack of willingness to engage with seeking support for his physical and mental health, as well as his mounting debts and poor budgeting skills. The referral stated that he was in receipt of a daily delivery of methadone and between 11am and 12am was the best time to see him because he would be at the property waiting for the methadone.

5.3.3 The ASafeC record reflects the alerts that were received from Police, NWAS and hospital staff and the difficulties in trying to contact Jason to follow concerns up. ASC established recent health concerns including Hepatitis C, malnourishment, a stab injury, and a fractured knee following a jump from height to avoid a further assault. From the Police, ASC were aware that since **November 2020** there had been 12 calls to Jason's property mainly because of domestic abuse by some male family members. Jason was also known to the IDVA the same month, his was also known to Turning Point for support with his substance misuse.

5.3.4 This ASafeC record reflects that this was a repeat concern and records who the alleged perpetrators of the domestic abuse were and that a safeguarding enquiry was not required.

5.3.5 The record notes what was working well and what was not working well, the working well findings could be viewed as overly optimistic given that it was known that Jason was not engaging with support offered to him and his physical health was deteriorating. There was a plan to refer him for a care act needs assessment and risk management, to notify the GP and for the IDVA to continue to attempt to contact him. Housing would also continue to offer their support.

5.3.6 The safeguarding adults managers decision is recorded as recognising that Jason does not want safeguarding support in relation to physical abuse from his family which follows the principles of making safeguarding personal. It does recognise that there were concerns around his self-neglect and that an assessment should be made and a multiagency risk management approach was required with input from health, housing and the Police. The needs assessment was allocated to a social worker and the safeguarding episode was closed.

5.3.7 Despite the safeguarding episode being closed by ASC there is evidence that MDT meetings were then put in place to share up to date information about Jason and whether risks were escalating. There were a further 4 MDT meetings held prior to **May 2022** chaired

[8] The abbreviation ASafeC is used when describing an Adult Safeguarding Concern document, the abbreviation ASC refers to the Adult Social Care department within Oldham Council

by a social worker however the minutes from these meetings were not on the system in ASC at the time of this review but were e-mailed out to those who had attended.

5.4 The fourth safeguarding referral was submitted on 14th June 2021

5.4.1 This referral was submitted by a housing worker from Jigsaw Support following disclosure by DP to the worker that a threat to his life had been made by an unidentified male due to an unpaid debt he owed him.

5.4.2 The adult safeguarding concern document reflects that Jason did not liaise with the Police over this threat. Housing had offered to support him to move accommodation urgently which Jason refused and that he appeared to use a lot of drugs which added to his vulnerability. It was noted that the housing worker had reported the threat to the Police but that Jason would not disclose who had made the threat.

5.4.3 The document does not reflect that there had been previous safeguarding concerns raised, the type of abuse was documented as domestic violence and financial or material abuse. The decision was recorded as safeguarding enquiry not required.

5.4.4 A strategy meeting was held with ASC, Police, Housing and a Turning Point recovery worker attending. Background information was shared, it was noted that ASC had requested the Police carry out a welfare check on Jason which was due to take place as soon as staff were available. This information was not recorded on the correct section of the Mosaic record, however this was not a significant error.

5.4.5 The outcome of the meeting was that monthly MDT meetings would continue to be held. Housing would offer ongoing support, Police would undertake the welfare visit to Jason and Turning Point would work with him on his substance misuse.

5.5 The fifth safeguarding referral was submitted on the 26th January 2022

5.5.1 This referral was submitted by NWAS following concerns that Jason was being targeted by drug dealers who wanted to use his home as a base for bagging up drugs for onward sale and that he had been physically assaulted in the face when he refused to allow this. He expressed a wish to be supported with his mental health as he felt suicidal and to have support to overcome his addiction and was taken to hospital for treatment. This information was shared with the hospital based social worker and was recorded in the case notes on this date, but no safeguarding documentation was created on the system as would be expected.

5.5.2 The management oversight following this referral reflects that this was an assault which required Police input. It identified that if the person had care and support needs a D2A[9] hub referral would be required by hospital staff prior to discharge from hospital.

5.5.3 There appears to be a communication breakdown between community and hospital based social workers in relation to who was managing the referral. The community social worker had received further concerns from the housing provider about the assault on Jason, this worker was advised by the hospital based social worker to ring the ward as they were not currently dealing with the case because he had been admitted to a ward. When the ward were contacted they informed the community based social worker that Jason had discharged himself from hospital, the ward staff felt there was no reason to suspect he did

[9] D2A Discharge to Assess is about funding and supporting people to leave hospital. https://www.nhs.uk>quick-guide-to-assess

not have the mental capacity to make this decision. The discharge also resulted in ASC not being able to establish what Jason wanted the outcome of the safeguarding referral to be.

5.5.4 The following day the social worker contacted the Police and managed to speak to Jason about the concerns raised. There was escalation by the safeguarding adults manager resulting in the case being presented to the 'complex case surgery' in **March** where appropriate agencies were present. The following actions were recommended:

- Support to move into temporary accommodation via housing
- Longer term plan to consider supported living
- Care Act assessment and mental capacity assessment to be completed
- Discussion about domiciliary care out of area to liaise with housing

5.5.5 In **April** and **May 2022** there appears to be a well-managed Team Around the Adult approach used in line with the Tiered Risk Assessment and Management[10] (TRAM) protocol; this was overseen by a manager from ASC. These meetings had other agencies in attendance and actions were allocated as appropriate. In **April 2022** the social worker who had taken over case management of Jason escalated her concerns about him to their head of service because of the significant risks and the continuation of the safeguarding concerns being shared by other agencies.

5.5.6 In **May 2022** the lead professional and the overseeing manager were reassigned, and the management was handed over to another social worker. In the same month an adult safeguarding concern notification of alleged abuse form was completed by the district nurses (DNs) about Jason and his safety at the property when they could not locate him for medical treatment; the referral was sent to the MASH, and there was discussion with the social worker in relation to escalating this to the Adults CaHRP due to the concerns about the risk of infection to his knee wound. A further concern was raised from the Jigsaw Support worker relating to theft from Jason's property and his vulnerability to exploitation by others, Jason had moved to his stepfather's address as a result. The case had been passed to the original worker and the centralised duty team were notified. This was a missed opportunity for other agencies to take the lead and call a TAA meeting if they felt this was necessary. **[Recommendation 1]**

5.5.7 On **21st July 2022** there appears to be an incomplete strategy discussion episode with no information or minutes uploaded onto the system by the social worker following the referral to the MASH. However the next action was documented as being to raise a safeguarding enquiry. The creation of this document is after the death of Jason. **[Recommendation 4]**

5.5.8 On **27th July 2022** there was a risk assessment and protection plan recorded which identifies that Jason was at risk of:

- Domestic abuse from family members and unknown others.
- Leading a chaotic lifestyle with high levels of substance misuse and engagement with services is poor making positive change difficult
- Risk of overdose

[10] TRAM protocol is used to support any practitioner working with adults where there is a high level of risk that would benefit from joint multi-agency management and senior oversight of risk management strategies. This protocol enables a coordinated and collaborative multi-agency response to risk. https://www.osab.org.uk>policies version 6 April 2023

5.5.9 The risk mitigation was to discuss with Jason a referral into MARAC which he declined and to encourage him to work with Turning Point in addressing his substance misuse. It was noted that although Jason stated he was being seen weekly his recovery worker had a different view, the record stated Jason had missed several appointments. The protection plan reflected that he had the mental capacity to make these decisions at that time. **[Recommendation 5]**

5.5.10 Following transfer of case management in **June 2022** case notes include a record of the social worker e-mailing various professionals for updates throughout **October 2022** until Jason sadly died at the end of the month.

