



Oldham Safeguarding Adults Board
Safeguarding Adult Review for Joe

Independent Reviewer: David Mellor

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1.0 Introduction

1.1 The purpose of a Safeguarding Adults Review (SAR) is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The SAR can also provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases¹.

1.2 Joe (a pseudonym chosen by his family) was a White British male who died by hanging in a wooded area in the Oldham Council area during September 2024. At the time of his death he was 27 years old. His sexual orientation is unclear. It is not currently known if he had religious belief. Joe lived with his mother and 2 younger brothers until his early 20s. He survived a serious stabbing incident which took place when males armed with knives entered the family home in June 2020. His family feel that this incident had a profound impact on Joe's mental health. Joe later moved out of the family home after a series of reported familial domestic abuse incidents in which he was perceived to be the perpetrator and his mother and one of his younger brothers the victims. He experienced accommodation instability including periods of rough sleeping and living in tents. He began using drugs (cannabis and cocaine principally) and alcohol and frequently presented as angry and aggressive to practitioners, particularly female practitioners, from a range of agencies who attempted to engage with him. His GP planned to refer him for an Autism Spectrum Condition assessment although this was not completed for reasons which are unclear. In early 2024 Joe was accepted by the Pennine Care NHS Foundation Trust (PCFT) early intervention team (EIT) as it was believed he may be experiencing a first episode of psychosis. The Probation Service arranged a professionals meeting in April 2024 which led to a referral for support to Adult Social Care which was rejected on the grounds that he had previously been assessed as not having Care Act eligible needs. The professionals meeting did not reconvene and over the following weeks several services, including the EIT closed Joe's case and his GP practice de-registered him after he did not attend appointments. During the months prior to his death, Joe attended the Royal Oldham Hospital in considerable distress on several occasions and was frequently assessed by the hospital liaison mental health team (LMHT) which is provided by PCFT. There were indications that he was being financially exploited but opportunities to make safeguarding referrals were overlooked. With hindsight, the risks to Joe appeared to be escalating but this was not recognised by the various agencies with which he came into contact in the months before he died.

1.3 After considering a referral from the Focused Care² Community Interest Company, Oldham Safeguarding Adults Board (OSAB) decided to commission a mandatory SAR on the grounds that Joe had died and that abuse in the form of

¹ Retrieved from <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

² Focused Care practitioners work with the patient's household to begin to unpick situations, assessing need and using local health and community contacts in order to begin to bring stability to the situation. They bring together agencies and patients and also establish accountability for the patient and for the agencies involved.

suspected cuckooing³ and financial abuse and self-neglect may have contributed to his death; that he had care and support needs in respect of his mental health, his ability to maintain a habitable home and to access community services; and there was reasonable cause for concern about how partner agencies had worked together to safeguard him. Despite several positive professional interventions there appeared to be a lack of co-ordination, and several agencies closed his case over the months prior to his death.

1.4 David Mellor was appointed as lead reviewer for the SAR. He is a retired chief officer of police and has 13 years' experience of conducting statutory reviews. He has no connection to any agency in Oldham. A SAR Panel consisting of representatives of the partner agencies which were involved with Joe oversaw the completion of the SAR report. Partner agencies provided chronologies of their contact with Joe and his family. The SAR is very grateful for the information and insights shared with by Joe's mother and aunt. Arrangements were made for them to read and comment on the final draft of the SAR report. A learning event attended by practitioners from involved partner agencies also contributed valuable observations which informed the review. The lead reviewer drafted reports on which members of the SAR Panel commented. The SAR commenced in May 2025 and was completed in January 2026.

1.5 An inquest will be held in due course.

1.6 OSAB wishes to express their sincere condolences to the family and friends of Joe.

2.0 Terms of Reference

2.1 The period on which the Safeguarding Adults Review focusses is from September 2023 until Joe's death in September 2024. Relevant information relating to agency contact with Joe and his family prior to September 2023 has also been considered.

2.2 The terms of reference questions addressed by the SAR are as follows:

- Explore the extent to which practice was trauma Informed (including case closure decision making), took account of any adverse childhood experiences (ACEs) and took account of feelings of shame which may affect a person's access to services.

³ 'Cuckooing' is a form of exploitation and the term used when an individual or criminal gang target the home of a vulnerable person so they can use the property for criminal purposes such as drug-dealing, hiding weapons and other criminal activities. Criminals often befriend a vulnerable person in order to exploit them and use their property. The term takes its name from cuckoos who take over the nests of other birds. There are different types of cuckooing including using the property to deal, store or take drugs; using the property for sex work; taking over the property as a place for them to live and taking over the property to financially abuse the resident.

- Explore the extent to which Joe’s presentation as an angry and aggressive male was explored and the extent to which this presentation may have alienated professionals and represented a barrier to accessing services.
- Explore professional responses to queried autism.
- Explore professional responses to Joe’s suicidal ideation.
- Joe experienced multiple exclusion homelessness. Explore the way that the risks arising from homelessness interact with people who may be at risk of exploitation.
- Explore the professional responses to indications of potential exploitation following reports of cuckooing, fraud, a lack of money/food/gas/electricity and presentations at hospital involving Joe’s rectal area.
- Explore the application of Care Act eligibility by Adult Social Care (ASC) and the opportunities for appropriate professional challenge to ASC decisions by partner agencies.
- Explore the positive multi-agency/Team Around the Adult (TAA) work that subsequently appeared to diminish as services closed Joe’s case due to an apparent lack of engagement and non-attendance at appointments.
 - Processes around deregistering someone from a GP practice.
 - Assessment of risk at the point of case closure and consideration of a ‘step-up and step-down’ approach involving preventative and statutory services.
 - Effective discharge planning and follow up care from both mental health services and primary care.
- Explore the opportunities partner agencies had to apply the OSAB Tiered Risk Assessment and Management (TRAM) processes in this case. Are there any barriers to the application of TRAM processes?
- Explore the extent to which Joe’s mental capacity was appropriately considered.
- Identify good practice.

3.0 Chronology of key events

3.1 Joe was born in 1997 and lived with his mother and 2 younger brothers, brother 1 (born 2005) and brother 2 (born 2011). His father had played no role in Joe’s life for many years.

3.2 Joe’s mother has contributed to this SAR and described her son as a “lovely lad” who “bounced down the stairs” and loved his family, which was exemplified by his courage in sustaining very serious stab wounds whilst trying to defend his family

from intruders in 2020. She went on to say that, as a child, she and Joe “got on brilliant”.

3.3 Joe’s aunt, who was an important figure in his life, has also contributed to this SAR and described him as a pleasant, caring and helpful boy. She said he was a “home bird” who helped his mother with jobs including fixing things and decorating. She said that he enjoyed playing football with his brothers and playing on his PlayStation.

3.4 Joe began using cannabis at the age of 13 and experiencing auditory hallucinations around the same time. He didn’t obtain formal qualifications but was able to read and write. He started a college course in plumbing and later began a thermal engineering apprenticeship but doesn’t seem to have been in employment since 2021.

3.5 Joe’s mother was the victim of reported domestic abuse from a partner between 2006 and 2008. Reported domestic abuse incidents in which Joe was the alleged perpetrator and his mother the victim, began in 2014, when Joe was 17. Brother 1 was also a victim of alleged domestic abuse by Joe from 2019.