5.5.11 The GP was aware of the many attendances by Jason at the ED and those that resulted in him staying long enough to receive treatment. There would have also been communication with the GP about nonattendance at hospital appointments and lack of engagement with the DN service. The GP surgery did not view Jason as an adult at risk, his vulnerabilities were not seen in the context of safeguarding and therefore no safeguarding referral was made. The focus appears to have been on managing Jason's clinical needs, there was evidence to show that the action plan from the TAA meeting were shared with the GP without any actions being allocated to them.

5.5.12 Regenda Homes staff reported 2 internal safeguarding concerns relating to concerns for Jason's safety but also to the safety of their staff due to the number of needles in the property. There was a level of expectation in the service specification that the primary role of Regenda was to inform all support professionals of any concerns for Jason with no other action than to manage the damage to the property. Annual safeguarding training prompted another member of staff to raise an internal safeguarding concern around the same issue shortly after the closure of the first. No external safeguarding referral was made by staff however information about ongoing concerns was shared with professionals.

6.0 Responses to the Terms of Reference

6.1 How well was making safeguarding personal understood by agencies making safeguarding referrals and was this evidenced

6.1.1 GMP iOPS[11] holds 2 records on Jason, the 2 records did not reflect the high risk on each and may have affected how the domestic abuse (DA) incidents were risk assessed. Markers on his police record indicated that he was a repeat subject, used drugs, could be violent and conceal drugs as well as having an urgent response marker in relation to his name (rather than any specific address). No safeguarding referrals were made by GMP as Jason would report crime but then decline to either name the individual/s or support investigation, this was a pattern of behaviour witnessed by other agencies who he reported crimes against himself to. When Jason would not engage staff may have felt making a safeguarding referral would not progress if in 'making safeguarding personal' he refused to cooperate with any subsequent support. In these circumstances police did make onward referrals to other agencies via the MASH recognising that Jason was still at risk even though he would not support a safeguarding referral.

6.1.2 Within GMP where vulnerabilities are identified a care plan referred to as an adult welfare care plan is created. The care plan allows for accurate recording of what occurred during the incident attended and what action was taken. Information gathered at the time of the incident is critical to understanding the risk to that individual and others and for making

[11] iOPS is an acronym for Greater Manchester Police's new integrated operational policing system which is the record management system that was launched in July 2019

appropriate decisions on what further action many be required. The process is supported by an aide memoir to help identify risk. GMP's panel member was satisfied that the vulnerable adult framework had been adhered to in the management of Jason.

6.1.3 There is evidence of an MDT in respect of Jason's vulnerabilities in **June 2021** the care plan is then used to document all strategy discussions that GMP were involved with from **June 2021** to **March 2022.** The ‘care plan’ title did not reflect what was documented within in it. It could be seen as being beneficial for a separate care plan to have been created for the purposes of recording the MDTs. Triage of care plans and domestic abuse records should result in any necessary referrals being made directly to the appropriate agencies, and not assumed to be completed by another agency. This could potentially result in ineffective information sharing with relevant partners and potentially necessary safeguarding measures being neglected for the vulnerable person.

6.1.4 Housing Options staff did make safeguarding referrals for Jason, during the TAA meetings they emphasised that when referrals were made requesting emergency housing for Jason these were made with his consent and that he needed to be involved in the decision-making process. Within the later stages of the TAA meetings housing staff felt that the voice of Jason and his consent to decisions being made was not being heard and the meetings were more process driven rather than focussing on how he could be involved himself in reducing risks to himself.

6.1.5 Probation staff made no safeguarding referrals for Jason during the timeframe of the review. Current standards within probation require a safeguarding check in all cases, this was not the case at the time of the management of Jason.

6.1.6 When Jason moved into housing provided by Howarth Housing Group (HHG) staff followed their own safeguarding, suicide risk and self-harm policies in line with expected practice and overseen by their safeguarding manager. Warning markers were placed on Jason's record and actions placed on handovers to mitigate risk. Due to the number of incidents involving Jason he was allocated a complex case worker; information was shared appropriately by housing staff to this care support worker.

6.1.7 Prior to Jason being placed with this housing provider no disclosure was made about his previous drug overdoses, suicide attempts, self-neglect, exploitation and having been the victim of domestic abuse. Prior to his death Jason had been arrested and taken to hospital as he had secreted drugs inside him. On discharge from hospital HHG were not made aware of the details of this admission either. Had they been made aware it would have afforded them the opportunity to make a note on handovers to perform visual welfare checks, something the family of DP refer to later in the report. Had the HHG been made aware of previous safeguarding concerns and the extensive prior involvement of other agencies it would have also allowed them to share their safeguarding reports to provide an up-to-date picture of how Jason was presenting.

6.1.8 Turning Point have a hospital liaison worker in post, due to the number of hospital admissions Jason had over the timeframe of the review this role supported multiagency team working. Substance detoxification and rehabilitation options were revisited when appropriate to do so despite Jason's regular refusal.

6.1.9 During **2020** and **2021** there were several missed opportunities to discuss and potentially raise safeguarding referrals on behalf of Jason following his attendances at Oldham Hospital ED. A DN did make a referral into safeguarding in **May 2022** following ongoing concerns about self-neglect. This referral does not appear to have triggered safeguarding procedures, the outcome was that Jason's social worker would make a referral

to the Adults Complex and High Risk Panel (CaHRP) but this does not appear to have been actioned. This was a missed opportunity to escalate the concerns **[Recommendation 2]**

6.1.10 Jason was only seen on 1 occasion at Manchester University Hospital prior to the scoping period of the review when attending with a mental health concern. At that time there is little evidence that his lived experience was explored, and any professional curiosity into the **November 2020** assault that required surgery or that 'think family' was considered. **[Recommendation 6]**

6.1.11 In assessing Jason the staff at Pennine Care NHS Foundation Trust recognised that he was an individual with multiple complexities and was vulnerable due to his substance misuse. He was seen in liaison mental health services and onward referrals to meet his assessed needs were made. Opportunities were given to Jason to express his views at the relevant times. His primary concern expressed was the level of his ongoing pain, his GP was made aware of this. Jason's view was that his GP was reluctant to increase his pain relief which led him to seek other ways to address his levels of pain.

6.2 How effective was the TAA, what worked well and what didn't, what learning from this is there for future case management?

6.2.1 GMP's care plan for Jason did reflect MDT meetings were attended from June 2021 to March 2022 and that agencies attending the meetings were conscious of the risks Jason was taking, but also subject to. There was evidence of strategy discussions and minutes being recorded on this document however the ‘care plan’ title does not reflect the content of what was documented. It would have been beneficial for a separate care plan to have been created for the purposes of recording the MDTs specifically. **[Recommendation 4]**

6.2.2 In **April 2021** when Jason was arrested for suspected burglary probation were informed. There is no evidence that staff discussed this with a senior manager to consider whether it would trigger a recall to custody. It was also found that Jason had not been contacted by his probation officer for 2 months, the expected review period would be monthly even with the COVID-19 restrictions.

6.2.3 There appears to be a lapse in the continuity of the TAA approach after its initial success at the start of **April 2022.** The change in manager and allocated worker in ASC and housing was a significant contributory factor, however this does not mean that other agencies who had been involved in earlier meetings couldn't have raised their concerns internally with their own managers or discussed the breakdown of the TAA approach with ASC. **[Recommendation 2]**

6.2.4 The first reference to a multi-agency risk management meeting was made in **April 2021** as a recommendation outcome from the MASH team when the 3rd safeguarding referral was closed. The social worker attempted to hold a safeguarding strategy discussion over the telephone although there were no minutes uploaded. A further 3 meetings were undertaken in **July 2021**, **October 2021** and **March 2022** but no minutes were uploaded. It was also identified that there was a lack of Multi Agency Risk Assessment (MARA) being reviewed regularly in **2021**, poor record keeping is a contributory factor and does not provide evidence of what was happening to support Jason and mitigate risk where possible. **[Recommendation 4]**

6.2.5 Following receipt of further information into ASC from agencies supporting him it is not clear from the records available whether this was escalated to managers within the team or why this had not prompted further safeguarding episodes. **[Recommendation 2]**

6.2.6 In **August 2022** the allocated worker had another change of manager. At supervision, they briefly outlined the case as part of the review process, shared that Jason was going to be referred to MARAC and that they would arrange a further TAA meeting with all the professionals. There is no evidence to support that a further TAA meeting was held.