2020

3.6 On 13th June 2020 Joe was admitted to the Manchester Royal Infirmary (MRI) with 2 stab wounds to his abdomen and liver along with kidney lacerations after several males armed with knives entered the family home and attacked Joe. He was treated in intensive care post-surgery and later re-admitted to intensive care after a pancreatic leak. He was discharged home on 2nd July 2020. Joe’s hospital admission took place during the first Covid-19 lockdown period. His then GP practice received a discharge summary from the MRI.

3.7 Joe did not feel able to support a prosecution of the males who stabbed him. It was suspected that the target of the attack was brother 1 (then 15). Children’s Social Care held a strategy meeting and brother 2 (then 9) was supported for a time on a child protection plan (CPP) on the grounds of neglect. Children’s Social Care documented that the child lived in “squalid surroundings, was left to his own devices without supervision and witnessed and experienced conflict, drug and alcohol fuelled behaviour by those around him”. Joe (then 23) was described as a “difficult child” and that “this had continued into adulthood” with “his parents struggling to cope with his violent and aggressive behaviour, cannabis addiction” and “other issues re gaming and money”.

3.8 On 23rd July 2020 Joe attended an MRI General Surgery clinic for follow-up. He was noted to be well and experiencing no bowel or urinary problems. He said that he had stopped taking codeine as pain “was not a problem”. Communication with Joe was documented to be “quite difficult” as his answers to questions were “not clear”. Joe was discharged from the care of the MRI, although the clinic unsuccessfully attempted to phone him on 23rd October 2022 to check that he had fully recovered from major surgery. Joe’s then GP Practice was notified of the July 2020 clinic attendance.

2021

3.9 During the year the Police attended 16 incidents in relation to Joe, of which 7 were domestic abuse incidents in which Joe was the alleged perpetrator. By October 2021 Joe was living in a tent in the garden of the family home. Joe's family state that he moved into a tent in the garden of the family home after Children's Social Care advised that he could not remain in the family home. Children's Social Care have informed the SAR that they were aware that Joe was living in a tent in the garden of the family home and accessing the family home to use the facilities but have not found evidence that Children's Social Care encouraged this arrangement. Joe also began sleeping rough. On 23rd December 2021 he was admitted to the ROH Oak Ward under the Mental Health Act (MHA) and discharged in early January 2022.

2022

3.10 During the year the police attended 26 incidents relating to Joe. He was arrested for several assaults on professionals. He was supported in Yale Housing accommodation for vulnerable adults for a time and also by ABEN (a bed every night).

3.11 In June 2022 the North West Ambulance Service NHS Trust (NWS) made a safeguarding referral as Joe was "suicidal, agitated and throwing items around his room". He was referred to the PCFT Mental Health Access Team but no need for secondary mental health support was identified. He was twice referred to Tameside Oldham and Glossop Mind who were unable to engage with him.

3.12 During August 2022 Joe attended the ROH with a suspected fractured eye socket but left prior to treatment.

3.13 During September 2022 Joe purchased a rope and a bucket with the stated intention of hanging himself.

3.14 During October 2022 Joe's mother was referred to the Multi-Agency Risk Assessment Conference (MARAC)⁴ following domestic abuse incidents in which Joe was the alleged perpetrator and his mother and brother 1 the victims. A Domestic Violence Protection Order (DVPO)⁵ was put in place which Joe repeatedly breached. Also during October 2022 Joe's aunt attempted to obtain support from Adult Social Care (ASC) for her nephew. She said that he was living in a tent (in a local wood) again. A risk assessment identified risks of self-neglect, homelessness, mental health deterioration, physical health decline, assaulting staff in supported housing, managing finances and domestic abuse. He was referred to primary care (registering

⁴ MARAC is a meeting where information is shared on the highest risk domestic abuse cases and is attended by representatives from police, health, child protection, housing, independent domestic violence advisors (IDVAs), probation and other specialists from the statutory or voluntary sectors. They share all relevant information they have about a victim, discuss options for increasing the victim's safety and create a co-ordinated action plan

⁵ DVPOs are a civil order that fills a "gap" in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.

with a new GP practice) in respect of his mental health needs. ASC completed a Care Act assessment and concluded that Joe did not have eligible needs. Changing Futures⁶ began supporting Joe.

2023

3.15 An autism spectrum condition assessment was considered by Joe's GP who observed that he had "a lot of autistic traits which he masks well" but no assessment appears to have been completed.

3.16 In January 2023 a professionals meeting involving Changing Futures and Probation was held at which a number of reasonable adjustments were implemented to better support Joe given his autistic traits.

3.17 On 9th March 2023 Joe was again assessed by the PCFT Mental Health Access Team who documented him to be "low risk, with no concerns about psychosis, no thought disorder, no current plans or intent to self-harm". He was using drugs and alcohol but did not agree to a referral to Turning Point drug and alcohol recovery service. (Joe had previously been referred to Turning Point in November 2022 but discharged in March 2023 following "lack of engagement").

3.18 On 13th May 2023 Joe went to his family home with a metal pole and was arrested. A second MARAC referral was made and his mother was supported by an Independent Domestic Violence Advocate (IDVA)⁷ for a time. Between 12th June and 14th September 2023 Joe was provided with accommodation provided by ABEN following his eviction from temporary accommodation.

3.19 On 5th September 2023 Turning Point began working with Joe. Initially he presented as highly agitated, angry and pacing around before settling, although he appeared suspicious and paranoid and fragile mentally. Difficulty was experienced in following his train of thought and responses. He disclosed feeling "empty, hopeless, having no meaning or purpose in life, with low self-worth and low confidence". He said that drug use helped him to "fit in socially". His clothing was clean and his hygiene intact. He spoke about feeling abandoned and rejected by his mother and thought she blamed him for a past relationship break-up.

⁶ Oldham was awarded funding to establish a new offer supporting adults with multiple and complex dependencies, where they do not meet statutory duties. The service has been co-designed with colleagues across the system and residents with lived experience.

The funding has been provided for Changing Futures by the then Department for Levelling Up, Housing and Communities (DLUHC) with the aim of improving outcomes for adults experiencing multiple disadvantages nationally. While the needs and background of people experiencing multiple disadvantages will vary across the country, the team at Oldham will work with adults experiencing three or more of, including combinations of, homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system. Two of the six case navigators will be working with women only.

The intention for this programme is for the Changing Futures Team at Oldham Council to work together with local partners to facilitate the reform of how services are delivered to improve outcomes for this particular group of beneficiaries.

⁷ An IDVA is a trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners, or family members, with the aim of securing their, and their children's, safety.

3.20 On 14th September 2023 Joe was sentenced to 30 weeks imprisonment for common assault and obstructing police after returning to his accommodation affected by drugs and alcohol. Whilst in prison he was supported on ACCT (Assessment, Care in Custody and Teamwork) for people at risk of suicide and self-harm. During a mental health assessment evidence of thought disorder was documented, he was struggling to retain information, had slow speech, flat mood and was struggling to focus. He presented as dishevelled with poor personal hygiene. During his prison sentence Joe appears to have been diagnosed with a first episode of psychosis. He was started on Olanzapine and was noted to already being prescribed Mirtazapine. Joe's self-care improved markedly.

3.21 On 21st December 2023 Joe was released from prison. Duty to refer documentation⁸ was completed and Oldham Housing Options completed a homelessness assessment and he was provided with temporary accommodation. He had been released with 14 days medication. Whilst in prison the Department for Work and Pensions (DWP) had awarded Joe PIP enhanced rate for daily living and mobility needs.

2024

3.22 From early January 2024 Probation began supervising Joe. He disclosed depression and anxiety and "seemed on edge".

3.23 On 10th January 2024 Joe was again assessed by the Mental Health Access Team and presented as thought disordered, distracted, with flight of ideas and suicidal thoughts but no current plan. He was referred to Oldham EIT. The Dual Diagnosis worker* was advised of the outcome.

*The SAR has been advised that at that time PCFT hosted a mental health practitioner post funded by Oldham Council. The postholder worked with homeless people with mental health and substance use issues. Funding for the post ceased at the end of the 2024/2025 financial year.

3.24 On 17th January 2024 the EIT assessed the referral and decided that the criteria for support were met and allocated a care co-ordinator to Joe.

3.25 Also on 17th January 2024 Probation assessed Joe. He said that he "wished he had a rope to hang himself" but had no plans to act on his suicidal thoughts. His Probation Officer was changed from female to male as "he did not work well with females".

3.26 On 22nd January 2024 Joe had a consultation with his GP. Joe was noted to be smiling, "feeling better" and looking forward to moving into his own flat. He said he wanted to "get better" and become a chef. He was continued on Mirtazapine and Olanzapine (one week's supply).

⁸ The Homelessness Reduction Act 2017 significantly reformed England's homelessness legislation by placing duties on local housing authorities to intervene at earlier stages to prevent homelessness in their areas, and to provide homelessness services to all those who are eligible. Additionally, the Act introduced a duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness/housing options teams.

3.27 On 31st January 2024 Joe ‘stormed out’ of a meeting with Probation. This was documented to be a pattern of non-acceptance of his own behaviour and a failure to take responsibility.

3.28 On 8th February 2024 Joe signed a tenancy with First Choice Homes Oldham (FCHO). He was identified as requiring support and referred to the FCHO community impact team (CIT) who were unable to engage with him.

3.29 On 12th February 2024 Joe attended an outpatients appointment with an EIT psychiatrist who felt that Joe’s diagnosis was more in keeping with drug induced psychosis.

3.30 On 24th February 2024 Joe was detained under Section 136 MHA after becoming involved in a fight in the waiting area at the ROH. He was assessed as not suffering from a relapse of his mental disorder to the extent to which a psychiatric hospital admission was required. He declined home treatment team (HTT) support and was discharged.

3.31 On 28th February 2024 Joe was seen by MRI LMHT after staggering in the street whilst apparently intoxicated. He was documented to have “suicidal thoughts of long standing which he knew how to manage and ensure his own safety”.

3.32 On 6th March 2024 Probation made a home visit to Joe as he had not been attending appointments. His flat was in a “poor state”. His mental health was said to have deteriorated leading to self-care issues.

3.33 On 14th March 2024 Joe had a GP consultation during which he was primarily concerned about his physical health. He said he had been struggling with back pain and had lost weight (one stone over 2 months). His medication was changed to repeat prescription so that he could access it more easily.

3.34 On 18th March 2024 Joe was seen by the PCFT LMHT. He appeared intoxicated and said he had been using heroin and cannabis. A full assessment was delayed until he was lucid by which time Joe had left the hospital.

3.35 On 22nd March 2024 Probation referred Joe to Turning Point who later discharged him after he did not attend two telephone assessments. Joe disclosed taking his 3 days prescription of Olanzapine at once because it made him feel better.

3.36 On 31st March 2024 Joe was treated at the ROH for a leg fracture after apparently kicking a wall and smashing furniture in his flat. Joe did not attend follow up Orthopaedic Fracture clinic appointments.

3.37 On 4th April 2024 cuckooing concerns were discussed by Probation. Two men had been staying at Joe’s flat. This concern was to be shared with FCHO. FCHO has advised the SAR that they have no record of receiving any information which indicated that Joe may be a victim of cuckooing.

3.38 On 9th April 2024 Sanctuary Trust⁹ submitted an online referral to ASC citing concerns about Joe's inability to manage his wellbeing, including not washing, not taking prescribed mental health medication, living in a severely unclean property. Sanctuary Trust received no documented follow up from ASC.

3.39 On 16th April 2024 a professionals meeting was held to formulate a plan of support for Joe. Concerns were stated to be lack of engagement, vulnerability, potential cuckooing, ongoing substance use, self-neglect, non-payment of bills leading to power being cut off and hostility and aggression if needs not met. The EIT submitted a referral for support to the Adult Referral Contact Centre (ARCC) which closed the referral on the grounds that he had previously been assessed as not having Care Act eligible needs.

3.40 On 17th April 2024 the EIT psychiatrist decided that there was no evidence of psychosis when Joe was not affected by illicit drugs. He was to be offered an opt-in letter to attend an outpatient appointment. If he did not attend, he would be discharged. He did not attend the appointment and was discharged on 25th April 2024.

3.41 Also on 25th April 2024 his GP practice decided to remove Joe from their list in accordance with Did Not Attend (DNA) policy, "no concerns" having been raised about Joe by any stakeholder.

3.42 On 23rd May 2024 Probation initiated breach action against Joe and a summons was issued. A Court date was set for 7th August 2024, which was subsequently adjourned until 16th September 2024.

3.42 On 8th July 2024 Joe smashed a member of staff's computer screen at the Oldham Job Centre after becoming frustrated because he wanted an immediate payment which the staff explained that they were unable to action as this would need to be completed at his usual Job Centre at Middleton. (His income from UC had been reduced for a time as a result of a sanction applied on 11th June 2024 after not attending appointments with his DWP work coach. The sanction was later lifted and a hardship payment made). He then left the location before returning and throwing a brick at the window. Joe was circulated as wanted by the Police and was arrested and charged on 4th September 2024.

3.43 On 10th July 2024 Joe was knocking on the doors of a ROH mental health in-patient facility. He said that he was "ready to die" and wanted hospital admission. He was directed to A&E and assessed by the LMHT. He reported having no money after being "scammed"* He was documented not to be taking prescribed medications, using cocaine and said he needed hospital admission for a "break". He was assessed as feeling suicidal in the context of his social situation and discharged. He denied any plan to self-harm but said he was feeling overwhelmed and unsure of where to seek help.

⁹ The Sanctuary Trust provides support to people who are homeless or at risk of homelessness. They began supporting Joe following his release from prison in December 2023.

*A sanction applied by the DWP to his Universal Credit (UC) which reduced his monthly UC payment from £334 to £0 in June and £174 in July 2024 although a hardship payment was made. His monthly PIP income of £737 was unaffected. £18 per month was also being deducted from his UC to pay Court fines by instalments. His housing costs were credited directly to FCHO.

3.44 On 11th and 18th July 2024 Joe made unplanned visits to Probation. He was noted to have paranoid thoughts and a strong sense of confusion. He said that he did not feel safe at home. A “gas and electric loan” and the delivery of a food bank parcel was arranged.