6.2.7 In **October 2022** the allocated worker did not raise any concerns about the ongoing management of Jason. It was noted that the allocated worker required additional support to manage their workload effectively and apply professional curiosity. **[Recommendation 6]**

6.2.8 Across all agencies it is essential that robust and appropriate information sharing takes place and recording of information is made contemporaneously whenever possible. Having up to date contact details is also key to avoiding 'drift' in case management. **[Recommendation 4]**

6.2.9 The TAA approach is an effective model to share risks and decision making and should not be compromised when those engaged with the adult move from their oversight role for whatever reason. Clear handover to the follow-on worker is crucial to the success of the multi-agency approach.

6.2.10 It is critical that all agencies understand they have a responsibility to escalate concerns if partner agencies fail to respond, complete actions or attend safeguarding meeting. Clear supervision structures would support practitioners in managing high risk cases and to seek advice if risk is not reducing or is escalating. **[Recommendation 2]**

6.2.11 There is evidence of a number of agencies working together and sharing information but the TAA does not appear to have identified a lead agency, when the TAA meetings broke down there was a lack of multiagency challenge, with no agency appearing to be willing to pick up the leadership role. **[Recommendation1&2]**

6.2.12 TAA meetings were attended by Regenda housing staff without actions being taken in a timely manner to address rehousing Jason when he had left his Regenda property. Better review of actions or escalation when actions were not complete would have avoided this. **[Recommendation 1&2]**

6.2.13 Probation records do not indicate that they were invited to attend any of the TAA meetings, resulting in them not being aware of any risk management plans for Jason despite his having licence conditions in place following his release from prison.

6.2.14 There is a common theme emerging from the review that the lack of business support staff impacted on meeting invites not going out to all the agencies who were supporting Jason, and records of the TAA meetings not always being made as would be expected in the TRAM protocol. Actions following the meetings were shared with the agencies that attended the meetings, but the lack of more detailed records of the meetings or full minutes potentially made it more difficult to see what the 'full picture' was and whether there was any ongoing cause for concern. Staff attending meetings should be empowered to say if they know or think that another agency needs to be invited so that a holistic picture of the needs and risk for the individual can be addressed. **[Recommendation1]**

6.2.15 As part of one of the actions from a TAA meeting there is evidence that Jason was kept at the centre of the support being offered. It was agreed on one hospital admission Jason would not be required to take the normal route through the ED and that he could be admitted directly to the surgical triage unit to allow for quicker treatment and reducing the likelihood of his leaving before been seen and treatment given. This action was driven by the social worker and the named nurse for safeguarding adults at NCA working together.

6.2.16 As concerns escalated in **2022** it appears from evidence available that there was little discussion with Jason about what he wanted outcomes to be, there appeared to be a lack of evidence to support person centred and outcome focussed risk mitigations and care planning.

6.2.17 Housing First staff recognised that Jason had complex needs and requested that a dual diagnosis practitioner (DDP) from Greater Manchester Mental Health Trust (GMMHT) supported the work with him. She offered a referral for inhouse psychiatrist support. Once she left her role this was not picked up by Housing First staff because it had been determined that Jason had fluctuating capacity, establishing whether Jason lacked capacity was one of the areas the DDP had been providing support around**.** Practitioners at the Learning Event felt that the dual diagnosis practitioner was an important role and that all community mental health teams should have people in these posts. **[Recommendation 5]**

Jason's life was affected by several abuse categories under the Care Act 2014:

6.3 Self neglect - how was this managed by agencies and was the MCA and HRA considered appropriately?

6.3.1 During **2020** and due to the COVID-19 restrictions very few home visits were carried out by agencies unless there was a clearly identified reason for doing so, this was to protect both the public and support workers from spreading the infection. Telephone contact with Jason was also difficult for staff as often he would be without a phone, he was provided with new mobile phones on 5 occasions by staff to try to maintain contact with him.

6.3.2 The opportunities to see Jason in person and assess him holistically were limited at times due to the COVID-19 restrictions and may have reduced the ability of staff to appreciate the ongoing state of his self-neglect. His limited mobility following the injury to his knee may also have contributed to his inability to manage his self-care.

6.3.3 From **July** to **December 2021** there is a recurring theme in a number of agencies records that Jason was self-neglecting and prioritising his substance misuse over his physical and mental health. He frequently missed appointments or was not available over the telephone for consultation which were intended to support his health and wellbeing. The general view by practitioners appeared to be that Jason when not under the influence of drugs did have the mental capacity to understand the risks he was putting himself at, importantly in relation to his physical health which was significantly poor for the period of this review. He was felt to have the capacity to make an 'unwise decision' in line with Principle 3[12] of the Mental Capacity Act 2005 when not following advice of practitioners who were making suggestions they felt were in his best interests to either keep himself safe or seek medical care. **[Recommendation 5]**

6.3.4 In **April 2022** Jason's support worker contacted GMP in respect of a concern for welfare, reference was made to the possibility that Jason lacked capacity. The GP was then asked to complete a capacity assessment of Jason. This was done over the telephone with his support worker present. The records show that the GP concluded that Jason had capacity however it is not clear in relation to which decision he was being assessed against. It is presumed that it was around accessing healthcare but there is no documentation to support how this conclusion was reached. **[Recommendation 5]**

6.3.5 On the occasions when Jason described feeling suicidal appropriate steps were taken to support him, there is no evidence in the records that he was detained under section 2 of

[12] Principle 3 of the MCA 2005 A person should not be treated as incapable of making a decision because their decision may seem unwise http://www.scie.org.uk.mca

the MHA[13] or of the Police having to use s136 powers[14]. Practitioners at the Learning Event expressed the view that it felt like they were being bounced between mental health and substance misuse services when trying to support people like Jason. Treatment options were available but only to those with a desire to want to engage, and that in alcohol misuse services the person had to be alcohol free for 3 months before being able to access the support service. Many people they worked with could not achieve this without earlier support.

6.3.6 The independent author understands that there used to be an assertive outreach service in Oldham that had been very successful but due to funding issues this had been withdrawn several years ago. Those practitioners with experience of working with the service felt that this was a great loss and had it been available people like Jason could perhaps have been referred to it. It was acknowledged however that the role of the housing support workers covers some of what the assertive outreach service provided.

6.3.7 The ongoing concerns for Jason's self-neglect were not escalated until he had left the Regenda property. Further training is to be undertaken by the Regenda safeguarding team and designated safeguarding leads about self-neglect. **[Recommendation 2]**

6.3.8 Evidence of self-neglect was recorded in the records of Jason held by probation, however there is no documentation to demonstrate whether these were discussed, escalated, and verified sufficiently with other agencies. It is not possible to confirm if this is because they were, but not documented, or that there was no discussion or professional curiosity applied.
[Recommendation 4&6]

6.3.9 Self neglect was not indicated on the risk referral provided to the second housing provider when Jason moved into their accommodation. Daily welfare checks did highlight that he had ongoing medical issues with his leg and Jason was encouraged to attend hospital. Staff did not feel he lacked capacity when he was making the choice not to seek medical treatment, they observed his HRA Article 8 rights[15]. The complex case worker did contact the care support worker on **24th October 2022** to share their concerns over his worsening mental and physical health, and requested consideration be given to a mental health assessment. **[Recommendation 5]**

6.3.10 Following referral to the mental health liaison team by ED staff in **May 2021** Jason appeared unkempt but was dressed appropriately for the weather conditions. At this appointment he disclosed that a family member had stolen his methadone and that his property was being used for cuckooing. Both GMP and the housing provider were made aware of this information. A mental health assessment was undertaken which concluded that there were no acute mental health needs. **[Recommendation 7]**

6.3.11 Throughout early involvement with Jason from **July to December 2021** a recurring theme of refusing support and declining intervention was documented. Correspondence at this time between housing and ASC suggests that Jason's mental capacity may have been fluctuating. Options were to revisit the decision in future, he was advised that if he should change his mind he could contact staff again. Proactive practice was not evidenced

[13] Under Section 2 of the Mental Health Act 1983 you can be kept in hospital for up to 28 days. https://www.nhs.uk>mental-health-act

[14] Section 136 of the MHA gives the Police emergency powers they can use these if they think you have a mental disorder and take you to a place of safety https://www.legislation.gov.uk>136-powers

[15] Human Rights Act 1998 Article 8 Right to respect for private and family life https://www.legislaton.gov.uk>schedules

particularly well and Jason was left to make decision rather than offering particular dates and times when the decision/s could have been revisited. **[Recommendation 5]**

6.3.12 Mental capacity assessments were carried out on Jason by Royal Oldham hospital staff when it was appropriate to do so and on the 1 occasion he was found to be lacking the mental capacity to consent to medical treatment a best interest decision was made on his behalf and a deprivation of liberty authorisation[16] was requested from ASC following the Trust granting the urgent authorisation. Staff highlighted that at this appointment Jason had no evidence of a mental health condition, his mental health was compromised by his level of pain, appropriate action to address this was taken.

6.3.13 During 2022 when Jason was discussed at MDT/TAA meetings and as his physical health continued to deteriorate there is no evidence to support that mental capacity was discussed by professionals or that attempting to record capacity assessments on Jason was felt to be necessary or otherwise. The more serious the consequences for Jason of the decision, the more rigorous the steps would be expected to determine whether he had the capacity to make the decisions.[17]

6.3.14 Staff felt that legal advice to support their management of Jason was not necessary, no court of protection application could have been made in respect of him and therefore no legal advice was given. Had it been required it would have been accessed via individual agencies adult safeguarding teams if this was the agreed process within that agency.

6.3.15 In managing Jason's self-neglect there were frequent occasions when staff could not locate him when he should have been at his home to meet with staff trying to support him. On several occasions support workers went above and beyond their remits to try to locate Jason to undertake 'safe and well checks' and Police support was often sought. Practitioners expressed their concerns at the Learning Event over the 'Right Care, Right Person' proposals being adopted by Greater Manchester Police, particularly in relation to their perception that Police support with 'safe and well' checks would soon be withdrawn and how this could impact vulnerable people. GMP's panel member confirmed support following the introduction of the Right Care, Right Person proposals would not be withdrawn however GMP would be undertaking significant analysis to better understand incoming calls to determine which require a police response, and for those calls where police are not the right agency who would be better equipped to respond. **[Recommendation 8]**

6.3.16 The independent author is aware of an NIHR-funded project[18] focusing on the assessment of the mental capacity of people who are experiencing multiple exclusion homelessness, a term used to capture the overlapping of a range of experiences associated with profound social exclusion, including not just homelessness but also institutional care, substance misuse, and 'street culture' activities. Factors such as poor mental health, addiction, and the effects of adverse childhood experiences in this population mean that capacity assessments under the Mental Capacity Act 2005 (MCA) can be particularly challenging. The research will explore and analyse health and social care practitioner approaches to mental capacity assessments with people experiencing multiple exclusion homelessness in England. Findings from mixed-methods research will inform the co-production of a revised and tested specialist assessment tool for this population. The OSAB

[16] A person can be deprived of their liberty and right to freedom only in certain circumstances. This form of deprivation of a person liberty is covered in HRA1998 Article 5 and in the MCA and DoL Code of Practice https://www.scie.org.uk>mca>at>a>glance

[17] The situation seems risky to me https://capacitygiude.org.uk/flaspoints/the-situation-seems-risky-to-me/

[18] Mental Capacity Report October HWDOL.pdf(39essex.com)

may wish to follow the progress of this research project and its outcomes. **[Recommendation 5]**

6.4 Exploitation - how was this managed by agencies taking into consideration financial abuse and cuckooing?

6.4.1 There is no direct reference in the GP record to suggest that the GP was aware of the exploitation that Jason was subject to or debt causing risk of harm to him. On the occasion that Jason left the ED following the bagging injury the GP actively tried to encourage him to attend hospital for treatment. It might be unfair to expect the GP or other agencies to know what this type of injury is specifically related to if knowledge of this type of injury were better known it may have triggered the curiosity of the GP and other agencies and the Police to consider cuckooing[19] at an earlier stage. **[Recommendation 7]**

6.4.2 In **January 2022** GMP attended Jason's property and NWAS raised concerns in respect of exploitation and cuckooing. Further investigation found that the housing provider disclosed that Jason had told him that male family members were damaging his property to gain entry to allow them to run drugs from within it. GMP shared this information with appropriate partners agencies as a result. **[Recommendation 7]**

6.4.3 There were also several reports made to GMP in respect of Jason's house being targeted by local adults/youths from the area. These reports prompted several crime reports being submitted; however, this would appear to have been seen as antisocial behaviour and there is a lack of professional curiosity in respect of this being possible exploitation. **[Recommendation 2]**

6.4.4 HHG were not aware of Jason previously being financially abused or exploited until he disclosed this to them himself. Once this was known the provider implemented their no visitor rule in relation to family and a warning marker was placed on his record with Jason's agreement to alert staff so that they could have an awareness of when his family were in the building As part of the licence conditions for supported temporary accommodation it is in HHG's policy that visitors are not allowed unless it has been agreed for a particular reason, this would not apply to professionals who needed to visit.

6.4.5 During the short interactions with Jason that hospital and community staff had they were not aware of the extent to which he was exposed to exploitation and financial abuse. There is only one recorded entry in **June 2021** when he did disclose that he had had all his money stolen from him. This does not appear to have triggered staff to report it to Police or make a safeguarding referral. In **April 2022** TAA meetings did address Jason's financial difficulties as he had reported sleeping rough in Manchester for 3 days to earn money to pay off a debt.

6.4.6 When Jason attended an appointment with his mental health worker in **July 2021** he disclosed that he had been cuckooed and that Police and housing were aware of this situation. There was no further exploration by the practitioner in relation to what was being done about this or if this was an historic issue, it would have been good practice to have had a further conversation about this to explore whether a safeguarding referral could be made. **[Recommendations 6&7]**

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[19] Cuckooing is the term used to describe the practice where drug dealers/criminal gangs take over the property of an adult at risk and use it as a place from which to run their drugs business/criminal activity http://www.stopadultabuse.org.uk

6.4.7 Jason presented as homeless due to having experienced several forms of harassment and abuse at his property from some family members and unknown others. A generic response was taken with advice provided to Jason to utilise the support of Police and other agencies to allow them to respond to incidents. This did not at the time consider Jason's ability to manage his own 'front door'. The Homelessness Code of Guidance[20] states housing authorities should consider whether it was appropriate for DP to remain in the property. Jason's case was closed however without a formal decision being made.

6.4.8 The Housing First team often deal with cases of cuckooing. They liaise with housing officers and the Police in these cases and although the person can see the cuckoo as a 'friend', the relationship is an abusive one. Staff were aware following conversations with Jason that some family members were involved in the abuse and challenged Jason over his allowing them into his property there was no further record of this being explored with him further or what other actions could be taken in relation to this. **[Recommendation 6&7]**

6.4.9 The OSAB have a document titled 'Exploitation in the form of 'Cuckooing' Guidance which was introduced in **May 2023**, therefore outside the scope of this review period. The guidance makes the link for practitioners between anti-social behaviour and what this might be an indication of in the wider context. Advice is given in relation to whether this should be reported to the Police as a crime. **[Recommendation 7]**

6.5 Domestic abuse - was this managed differently due to family members being alleged perpetrators and not between 'intimate partner'? How effective was MARAC in dealing with DA in this situation?