3.45 On 27th July 2024 Joe was arrested after visiting the family home and assaulting his mother and brother 2 and stealing alcohol. He was charged, placed before Court and bailed with conditions. His mother was referred to MARAC.

3.46 On 19th August 2024 Joe was conveyed to ROH by ambulance and assessed by LMHT. He demanded to be “sectioned” as he was feeling suicidal because he had no money. He had not taken prescribed medication for some months. When informed that a MHA assessment would not be taking place as he had capacity and there was help in the community to support him, he became verbally abusive. He declined all referrals and was escorted from the premises by security.

3.47 On 5th September 2024 Joe appeared at Court in relation to the charges relating to the 8th July 2024 Job Centre incident and was bailed to 30th October 2024.

3.48 On 6th September 2024 his Sanctuary Trust worker saw Joe on his phone to the DWP complaining that he had not received PIP for 3 months (There had been no interruption in Joe’s PIP payments). He appeared irate and was swearing.

3.49 On 8th September 2024 Joe attended ROH reporting a sore chest and bottom. He said his bank account had been “frauded 3 times”.

3.50 On 9th and 11th September 2024 Greater Manchester Police (GMP) responded to 2 incidents of shoplifting accompanied by violence and the threat of violence involving Joe.

3.51 On 11th and 12th September 2024 Joe attended the ROH with rectal pain and was treated for a perianal abscess. He was referred to LMHT but self-discharged before being seen. The ward sister was unable to arrange a welfare check for Joe.

3.52 On 12th September 2024 FCHO received an anti-social behaviour (ASB) complaint in respect of Joe, who was said to have been “screaming, shouting and banging”. The neighbour reporting the ASB said that they had temporarily moved out of their home because of distress arising from Joe’s conduct.

3.53 On 18th September 2024 Joe was found deceased.

4.0 Views of Joe's mother and his aunt

Joe's mother:

4.1 Joe's mother felt that the 2020 stabbing caused a steep decline in her son's mental health and that he "never got over it". She added that Joe was reluctant to discuss the incident because she felt that he did not wish to relive it.

4.2 She added that before this incident he was a "lovely lad" with whom she got on "brilliant". After the incident she said that he seemed "tortured". It also affected his employment as she said he had difficulty concentrating.

4.3 She went on to say that Joe started taking drugs to blot things out. Before the incident he had been "very OCD" – meticulous about how he looked and needed everything to be in its place – after the incident his self-care deteriorated significantly.

4.4 Joe's mother said that she wasn't fully aware of her son's contact with services as an adult. She said he was supported by her sister (Joe's aunt) who she said was more methodical than her. Additionally, Joe's mother said that she eventually stepped away from supporting her son as it became "pointless" because he would spend any money she gave him on alcohol and drugs and would pawn any phone she bought him.

4.5 She felt that professionals did not have all the information about Joe's history to enable them to understand him. She added that he did not get the help he needed and that instead of being locked up he should have been taken to hospital.

4.6 Joe's mother said that she eventually began to feel quite afraid of her son as he had become "such an angry person".

4.7 She thought he may have been financially exploited, adding that the people he "hung around with" would often loan or steal money from each other until the date on which they could access their benefits. When she read a late draft of the SAR report, Joe's mother recalled an incident in which he "barricaded" himself in his FCHO flat and would not let her in. She couldn't remember when this incident took place but it is assumed it took place during his February to September 2024 tenancy with FCHO. She said he opened the window of his first floor flat in order to speak to her and told her that someone was "trying to get him". There is no indication that this specific incident was reported to any agency.

4.8 She felt Joe's arrest in July 2024 was the "nail in his coffin" because the bail conditions isolated him from family support. This isolation plus his fear of "being sent down" "tipped him over the edge".

Joe's aunt

4.9 Joe's aunt described her nephew as a pleasant, caring and helpful boy who suffered trauma arising from the stabbing incident in June 2020 when he was trying to protect his mother and 2 younger siblings.

4.10 She said that during his MRI admission Joe received no visitors because of the pandemic and there was no follow up after he was discharged home. She felt that he suffered undiagnosed Post-Traumatic Stress Disorder (PTSD) as a result of the stabbing and this contributed to a deterioration in his mental health.

4.11 She said that Oldham Children's Services insisted on Joe leaving the family home and bought him a tent in which he lived for 3 months (Paragraph 3.9 includes Oldham Children's Social Care's response to this point).

4.12 Joe's aunt said that she became involved in supporting Joe from October 2021 after his relationship with his mother broke down.

4.13 She felt that other residents in the accommodation in which he was placed had a negative impact on him, using drugs and alcohol and stealing from him. She also felt that his accommodation instability affected his ability to attend GP appointments and contributed to his de-registration.

4.14 Whilst she felt that some professionals were supportive of Joe, she felt that too many services just "dropped" Joe.

4.15 After being diagnosed with cancer in January 2022, Joe's aunt said that she stepped back from supporting him for a time. Following her recovery in March 2023, she began supporting Joe again. She said he would turn up at her home on an almost daily basis and she would support him with food and money and replace phones which had been lost or stolen. This continued until January 2024 when she felt that she had no option other than to stop Joe visiting her address because of the toll this was taking on her as she was still recovering from the effects of chemotherapy. She said that she had no further contact with Joe after this time.

4.16 Joe's mother and aunt were provided with an opportunity to read and comment on a late draft of the SAR report. Joe's mother preferred to discuss the contents of the report with the independent reviewer by phone. After the SAR findings were shared with her, Joe's mother said that she was "dumbfounded" that his GP practice removed him from their patient list whilst Joe was under the care of the Early Intervention Service. She went on to say that she was shocked that Joe received so little support when he subsequently attended ROH hospital on several occasions. Overall, she said that she felt angry because she felt that if Joe had received the support he needed "he could still be here".

4.17 Joe's aunt met with the independent reviewer and read a late draft of the report. She was very upset to read of the difficulties Joe experienced in the last few months of his life when several agencies closed his case and she felt that opportunities to make safeguarding referrals were missed. She felt that there should have been a stronger focus on encouraging Joe to support the prosecution of the males who stabbed him in June 2020 given the seriousness of the incident. She said that she hoped that the SAR report's recommendations would be fully implemented and requested an update on progress to be sent to her in due course.

5.0 Analysis

5.1 In this section of the report each terms of reference question will be addressed in turn.

Explore the opportunities partner agencies had to apply the OSAB Tiered Risk Assessment and Management (TRAM) processes in this case. Are there any barriers to the application of TRAM processes?

5.2 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

5.3 "Vulnerability factors" are not defined in the TRAM protocol but the SAR has been advised that the TRAM protocol training programme refers to "Domestic Abuse" and "Homelessness" as "vulnerability factors". The wording of the TRAM protocol implies that there are a number of "vulnerability factors", and that two of them must be present before an adult can be supported via the TRAM protocol. The SAR Panel felt that 'two or more vulnerability factors' needed to be clarified so that professionals did not limit their consideration of 'vulnerability' to 'domestic abuse' 'homelessness' and did not exclude adults from TRAM because they were experiencing just one 'vulnerability' which may be a very significant vulnerability. The SAR Panel also discussed the need for clarity over how acute services defined 'frequent flyers' and also suggested that the term 'frequent flyers' should be more appropriately defined as 'high intensity users' or similar.