6.5.1 The GP was aware of the assaults on Jason that resulted in hospital attendances but given the limited opportunities to engage with Jason in person there was not much opportunity to apply professional curiosity in the context of him being an adult at risk. There is no evidence in the GP record to suggest that they were asked for information prior to the MARAC meetings or that they were given documents following the MARAC meetings. Better liaison with GPs in relation to MARAC would potentially be beneficial in sharing appropriate information held on the GP record.

6.5.2 GMP responded appropriately to the reports of domestic abuse, when responding to reports a record is created and the attending officer sets the level or risk. In line with GMP's Domestic Abuse Policy (May 2023) there are three levels of risk:
Standard
Medium
High

6.5.3 During the timeframe of the review there were 11 recorded domestic abuse records most of which were assessed correctly, however there was evidence when the risk was not assessed correctly (standard) this resulted in it not being triaged by MASH and onward referral was not made. There was evidence of a medium risk being escalated to high this was referred into MARAC and an IDVA allocated. **[Recommendation 3]**

6.5.4 Jason was initially referred to MARAC in **March 2021** following the report of a serious assault perpetrated by family members. There were 2 subsequent repeat MARAC referrals. There is however evidence of missed opportunities to refer back to MARAC as a repeat and it would appear that these missed opportunities have come from either the domestic abuse incident being risk assessed as standard or the incident not being recognised as domestic abuse possibly because it involved male family members and was not linked to 'intimate partner' abuse. **[Recommendation 3]**

[20] The homelessness code of guidance s6.39: (c)

6.5.5 Although several crimes were recorded positive action was not always taken and evidence led prosecution was not always considered, mainly due to Jason not supporting this. There appears to be a lack of professional curiosity around why he would not support a criminal investigation. By not taking positive action this allowed perpetrators to return to his address and potentially place him at further risk of harm. Had positive action been taken consideration could have been given to issuing a Domestic Violence Protection Notice (DVPN).[21] **[Recommendation 6]**

6.5.6 Regenda staff followed their internal and external safeguarding policy and procedures following incidents of domestic abuse against Jason. There was no evidence to suggest staff treated these incidents any differently because they were perpetrated by family members and not an 'intimate partner'.

6.5.7 The probation representative at MARAC attended the meetings and did alert their responsible officer in their team to the meetings. There is a basic summary of discussions recorded and no actions were allocated to probation because of the 3 meetings.

6.5.8 The second housing provider was again unaware of the level of domestic abuse being perpetrated against Jason by family members until he disclosed some of this himself. Prior knowledge of this could have been used to alert staff and allow for assessment of risk.

6.5.9 On **24th March 2021** Jason attended Oldham hospital following an alleged assault carried out by male family members. No DASH risk assessment [22]was carried out by staff which was potentially a missed opportunity to assess risk although Jason was accompanied by Police at this attendance. Throughout **2022** staff felt Jason had a good relationship with his stepfather and was asking to be discharged so that he could go and see him. At some home visits Jason was seen in the presence of his stepfather by district nurses and no concerns of domestic abuse were reported. **[Recommendation 6]**

6.5.10 MFT hospital staff did not raise any concerns around exploitation of Jason following conversations with him, there was no documented evidence that opportunities to explore factors leading to Jason's assaults were attempted by practitioners. This was a missed opportunity. **[Recommendation 6]**

6.5.11 Regardless of the perpetrators of domestic abuse sometimes being some of Jason's male family members had the IDVA service been successful in meeting with him an individual safety and support plan could have been implemented.

6.5.12 Jason's reason for presentation to housing in **November 2021** was documented as 'domestic abuse' and his case was assigned to one of the specialist housing IDVA's. From a procedural perspective Jason was treated as with any other type of domestic abuse case. Housing found it difficult to carry out effective safety planning work beyond the provision of safe accommodation, not just because of familial relationships but because of needing to assess Jason's physical and mental health needs. Having numerous potential perpetrators of abuse of him made it more difficult to safeguard him unlike a single 'intimate partner' being the perpetrator. Information sharing between agencies and TAA were the best opportunities to safeguard Jason as well as effective management of 'front door' at his accommodation.

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[21] Domestic Violence Protection Notice Police can serve a DVPN on any individual aged over 18 who they believe has been violent or threatened violence against another person and the victim requires protection. https://www.gov.uk>publications

[22] DASH Domestic abuse, stalking, harassment and honour based violence assessment

6.5.13 Housing First staff recognised that Jason had a sometimes difficult but close relationship with his family members which included violence against him, in the records it is not recognised as domestic abuse but noted as financial abuse. As a result there were no discussions between staff and Jason around domestic abuse in the context of his family relationships. **[Recommendation 6]**

MARAC Referrals

Jason was referred into MARC on 3 separate occasions **31.03.2021**, **26.04.2021** and **17.05.2021**.

First discussed at MARAC on **15th April 2021** as below:

Identified Risk	Agreed Action	Agency
Victim is vulnerable	Try to make contact with victim	IDVA
Victim is currently on methadone prescription for methadone		
Known to mental health services but doesn't engage		
The victim does not support any Police prosecution		
Possibility of cuckooing		

There is only one action allocated following discussion at MARAC on this date.

Jason was discussed at a 2nd MARAC on **13th May 2021** as below:

Identified Risk	Agreed Action	Agency
Repeat MARAC - Siblings	Look at the victim's licence conditions	CRC[23]
High level of violence within the family	The victim's case worker to contact housing	CRC
The perpetrator was removed from the victim's property to prevent a breach of the peace	To contact the victim	IDVA
The perpetrator has been refused to be rehoused by housing due to outstanding case with his case worker	Speak to Victim's recovery worker re housing	Turning Point
Theft by the perpetrator of the victims personal belongings		
Drug misuse by the victim		
The victim is currently on licence for burglary until Oct 2021		
The victim and perpetrator have extensive DV history with previous partners		
Mental health issues by both the victim and perpetrator		

[23] CRC – Community Rehabilitation Company managing low and medium risk of harm cases.

Chaotic lifestyle by both		
The victim has not engaged with mental health services		
The victim will not support Police prosecution		

Jason was discussed at a 3rd MARAC on **10th June 2021** as below:

Identified Risk	Agreed Action	Agency
Repeat MARAC	No actions	
Victim states he has been robbed by a family member		
On Police attendance both appeared to be under the influence of drugs		
IDVA has been unable to make contact with the victim and have liaised with the victims Social Worker to try and make contact		
Drug mis-use by both victim and perpetrator		
Chaotic lifestyle		

Analysis

6.5.15 At the time Jason's referrals were heard at MARAC all the meetings were held by virtual conference due to COVID-19 restrictions being in place. There were limited actions recorded on the MARAC documents which do not appear to address the risks identified at the meetings. **[Recommendation 3]**

6.5.16 It is not clear from probation records whether staff who were monitoring Jason's licence conditions were invited to join the MARAC meetings or were required to share information ahead of the meetings taking place. Recording on the probation system does not indicate that the probation officer requested to see the reason for the MARAC referral in full or to receive the MARAC minutes in full. There is an agreement in MARAC that it is victim led, probation do not record full information to protect victims, however in this case Jason was the victim and therefore it may have been beneficial for the full disclosure of records relating to the MARACs to be shared with the MARAC representative. **[Recommendation 4]**

6.5.17 Both Jigsaw Support and HHG were not aware that Jason was subject to MARAC meetings, they potentially could have held information that it would have been beneficial to the meeting discussions. As a result of the 2nd MARAC meeting there was an action for the CRC representative to contact the housing provider, but this would appear not to have been actioned.

6.5.18 Following the inability of the IDVA to contact Jason because of the actions identified at all 3 MARAC meetings there was no further exploration held to establish whether other agencies could offer support to the IDVA in meeting with Jason after the social worker had been unable to support this. This is potentially a missed opportunity to utilise other agencies in speaking to Jason.