Recommendation 1

That Oldham Safeguarding Adults Board reviews the criteria by which it is decided to support adults through the TRAM process to ensure there is

- *clarity over eligibility*
- *whilst retaining room for professionals to use their judgement and*
- *that eligibility criteria do not inadvertently exclude some vulnerable adults.*

5.4 The TRAM protocol goes onto provide guidance to help practitioners working with adults with multiple and complex needs who are at serious risk of harm or abuse, including:

- how to run shared risk management processes that balance positive risk taking with an individual's human rights and
- when and how to escalate risk into a multi-agency setting,

5.5 There were several opportunities to consider utilising the TRAM protocol to work with Joe but there is no indication that this approach was actively considered at any point.

5.6 Joe largely met the criteria for TRAM support in that he was deemed to have capacity to make his own decisions (although there was an absence of formal assessments of his mental capacity); his behaviours put himself at risk (drug and alcohol misuse) and others at risk (alleged domestic abuse of his mother and brother and physical assaults on practitioners); his self-care appeared to deteriorate significantly from around April 2024; agencies experienced long term challenges in engaging with Joe; he had experienced the “vulnerability factor” of homelessness although by February 2024 he had begun his first tenancy; and he was an alleged perpetrator of domestic abuse rather than a victim. He might also have been considered a “frequent flyer” user of acute services but not until July 2024 onwards.

5.7 The closest partner agencies working with Joe came to initiating the TRAM process was when Probation arranged a meeting held on 16th April 2024 which was variously described as a “professionals meeting”, a “multi-disciplinary team (MDT)” meeting and a “team around the adult (TAA)” meeting.

5.8 The meeting was attended by Probation, Changing Futures, the PCFT EIT and the Sanctuary Trust. Turning Point – to whom Probation had recently referred Joe – did not attend. Joe’s GP and his housing provider (FCHO) were not invited. The focus of the meeting was to address the challenges partner agencies experienced in engaging with Joe and build a plan of support for him. By this time professionals had begun to feel that Joe’s psychosis was drug-induced. The outcomes of the meeting were referrals to ASC for an assessment of Joe’s care and support needs and a referral to KeyRing¹⁰ for additional 1:1 support to manage his tenancy. KeyRing declined the referral as their service is provided by lone workers.

5.9 On the same date as the above meeting the EIT completed an online request for support for Joe from ASC. In answer to the online template question “Please tell us about the care and support needs” the reply was as follows: “High risk of self-neglect and vulnerability from others. Joe reports he is declining to pay his bills at his home address. He is urinating in bottles and leaving them around the house. Appears unable to retain information. He has a history of attempting to become intentionally homeless. He has a family history of autism and is awaiting an assessment for Autism Spectrum Condition (This was incorrect). He reports he has people in his flat that he can’t get rid of - unknown who. Currently has a broken leg. Joe is using illicit substances”.

5.10 The online request for support did not include all the concerns shared at the professionals meeting about Joe, including “poor engagement with services”, “no gas or electric” as a result of not paying his bills, “smashing things in his home”, that he had a broken leg which appeared to have been caused by “kicking the wall”, “flat untidy”, “becomes hostile and aggressive if needs not met”, “history of intimidating females” and “history of domestic abuse with family”.

5.11 It is not known why the online request for support did not include all the concerns shared at the professionals meeting, given that the online form was completed on the same day as the professionals meeting had taken place. Nor is it known why the professionals meeting did not decide to submit a safeguarding

¹⁰ KeyRing is a charity which provides social care support.

referral given the indications of self-neglect and the implication that Joe may be at risk from cuckooing. It may be worthy of note that possible cuckooing was documented as “people in his flat that he can’t get rid of” which may have been an accurate description of what Joe had reported but may also have been language which inadvertently minimised the issue. Had the professionals meeting adopted a TAA approach and completed the TAA risk assessment and management tool, this may have helped them to clarify the risks of abuse and/or neglect. It may be worthy of note that the task of completing the request for online support was delegated to possibly the most junior person to attend the professionals meeting - a trainee nursing associate who may, or may not, have received the necessary training. SAR Panel members felt that cuckooing may not be widely understood by practitioners from some partner agencies (See Recommendation 14).

5.12 The SAR Panel discussed the quality of safeguarding referrals. OSAB offers regular ‘How to Make a Safeguarding Adult Referral’ training which addresses the Section 42 criteria, and all the information needed to be included in a referral. The PCFT Panel member advised that their Level 3 Safeguarding training had recently been updated with a renewed focus on what a “good” ASC referral looked like and how to support Section 42 processes. She went on to say that PCFT is developing ‘bitesize’ training on how to complete a safeguarding referral in each of the five Greater Manchester boroughs in which they operate. PCFT also advised that they are planning a series of dip samples to better understand the quality of referrals made by their staff. However, the SAR Panel felt that training only goes so far and that there needed to be better oversight and support for professionals submitting referrals, particularly when they are inexperienced, as in this case. The NCA Panel member said that their Safeguarding Team review all of the hundreds of safeguarding referrals submitted each month and provide feedback on the quality of referrals, including praise for well completed referrals. The NCA went on to advise the process of completing safeguarding referrals is covered in depth in their Level 3 Safeguarding training. Additionally, the SAR Panel was advised that Oldham MASH is particularly good at requesting more information if it is required and will not close a case on the grounds of insufficient information.

5.13 The SAR Panel feels that a proportionate response to the insufficiently comprehensive online request for support for Joe and the missed opportunity to complete a safeguarding referral, would be to acknowledge that the quality of safeguarding referrals remains a live issue. This SAR recommends an approach which builds upon and co-ordinates efforts that partner agencies are currently making to address the quality and comprehensiveness of safeguarding referrals through steps such as enhanced training, monitoring of quality of referrals, provision of developmental feedback to referrers and a commitment by the MASH not to reject or close safeguarding referrals as a result of incomplete information. A strong multi-agency focus on improving the quality of safeguarding referrals, drawing upon the good practice demonstrated by partner agencies could make a substantial contribution to strengthening the safeguarding system in Oldham.

Recommendation 2

That Oldham Safeguarding Adults Board works with partner agencies to adopt a co-ordinated multi-agency approach to improving the quality of safeguarding referrals

including making use of the good practice which already exists in pockets of the whole system.

5.14 The April 2024 online request for support was considered by the ARCC who closed the referral on the grounds that Joe was deemed not to have consented to the referral and he had previously been assessed as not having any care and support needs. ASC have advised the SAR that the ARCC should have directed the online referral for support to ASC Safeguarding given the safeguarding concerns indicated in the referral.

5.15 One week before the EIT completed the online request for support for Joe from ASC, the Sanctuary Trust also submitted an online referral to ASC citing concerns about Joe's inability to manage his wellbeing, including not washing, not taking prescribed mental health medication, living in a severely unclean property (Paragraph 3.38). This earlier online referral was also dealt with by the ARCC. It is assumed that this referral was also closed as the Sanctuary Trust has advised the SAR that they received no documented follow up from ASC.