6.5.19 Across Oldham MARAC's run fortnightly over 2 days with approximately 20 – 24 cases being discussed over the 2 days. The MARAC process was reviewed at the beginning of 2022 by Safe Lives[24] to evaluate how well the MARAC process was managed across Oldham. The Oldham Domestic Abuse Partnership owns the actions from this Safe Lives review. The findings from this review in respect of having clear information on which agencies are working with the victim, what information they might hold to aid safety planning and clearer actions to mitigate risks identified should be shared with the partnership to identify any additional learning. **[Recommendation 3]**

6.6 What evidence of ongoing professional curiosity was there when repeated safeguarding referrals did not appear to address increasing risk?

6.6.1 Across the agencies there appears to have been a varied response in respect of repeated safeguarding referrals not evidencing risk reduction.

6.6.2 MFT staff had minimal contact with Jason during the timeframe of this review however he was admitted to them following the 'bagging' injury and fracturing his knee. During this inpatient episode there is no evidence of staff exploring Jason's lived experience or of applying wider professional curiosity in **November 2020. [Recommendation 6]**

6.6.3 The GP was aware of a diagnosis of post-concussion syndrome in **April 2022** along with the historic injuries Jason had suffered, this should potentially have raised professional curiosity in viewing Jason as an adult at risk and potentially questioning his mental capacity around his decision making which may have highlighted coercion and control by family members, but in the context of limited engagement and no face to face appointment this was a lost opportunity. **[Recommendation 6]**

6.6.4 Professional curiosity by Regenda staff at TAA meetings was not sufficient to discuss the rehousing of Jason and extended the length of his tenancy when he was no longer living there. Professional curiosity training will remain a priority across Regenda, and this review will be used an as example of how important good record keeping is. **[Recommendations 4&6]**

6.6.5 At a time when Jason was arrested for an offence of burglary this was not discussed with him to fully establish what his motivation for this offence was. There were no obvious consultations with a manager about possible enforcement in response to committing an offence on licence by probation staff. Their lack of professional curiosity in this case and seeing the wider picture of what Jason was disclosing to the practitioner and how this was responded to was another missed opportunity for multi-agency working. **[Recommendation 6]**

6.6.6 There was no evidence on probation systems to indicate that Jason was open to ASC under safeguarding procedures during the time of the review, nor was there a flag identifying him as a 'Safeguarding Adult at Risk'. There is no evidence of probation being invited or attending any strategy meetings or TAA meetings despite Jason being released from prison under licence conditions.

6.6.7 Probation staff do not appear to have contacted Turning Point to establish how well he was engaging with his recovery plan, this was important as he had a licence condition to engage with this service. The probation officer was informed by DNs and housing support

[2424] Safe Lives – is an organisation that works with multi-agency partners and survivors of domestic abuse to review how well services respond. https://www.safelives.org.uk

workers of his hospital attendances some of which were for drug overdoses however there was a lack of professional curiosity in this respect and consideration over whether this information should have or would have resulted in safeguarding meetings, and if so, why probation were not being invited to multiagency meetings. **[Recommendation 6]**

6.6.8 There were no open safeguarding process open when Jason was living in the second housing provider's accommodation. Concerns over his self-neglect did not trigger staff to make a new referral into safeguarding procedures, information was shared with his support worker and when staff felt the level of pain that Jason was suffering due to his leg was negatively impacting on his mental health this was again flagged with his support worker for consideration of a mental health assessment.

6.6.9 NCA staff were not involved in the safeguarding procedures that took place in relation to Jason in **2021**. In **2022** the TAA meetings following safeguarding concerns appropriate professional curiosity was applied when trying to mitigate the risk he was exposed to.

6.6.10 The housing first worker brought a dual diagnosis practitioner (DDP) into the TAA for additional support around safeguarding. The DDPs are employed as part of the contract, with one worker in each of the 4 zones across Greater Manchester. The DDP has a role within the housing first team in providing support and expertise around dual diagnosis; this promotes professional curiosity within the team.

6.7 Was escalation of concerns within different agencies utilised or effective?

6.7.1 A number of the agencies involved in the review reflected that staff in their teams did not always escalate the ongoing concerns both within their own agencies or with partners outside their own agency, or if they had this was not able to be evidenced due to poor record keeping. There were some really good examples but these were not always consistent.
[Recommendation 2]

6.7.2 The social worker who initiated the first TAA meeting in **April 2022** did escalate their concerns to senior managers in ASC at this time but there is no evidence to support any advice being given in response to this request. When the TAA meetings did not continue following the change in social worker and housing worker, and the risks to Jason being able to keep himself safe were increasing there appears to have been no further escalation taken by any agency to escalate this**.** The TAA meetings in **2022** do not appear to have considered the possibility of escalating to the Adults CaHRP. This would have given opportunity to consider whether any additional support could have been offered or have offered a new perspective to this long standing case where options appeared limited.
[Recommendations 1& 2]

6.7.3 It is not clear how supervision supported the discussion with practitioners about cases of concern where risk mitigation was difficult due to the barriers of working with Jason effectively and where risk was continuing to escalate. **[Recommendation 2]**

6.7.4 There does not appear to have been consistent discussion about the risks to Jason with safeguarding leads in agencies to seek advice on any further action that could have supported multiagency working. **[Recommendation 2]**

6.7.5 In respect of multiagency working staff need clear support and guidance about which routes to take if other agencies are not responding or engaging with TAA and safeguarding meetings. Coordinating such meetings can be time consuming and difficult when staff are already busy, but managers must be clear that these meetings must be prioritised and if the staff member cannot attend a deputy will step in, or a written report will be shared for consideration at the meeting. Good minute taking and timely distribution is again a

challenge without adequate administrative support for practitioners something that most practitioners representing their organisations at the practitioner learning event highlighted was an issue for them **[Recommendations 1, 2&4]**

6.7.6 There were numerous agencies that escalated concerns to housing about Jason and the need for support with his accommodation, this was mostly effective as it was timely and involved key individuals who were supporting him at the time. It may not have always involved Jason which meant that at times he would decline, or refuse offers of support. Engaging with the individual to establish what outcomes they want is an important part of building trusting relationships with people who have complex needs.

6.7.7 The brother of Jason expressed the view of his family that they felt Jason had been 'let down' in the final weekend of his life. One of his brothers had accompanied Jason back to his flat when he had been discharged from hospital for the last time after having spent time on the ICU. This brother was very concerned about the frailty of Jason and requested that he be allowed to stay with him over the weekend until he had recovered more. Documentation by the housing provider supports that Jason asked his brother to leave on his arrival back at his flat and due to procedures not allowing this the request was declined. Jason's family felt that more effort by the housing provider should have been made over that weekend after concerns about his frailty had been raised with them. The next contact the family had with Jason was on the Monday when they raised their concerns with the housing provider that they had not heard from their brother over the weekend, when his flat was accessed, he was found deceased. Jason had last been seen by staff talking to another resident on the Saturday night on CCTV.

7.0 Good Practice

7.1 Greater Manchester Police (GMP)

7.1.1 On 2 occasions officers have submitted domestic abuse records which had initially been filed as standard risk. A standard risk DASH would not prompt a referral to ASC, however this was recognised at the point of triage so on one occasion the necessary referral to ASC was made and on the other occasion a repeat MARAC referral was made.

7.1.2 The arrest for the serious assault in March 2021 was an expected and appropriate response.

7.2 Howarth Housing Group

7.2.1 There was good communication between housing staff and Jason's care support worker, they worked well daily to support him as far as he would allow. There is a template safeguarding incident report that the group have developed that logs what happened and what actions are needed by both staff and the resident involving them in the planning process. This document was used on more than one occasion, the template has been shared with Oldham Housing Options for others to adopt if they wish.

7.2.2 Housing staff were not aware that Jason had been subject to MARAC referrals prior to them accepting him, he informed staff himself that some of his family were abusing him. Once this information was known their no visitor rule was implemented and a warning marker was placed on his profile.