5.16 The SAR has been advised that the ARCC was launched as the wellbeing 'front door' in September 2022, splitting from the multi-agency safeguarding hub (MASH). This effectively created separate wellbeing (ARCC) and safeguarding (MASH) 'front doors'. The SAR has also been advised that there is now a step up step down approach is now in place between ARCC and MASH, in which cases referred to ARCC which require a safeguarding response can be stepped up to MASH. Whilst the introduction of a process which facilitates step up step down between the ARCC and the MASH is very welcome, the SAR Panel questioned whether ARCC decisions in more complex cases were always being made by appropriately qualified professionals and whether there was sufficient managerial oversight on this issue.

Recommendation 3

That Oldham Safeguarding Adults Board requests a report on the effectiveness of 'step up step down' arrangements between the ARCC and the MASH, with a specific focus on the process by which requests for support are screened by the ARCC and the extent to which the ARCC has a robust process to identify any safeguarding concerns within requests for support.

5.17 There is learning for the ARCC arising from their reliance on an assessment of Joe's care and support needs carried out in November 2022 which concluded that he did not have eligible needs (Paragraph 3.14). Relying on an assessment carried out 18 months earlier appeared to overlook the possibility that a person's needs may change over time. Additionally, the April 2024 online referral stated that Joe was receiving the support of an EIT care co-ordinator. This suggested that Joe may have care and support needs linked to his mental health. Whilst it would have been inappropriate to assume care and support needs on the basis that Joe was receiving support from the EIT, the ARCC could have demonstrated greater professional curiosity and potentially contacted the EIT to explore Joe's needs more fully.

The November 2022 Care Act assessment

5.18 ASC have advised the SAR that the November 2022 assessment could have been more comprehensive and considered specific Care Act outcomes such as making use of services in the community, developing and maintaining family and personal relationships, and maintaining a habitable environment. A risk assessment completed shortly before the November 2022 Care Act assessment identified risks of self-neglect, homelessness, mental health deterioration, physical health decline, assaulting staff in supported housing, managing finances and domestic abuse (as a perpetrator) (Paragraph 3.14). ASC have provided helpful context to the November 2022 decision that Joe did not have eligible care and support needs. The contact with Joe took place during the post-Covid recovery period when the service continued to feel the impact of the pandemic and were attempting to 'build back'. At that time, the service was experiencing significant capacity and demand challenges, staff wellbeing issues related to long Covid¹¹, other sickness and retention to the point where high risk and safeguarding cases could not be allocated in real time. A 'one-service' approach was adopted in order to ensure that individuals referred into ASC were responded to. A consequence of this was that responses were sometimes provided from teams other than the expected teams, or teams held onto cases they would have usually transferred for longer periods.

5.19 Additionally, at the time of the November 2022 Care Act assessment of Joe, trauma informed approaches were not fully embedded in practice and a consequence of this is that Care Act screening often tended to focus on physical capability and domains such as maintaining relationships and making safe use of the community were not as well recognised then as they are at the current time. Furthermore, Care Act assessments were not completed at the 'front door' at that time (as is the case now) and went directly to long term teams for completion. The assessors in the long term team were heavily reliant on information provided by the individual and/or referrer which adversely affected their appreciation and understanding of complex wellbeing needs and risks.

5.20 Relying on an earlier insufficiently holistic Care Act assessment ultimately had significant consequences for Joe. The lead reviewer was minded to make a recommendation for assurance to be obtained that Care Act assessments are completed sufficiently comprehensively, particularly that they address the Care Act outcomes overlooked in Joe's case such as making use of services in the community, developing and maintaining family and personal relationships, and maintaining a habitable environment. However, the context in which the November 2022 Care Act assessment was completed was uniquely challenging and assurance has been provided to this SAR that much positive change had been made since that time including the completion of Care Act assessments at the 'front door' and further embedding of the trauma-informed approach, although as this case demonstrates, achieving trauma-informed practice across the partnership remains a work in progress. The SAR has been advised that the application of the Care Act is examined in ASC audit activity and that it was open to the Safeguarding Adults Board to request reports on such audit activity.

¹¹ Long COVID, sometimes called post-COVID syndrome, happens when the symptoms of COVID-19 last longer than 12 weeks. It's a new condition that's still being studied, but treatment can help.

Lack of consent

5.21 One of the grounds on which the ARCC closed the 16th April 2024 referral from the EIT was lack of consent from Joe. Joe's aunt has advised the SAR that when she attempted to obtain support via the ARCC in August 2023, the absence of Joe's consent was also a barrier. The ARCC online guidance states "If you are contacting us on behalf of someone else, then whenever possible, you should make sure that they are aware that you are planning to do so". Had the safeguarding concerns within the online request been recognised in the ARCC, then Joe's consent, though desirable, would not have been required. Additionally, had it been possible to involve Joe in the professionals meeting in some way – which would have been expected practice had a TAA approach been adopted – then it is likely that there would have been a stronger focus on the issue of Joe's consent.

Absence of any challenge to the ARCC decision

5.22 There is no indication that either the EIT or any other agency which attended the professionals meeting questioned or challenged the ARCC decision in April 2024. Lack of challenge and of holding colleagues in partner agencies accountable for their decisions was highlighted in the second national analysis of safeguarding adult reviews (1). The second national analysis highlighted a barrier to professional challenge of practitioners not having a clear understanding of other organisations' role and remit (2). This may have been a factor in this case but the key barrier to the consideration of any challenge in this case was the absence of any follow-up to the April 2024 professionals meeting.

The TRAM Protocol

5.23 The TRAM Protocol advises that cases should be managed through that TAA meetings in cases of "moderate risk" i.e. "some wider health and vulnerability risk to an individual or those around them that need support from more than one agency".

5.24 The 16th April 2024 meeting contained some elements of a TAA meeting in that:

- a range of practitioners from agencies who were working with Joe, or had worked with Joe previously were invited
- information was shared by partner agencies
- many of the risks to which Joe were exposed were articulated although "suicidal ideation" was omitted (however, the TAA risk assessment and management tool was not utilised) and
- actions were agreed.

5.25 However, the meeting departed from the TAA process in that;

- a lead professional was not identified
- a risk action plan was not completed
- Joe was not invited to attend although his involvement in the meeting may have proved challenging to manage
- no follow up or review meeting was arranged
- as there was no follow up or review, there was no opportunity to consider a formal "step down" when partners felt that the risks to Joe had been mitigated

5.26 In addition no minute or note of the meeting was made. When the two actions agreed at the meeting (referrals for support from ASC and 1:1 support from KeyRing) did not achieve the desired outcome the absence of any follow up or review meeting did not bring this to the attention to those who had attended the meeting. This limited the opportunity to challenge the ARCC decision (Paragraph 5.21).

5.27 The absence of any follow up or review meeting meant that the meeting was simply a 'one-off' event which did not have the capability to monitor progress in stabilising the situation for Joe, reviewing risk or noticing any escalation in risk. (The TRAM process envisages that where risks cannot be mitigated through regular TAA meetings or where risk escalates further, a referral may be made to Oldham's Adults Complex and High Risk Panel (CaHRP)). When the risks to Joe began to escalate markedly during the final two months of his life, there was no process in place to help hard-pressed individual practitioners to fully appreciate that the risks to Joe were escalating.

5.28 An earlier professionals meeting took place in January 2023, involving Probation, Changing Futures and Turning Point. A key outcome of this meeting was the implementation of reasonable adjustments for Joe's suggested autism. There is no indication that the TRAM Protocol (which had been adopted in January 2022 but was not consistently embedded because of the challenging contextual issues described in Paragraph 5.15) was considered at that time.

5.29 The barriers to the application of the TRAM process evident in this case were as follows:

- The TRAM process is intended to "build on rather than replace" single agency risk management arrangements. Whilst there was considerable effective individual and multi-agency work with Joe to "build on", there were also several examples of agencies not following their own single agency risk management processes (see Paragraph 5.51).
- It is intended that where there is a concern that an adult with care and support needs is experiencing or is at risk of neglect or abuse, the TRAM Protocol should be read in conjunction with the OSAB Multi-Agency Adult Safeguarding Policy and Procedures and OSAB Multi-Agency Strategy. The Multi-Agency Safeguarding Policy was not followed in this case as the risks documented at the April 2024 Professionals Meeting justified a safeguarding referral which unfortunately did not appear to be considered.
- If the TRAM process is intended to "build on rather than replace" existing single and multi-agency processes, then what this SAR reveals is that the "foundations" on which the TRAM process is "built" provided an insufficiently solid base. In particular Care Act assessments were being completed insufficiently holistically in 2022; historic Care Act assessments were being inappropriately relied upon to assume ineligibility for care and support in 2024; the step up step down process between the ARCC and the MASH was not in place or working sufficiently effectively in 2024 and practitioners, particularly inexperienced practitioners appeared to have difficulty in recognising when a

safeguarding referral was required and ensure that any such referral included all known concerns in 2024.

5.30 Around two thirds of the colleagues who attended the practitioner learning event arranged to inform this SAR had some level of awareness of the TRAM process but were generally unaware of how to initiate the process and there was a belief on the part of several attendees that responsibility for initiating the TRAM process rested with ASC (any agency can call a TAA meeting and any professionals can chair the meeting) and that a referral needed to be made (a referral is not required). There appeared to be a reticence about putting oneself forward for the lead professional's role because this could bring quite substantial responsibilities, particularly if the case was complex. (The SAR has been advised that OSAB had developed separate lead professional guidance which stresses that the TAA process is also intended to be the 'team around the lead professional' including support with minutes and actions). At the practitioner learning event there also appeared to be some anxiety about volunteering to lead a process which was dependent on comprehensive and consistent multi-agency engagement which may, or may not, be forthcoming.

5.31 The SAR Panel felt that professionals who fulfilled the TAA lead professional role needed greater support and encouragement from their line manager who should adopt a positive approach to the TRAM protocol and reinforce its' importance through performance management processes. Line managers would also need to become involved in discussions about the implications of taking on the TAA lead professional role for their workload. The SAR Panel felt that there was a need to re-focus or extend existing TRAM training, which is heavily focussed on practitioners, to line and more senior management. The SAR Panel also felt that encouraging professionals to fulfil the TAA lead professional role in lower or medium risk cases which were likely to have less heavy workload implications could help to further embed the TAA process as 'the way things are done around here' and prevent lower or medium risk cases escalating to higher levels of risk.

Recommendation 4

That Oldham Safeguarding Adults Board ensures that TRAM training is targeted on line management and more senior management in order to raise managerial awareness of the TRAM process and to emphasise the importance of managerial support and encouragement to practitioners to fulfil the TAA lead professional role.

Explore the positive multi-agency/Team Around the Adult (TAA) work that subsequently appeared to diminish as services closed Joe's case due to an apparent lack of engagement and non-attendance at appointments.

- **Processes around deregistering someone from a GP practice.**
- **Assessment of risk at the point of case closure and consideration of a 'step-up and step-down' approach involving preventative and statutory services.**
- **Effective discharge planning and follow up care from both mental health services and primary care.**

5.32 As previously stated the multi-agency meeting which took place on 16th April 2024 contained some elements of a TAA meeting but more closely resembled an ad

hoc professionals meeting. It was good practice by Probation to arrange this meeting. However, what is particularly striking in this case is the rapid disengagement by services from working with Joe in the weeks following the multi-agency meeting.

GP Practice

5.33 On 25th April 2024 Joe's GP practice (which had not been invited to the 16th April 2024 meeting or advised of the outcome) decided to remove Joe from their patient list as a result of his non-attendance at appointments. One week earlier, Joe was informed by text that he was at risk of removal from the practice list and invited to make an appointment to discuss the issue. He did not respond to the text and given that Joe had "not been raised by any stakeholder as a concern", he was removed from the patient list. The GP practice was aware that Joe was under the care of the EIT.

5.34 There were many "stakeholder concerns" about Joe at the time the GP practice removed him from their practice list. That the GP practice was unaware of any "stakeholder concerns" suggests that information sharing across the whole system for safeguarding adults in Oldham was capable of being enhanced including sufficient feedback loops (specifically feedback to referrers on the outcome of their referral). However, it is noticeable that Joe's consultations with his (female) GP were generally constructive with some expressions of optimism for the future. Had Joe's GP been invited to the 16th April 2024 professionals meeting, they would have had the opportunity to become aware of "stakeholder concerns". The TAA guidance is not prescriptive about who should be invited to meetings, stating that invitees should include "agencies or services known to be currently working with the individual".

5.35 Not inviting Joe's GP to the April 2024 professionals meeting was an omission which had significant implications for Joe. The SAR is aware of the challenges involved in GPs personally attending multi-agency meetings and has been advised of the work being done in Oldham to encourage attendance at multi-agency meetings, particularly if they are statutory meetings. The option of the practice manager or a practice nurse representing GP practices at multi-agency meetings is also being encouraged. The TRAM process is not statutory but the SAR has been advised that a template had been developed to support GP practices and any agency to provide information to TAA meetings that they are unable to attend. Additionally TAA leads have been asked to send notes of the meeting to GP practices. In this case no note was taken of the April 2024 professionals meeting. The GP practice has advised the SAR that they have amended their process for removing patients from their list as a result of the learning from this SAR. In particular, where a patient has a mental illness and social and economic complexities the patient may be requested to liaise more closely with the GP practice's Focused Care worker before any decision is made to remove them from the patient list. The action taken to reduce the risk of removing patients from the GP practice list who are at risk and whose risk level may increase if removed from the GP practice list is welcome. It is not possible for this amended process for removing patients from their list to be replicated by all Oldham GP practices as not all of them have commissioned Focused Care. In any event, all GP practices follow the General Medical Council guidance Removing patients from a GP practice list - The MDU

which advises GPs to do what they can to restore the professional relationship by, for example, finding out what might be behind the patient's actions and whether this might be addressed by extra support or possibly an acceptable behaviour contract. However, it is recommended that the changes introduced by Joe's former GP practice are shared as good practice with all Oldham GP practices and where GP practices do not have commissioned Focused Care, they are encouraged to enhance professional enquiry about patients with mental illness and social and economic complexities before removing them from their lists.

Recommendation 5

That Oldham Integrated Care Partnership shares the revised DNA policy adopted by Joe's GP practice in response to the learning from this SAR with all Oldham GP practices and encourage them to adopt a similar approach where they have commissioned Focused Care and enhance professional enquiry into the circumstances of patients with mental illness and social and economic complexities where the GP practice does not have commissioned Focused Care.