7.3 Greater Manchester Housing First - Jigsaw Support

7.3.1 Jason's support worker made numerous efforts to contact him to inform him that his tenancy would be available because he knew the temporary accommodation was having a negative impact on his mental health and his risk of taking non prescribed drugs. He also

arranged for some furniture to be delivered which Jason was unaware of and grateful for when he moved in.

7.3.2 Within weeks of moving into his tenancy accommodation Jason was already evidencing to his housing support worker that he couldn't manage his finances, was in rent arrears and was requesting food parcels and bus passes. Jason was respectfully challenged over this when it was clear he was being untruthful about his benefit payments.

7.3.3 Staff remained fully involved with Jason during the safeguarding process, attending MDTs, carrying out the actions specified and feeding back to him. They also went to great lengths to locate him when he was missing from his accommodation when DN's were due to visit.

7.4 Northern Care Alliance NHS Foundation Trust

7.4.1 When staff did attend TAA meetings in respect of Jason senior managers at the Trust were made aware. The DNs were flexible in their working with him attempting to agree with him when the best times to visit would be.

7.4.2 NCA have a representative who attends MARAC meetings and have specialist domestic abuse trained nurses who offer support and training to staff in relation to this topic. Staff are aware how to complete a DASH risk assessment.

7.4.3 There is a bi-weekly senior nurse walk arounds that include the Adult Safeguarding Team, there are dedicated safeguarding champions in every area of the Trust and bespoke training as required alongside mandatory training.

7.5 Manchester University NHS Foundation Trust

7.5.1 MFT staff made Police aware and a password was instigated for Jason following his admission for a stabbing injury as per Trust policy following suspected knife crime. Jason's substance misuse was recognised and post discharge follow up was made appropriately.

7.6 Pennine Care NHS Foundation Trust

7.6.1 Pennine Care staff provided him with the right mental health assessments which are needed to access mental health services and is a conversation between an individual and a mental health professional about symptoms and risk factors, to determine what kind of support is required. This differs from a mental health act assessment which is an assessment to decide whether an individual should be detained in hospital under the Mental Health Act to receive care and medical treatment for a mental disorder.

7.6.2 On every referral to the service Jason was given the opportunity to talk and express his feelings when he would engage. It was recognised from these discussions that he needed support with his pain management as this was impacting on his mental health and an appropriate referral was made back to his GP.

7.7 Primary Care

7.7.1 There is evidence of multi-agency consultation and working outside the TAA meetings with the GP working collaboratively with various agencies in attempts to assess Jason's heath needs during the scope of this review.

7.7.2 Following the violent assault on Jason in **November 2020** when he left the ED without being seen the GP made attempts to contact him and encourage him to seek appropriate

medical attention for the injury in addition to continually making attempts to engage Jason in attending appointments into secondary care.

7.8 Regenda Group

7.8.1 Regenda staff shared information directly and quickly with professionals supporting Jason and attended meetings when invited. Detailed records of all contacts had been kept in their internal safeguarding database.

7.8.2 Regenda staff kept in regular contact with support agencies to secure termination of Jason's tenancy which would ensure perpetrators became aware that he was no longer living there decreasing the likelihood of it being targeted. Repairs were also carried out promptly.

8.0 Agency Learning and Developments

8.1 Greater Manchester Housing First - Jigsaw Support

8.1.1 Housing First workers meet monthly with DDP's for clinical case reviews. These reviews provide challenge and support around complex individuals, where the DPP will challenge the worker’s assumptions and promote professional curiosity to understand and explore options for the person. In addition, the DPP meets the service team leaders regularly to review cases, which provides additional support and expertise around complex safeguarding.

8.1.2 Jigsaw Support is currently developing a core keyworker training package that can be tailored for specific services.

8.1.3 GMMT central team is evaluating additional training needs across all its delivery partners. Refresher case note and safety plan training is planned for September 2023 and learning from this SAR will be incorporated into this.

8.1.4 Complex cases are now taken to the bi-monthly Assurance and Learning meeting with central team for further scrutiny and review.

8.1.5 The DDP's employed through GMMT contract now provide regular clinical reviews with staff and also meet regularly with GMMT team leaders to review complex cases.

8.2 Greater Manchester Police

8.2.1 The Oldham vulnerability Detective Chief Inspector advised that a new process would allow for actions to be recorded appropriately and a Tactical Steering Group will meet every six weeks. One item on the agenda will be modern slavery, which would include those at risk of cuckooing. A cuckooing tracker has since been developed which will help to identify those who are at risk, those who were potentially at risk and locations to try and build up a picture and consider potential suspects and targeting opportunities.

8.2.2 The Domestic Abuse Matters training programme was launched in GMP in **November 2022.** The College for Policing and SafeLives worked with key stakeholders to develop 'Domestic Abuse Matters' a bespoke cultural change programme for police officers and staff in England and Wales. It aims to create long term sustainable improvements and consistency in the response to domestic abuse. It tackles all issues relating to domestic abuse and also covers such issues as coercive control, victim blaming, and recognition of manipulation by the perpetrator.

8.2.3 It has been designed to transform the response to domestic abuse ensuring the voice of the victim is placed at the centre. Highlighting the importance of having the right attitude and behaviours when responding to domestic abuse and the positive impact this can have on the victim.

8.2.4 GMP's domestic abuse policy from **May 2023** makes specific reference to evidence led prosecutions and intrafamilial abuse.

8.3 Greater Manchester Probation Service

8.3.1 At the time of Jason's release from prison there was no drug testing condition on his licence due to COVID-19 restrictions. Should he have had this condition under normal circumstances the current policy is that 'enforcement takes place after 3 consecutive positive drug tests or 3 positive drug tests in a 6-week timeframe'. If the policy relating to drug testing an enforcement on licences had been followed Jason would have been returned to custody. Drug testing is now back in full operation.

8.3.2 Jason was not seen in the office on a face-to-face basis as frequently as he would in normal practice due to the limitations imposed by COVID-19 restrictions. As the case became more 'complex' this should have been escalated to a manager to agree bypassing the restriction guidance. Had he been seen more frequently it would have allowed for better observation of the deterioration in his health, his self-neglect and his injuries.

8.3.3 From **April 2022** but not directly because of this case there has been a practice direction introduced by GM Probation instructing that all MARAC cases trigger management oversight and formal review within 3 weeks of the MARAC meeting. The senior probation officer for domestic abuse has supported staff in learning how to present at MARAC meetings.

8.3.4 In **June 2023** GM Probation launched a new practice direction regarding their safeguarding strategy. This sets out a 3-pronged approach to improve inter-agency understanding, co-working and information sharing between GM Police, Probationary Delivery Unit (PDUs), and Local Authority Safeguarding Hubs/MASH to improve public protection, including placing a practitioner within the MASH to support with safeguarding checks.

8.3.5 A new practitioner dashboard has been implemented, this system effectively monitors the quality of case recording and enforcement timescale. Any such issues with a case are now escalated to managers.

8.3.6 There has been significant revival of the management oversight touchpoint model since the unification of the Probation service in **July 2021**. In addition to this there has been a published Practice Direction for GM Probation to ensure that MARAC cases (that don't already fit the improved Touch Point Model) are brought into this review with case management.

8.3.7 There has been a re-issuing of the licence enforcement guidance in **November 2021**. Any 2nd warning letters can only be issued after having management oversight should recall not be the initial decision. Subsequent enforcement decisions must be discussed with the head of any probation unit.

8.3.8 GM Probation has reissued the minimum expectations guidance in **July 2022** which dictates the minimum expectations for completing safeguarding checks, enforcement and management oversight, assessments of risk and review of risks.

8.3.9 The quality and audit team within the probation service are completing audits using a regional case audit tool (RCAT) which is checking staff compliance with the minimum expectation. Feedback is shared with the senior probation officers and then taken to supervision for any learning and development with relevant staff.

8.3.10 There is a continuous professional development programme of work underway within the service and topics that are due to be completed include safeguarding and domestic abuse. All mandatory training for safeguarding children, adults including domestic abuse are being reviewed.

8.3.11 The senior probation officer for safeguarding has recently completed a briefing in the Oldham probation team meeting around the TRAM protocol and training events are shared with all relevant staff. Monitoring of staff attendance at TRAM meetings will be picked up in staff supervision sessions.

8.4 Howarth Housing Group

8.4.1 The review has highlighted the need for a more specific and uniform way of recording whether a resident was seen on a daily check. Previously a check could be recorded as 'Not Seen'. It was identified that this was unclear if any attempt had been made to contact the resident. A new protocol has been implemented utilising terminology that would identify what attempt had been made to contact the resident. If a resident has not been able to be contacted for over 3 days this would now trigger a safeguarding concern and appropriate action would be taken.

8.5 Independent Domestic Violence Advisor service

8.5.1 The IDVA service has grown since their attempts to work with James with funding coming from the Mayor's Office. There have been an additional 2 IDVA's, a senior IDVA and 2 additional engagement workers recruited. However, all these posts are fixed term contracts which does not support longer term continuity either for the service and its service users.

8.6 Northern Care Alliance NHS Foundation Trust

8.6.1 There is now a monthly Multiagency Frequent Attenders meeting to support high impact users to put action plans in place to mitigate frequent attendances in ED.

8.6.2 Investment has been made into the safeguarding team, the Oldham team is now made up of a full time Named Nurse and a full time Specialist Nurse. There is also an adult safeguarding duty practitioner available Monday – Friday during office hours.

8.7 Oldham Adult Social Care

8.7.1 The Tiered Risk Assessment and Management (TRAM) protocol[25] came into effect in **January 2022** and for the timeframe of this review was only in use in the latter period of the management and support of Jason, as a result not all practitioners and managers would have had a working experience of the TRAM process. This was confirmed by practitioners who attended the Practitioner Learning Event, some were aware of the protocol others were not.

[25] TRAM protocol https://www.osab.org.uk/post/?permalink=updated-tram-protocol-and-referral-process-for-adults

8.7.2 The TRAM protocol is designed to support professionals working with adults deemed to have capacity to make their own decisions, but who are at risk of serious harm or death due to:

- Behaviours that put them at risk
- Self-neglect and hoarding
- Refusal or inability to engage
- Two or more vulnerability factors
- 'Frequent Flyers' from acute services

From the review findings Jason met all the above criteria.

The protocol is set out under 3 sections:

- Understanding and working with risk
- Help setting up and running TAA meetings
- Processes for escalating cases to high risk and critical risk levels.

This document links with the OSAB safeguarding adults policies and procedures[26] and is an excellent resource for staff.

8.7.3 There was a restructuring process in place within ASC at the time which resulted in less robust management oversight of the complex case workload than would otherwise have been the case.

8.7.4 The team working with the complex cases have a good understanding of the TRAM protocol now with standardised processes and pathways on when to utilise the process.

8.7.5 Individual staff have knowledge of how to escalate concerns to the Adults Complex Adults and High Risk Panel (CaHRP) having done essential 'golden thread' work including MARA, MCA, TAA etc

8.7.6 Regular scheduled supervision is provided with dedicated managers overseeing the high-risk complex register where weekly allocations are discussed and distributed based on the skill set of the practitioner.

8.7.7 Staff have attended Blue Light Training aimed at supporting staff to better understand substance misuse and how to engage with users and in using the blue light approach in all complex interventions, scheduling TAA meetings, reviewing MARA at regular intervals ensuring there is a consensus.

8.7.8 Staff are familiar with the various legal frameworks and legal processes and when to apply them.

8.8 Pennine Care NHS Foundation Trust

8.8.1 Since the timeframe of this review the Trust has a new policy for patients who disengage from service which aims to improve the Trust response to patients who no not attend (DNA) or disengage from services.

8.9 Primary Care

8.9.1 Greater Manchester Integrated Care Board (ICB) have secured funding to support a 2 year independent domestic violence advisor (IDVA) post dedicated to Primary Care. This post will provide guidance and training to GPs to support them when working with victims of

[26] OSAB safeguarding policy and procedures – https://www.osab.org.uk/professionals/policies

domestic abuse. The IDVA will attend MARACs to strengthen information sharing between MARACs and Primary Care.

8.10 Regenda Group

8.10.1 Additional information will be added to regular internal training for staff that points out good practice examples such as including the name of the professional and the date of any correspondence when uploading attachments to safeguarding records. **[Recommendation 4]**

8.11 Turning Point

8.11.1 Internal MDTs are now in place to offer support to frontline workers.

8.11.2 Turning Point recognised that further communication and training need to be completed regarding documenting the discussions in TAAs. **[Recommendation 4]**

8.11.3 Turning Point also recognised that ongoing training for staff in relation to 'professional curiosity' and regarding the quality of interviewing being offered in sessions is needed.

8.11.4 DP had multiple hospital admissions, closer links with the hospital would have supported better liaison between the 2 agencies, there is now a hospital liaison worker in post.

9.0 Recommendations

9.1 The recommendations are agreed by the independent author and panel members after careful consideration of the information shared by the multiple agencies involved in this review and as a result of the feedback from the practitioner learning event and engagement with the family of DP. The recommendations if implemented will improve the quality of service for the people of Oldham reliant on services for support.

<table>
<tr><th>Recommendation 1</th></tr>
<tr><td>That OSAB seeks assurance that the TRAM protocol is embedded in staff training across partner agencies using anonymised case examples and highlights:

The tiered approach to risk management
That any agency can call a TAA meeting and any professional can chair the meeting
The importance of a jointly agreed risk assessment and risk action plan
Where partners feel there are significant risks that cannot be mitigated through TAA meetings, or there is an incident that significantly increases the risk, partners consider referring to Oldham's Adults Complex Adults and High Risk Panel (CaHRP).
</td></tr>
<tr><th>Recommendation 2</th></tr>
<tr><td>The OSAB seeks assurance that partner agencies have clear single-agency escalation guidelines for practitioners which includes how legal advice should be sought if risk is high.</td></tr>
<tr><th>Recommendation 3</th></tr>
</table>

That the OSAB shares the learning from this SAR with the Oldham Domestic Abuse Partnership to ensure that the work being undertaken to strengthen the MARAC process in Oldham will be effective in also addressing the learning in relation to MARAC in this SAR.

Recommendation 4

The OSAB is assured that partner agencies safeguarding training includes the importance of contemporaneous record keeping to evidence information shared and outcomes.

Recommendation 5

- That the OSAB determine whether staff within its partner agencies are sufficiently supported to record mental capacity assessments adequately, are sufficiently confident to do so and that there is not an over reliance of principle 1 of the MCA; that there is a presumption of capacity when 'risk' is escalating
- That the OSAB tracks the progress of the NIHR-funded project. The research will explore and analyse health and social care practitioner approaches to mental capacity assessments with people experiencing multiple exclusion homelessness in England. Findings from the final report should be considered by the OSAB to identify any changes to practice or support that should be offered to front line workers to support MCA assessment.

Recommendation 6

That the OSAB takes actions to ensure staff are empowered to have professional curiosity when interacting with service users to gain a better understanding of the person and to try to build 'trusting relationships'.

Recommendation 7

That the OSAB undertakes an audit of its partner agencies staffs awareness of the additional guidance documents on their website to support staff in working with complex cases, including Professional Curiosity, Exploitation in the form of Cuckooing and Where the individual or family are not engaging with service. Dependent on the audit findings an action plan is developed to address any learning.

Recommendation 8

- The OSAB should be made aware of the concerns of practitioners about the future adoption by Greater Manchester Police in relation to the Right Care, Right Person (RCRP) which is a national initiative and how they believe this will impact the checks on the most vulnerable people who often have complex needs.
- The OSAB should seek assurance from its partners that clear communication to practitioners will be shared about how RCRP will work in future alongside clear pathways established.