PCFT Early Intervention Team

5.36 On the same day that the GP practice removed Joe from their patient list (25th April 2024), the EIT discharged Joe on the grounds that there was no evidence of psychosis without the use of illicit substances. Joe had been referred to the EIT following an assessment by the PCFT Criminal Justice Mental Health team on 10th January 2024. At that time Joe presented as thought disordered, distracted, having flight of ideas and a history of hearing voices. Contact was made with HMP Lancaster (from which Joe had recently been released) which advised that Joe had experienced a first episode of psychosis whilst in prison and had been started on Olanzapine and Mirtazapine. Joe was accepted by the EIT and allocated a care co-ordinator who made determined efforts to engage with Joe over the following 3 months. Whilst it is true to say that during February and March 2024, Joe had been using cocaine and cannabis regularly, at the time of his January 2024 assessment he informed his GP that he had stopped using cocaine and provided a negative drug test to Probation at the end of January 2024. It does not appear that the EIT had been able to fully complete an assessment of Joe.

5.37 The SAR has been advised that prior to discharging Joe, if it was felt that there was a risk of him disengaging from services, then the relevant EIT clinician should have contacted Joe's GP to advise them that the EIT were planning to discharge Joe so that an action plan could be considered. There is no indication that the EIT contacted Joe's GP for this purpose during the period prior to discharging him.

5.38 At the point at which they discharged Joe, the EIT advised his GP practice by letter. As Joe had been removed from the GP practice list on the same date, the letter to the GP would have been automatically returned to the EIT, unless Joe had registered with a new practice in which case the letter from the EIT would have been forwarded to the new GP practice. GP practices and mental health services operate on two different clinical information systems and there is no automatic or real time cross referencing of patient status between the two. However, assuming the EIT letter advising Joe's GP that they had discharged him from their care was returned to

the EIT, then the EIT had an opportunity to consider whether they could take any action. They would have been aware that there could well be an interruption in the medication prescribed to Joe and, unlike the GP practice, the EIT had attended the professionals meeting and so they were aware of the risks to Joe identified at that meeting. Amongst the options open to the EIT were to contact Joe's GP practice to discuss his case, given that he had been removed from the GP practice list on the same day as the EIT discharged him. The EIT could also have contacted Probation who had convened the professionals meeting which had taken place 9 days earlier. The EIT could also have considered re-contacting the ARCC as the online request for support they submitted following the professionals meeting now needed to be updated to reflect the risks arising from Joe no longer being registered with a GP. The EIT could also have considered informing the mental health practitioner then working with homeless people with mental health and substance use issues (Paragraph 3.23).

Recommendation 6

That Pennine Care NHS Foundation Trust review the process by which patients are discharged from mental health services to ensure that early contact is made with the patient's GP if it is known that agencies are experiencing difficulties in engaging with that patient.

5.39 PCFT has advised the SAR that Joe's EIT care plan documented that support for his substance use was considered but that Joe declined this. It is not known whether the EIT explored what lay behind BR's refusal of support in respect of his substance use or considered whether Joe had capacity to understand the risks he may be exposing himself to if his drug induced psychosis went untreated. Additionally, there is no indication that the EIT checked whether Turning Point had managed to engage with Joe following the earlier referral from Probation. Given that they were discharging Joe because they had concluded that his psychosis was drug induced, this appears to be an omission.

Recommendation 7

That Pennine Care NHS Foundation Trust review the process by which patients who are discharged from the Early Intervention Service on the grounds that their psychosis is drug induced, and they decline support from substance use services. In particular, Pennine Care are requested to ensure that practitioners explore what may lie behind any refusal of substance use support and that practitioners consider whether patients have the mental capacity to understand the risks they may be exposing themselves to if their drug induced psychosis goes untreated.

Turning Point

5.40 Turning Point held Joe's case until 28th August 2024 when the referral received from Probation in March 2024 was closed after Joe had not engaged with two offers of an assessment.

Probation

5.41 After determined efforts to supervise Joe during the early months of 2024 following his release from prison including home visits, effective joint working, reporting him to the Police as a missing person, appropriate referrals and arranging the 16th April 2024 professionals meeting, Probation appear to have had no further structured contact with Joe after 28th March 2024. Joe's record of attendance at Probation appointments had justified breach action which was initiated on 23rd May 2024 and a Court date set for 7th August 2024, which was later rescheduled for 16th September 2024 at the request of Joe's solicitor so that this could be dealt with alongside other matters. The SAR has been advised that Probation Reset¹², an operational response to high Probation Service workload was introduced in July 2024, which meant that active supervision of the majority of offenders generally ceased for the final third of the licence period. Joe was subject to Probation Reset and so meetings were scheduled with him from July 2024. There were exceptions to Probation Reset including all cases identified as very high risk of serious harm. Probation has advised the SAR that Joe was not considered to meet this or any of the other exceptions to Probation Reset. As the risks to Joe escalated from July 2024 and he made unplanned visits to the Probation office, the responsible officer could have brought his case for management oversight to discuss any ongoing concerns.

First Choice Homes Oldham (FCHO)

5.42 Joe's tenancy with FCHO began on 8th February 2024 and he was identified as requiring tenancy support. After difficulties engaging with Joe, FCHO closed the tenancy support referral on 12th March 2024. A FCHO neighbourhood co-ordinator referred Joe back to tenancy support on 19th April 2024 but this second referral was closed because it was thought that tenancy support would duplicate the support being provided by the Sanctuary Trust. It would have been better for tenancy support to joint work with the Sanctuary Trust.

5.43 The impression gained is that FCHO did not get to know Joe or understand his needs and was therefore not well placed to play a significant role in efforts to safeguard him when the risks to which he was exposed began to escalate from July 2024. FCHO were not invited to the April 2024 professionals meeting. However, the SAR has been advised that housing providers such as FCHO have access to information held on the Oldham Council Housing Options Team's information systems so that they are able to make an informed offer. The most recent assessment by Housing Options was conducted around six weeks prior to the commencement of Joe's FCHO tenancy and highlighted risks of physical violence, verbal aggression, bullying and threatening, damage to property, binge drinking and some cocaine use. All of these risks were included as risks to self rather than others.

¹² 2.1 Probation Reset is an operational response to high probation service workload priorities, prison capacity issues and the impending 'SDS40' 4 temporary reduction in sentence served Prisoner Release scheme. The response represents an operational rather than a legislative change, although changes to legislation may follow. The operational changes that the reset brings are mandated for all staff in all probation areas with no possibility for any local or regional decision making. The changes are: • For individuals sentenced to under four years custody, the final face-to-face appointment will be undertaken at the two-thirds point of the licence, unless the individual meets the exemption criteria.

It is assumed that the risks were recorded in the incorrect column. The assessment also stated that Joe had experienced suicidal ideation but not acted on this. During his tenancy, FCHO also became aware that he was being supported by the Sanctuary Trust.

The Sanctuary Trust

5.44 The only agency which continued to provide support to Joe over the period from May 2024 until shortly before his death was the Sanctuary Trust. Joe's Sanctuary Trust support worker maintained a degree of contact with Probation and the DWP on Joe's behalf but appeared to struggle to maintain in-person contact with Joe, making 4 no contact home visits during this period.

5.45 The Sanctuary Trust has advised the SAR that a key element of the support they provided to Joe was to help him attend appointments. Given that Joe was hardly offered any appointments from the end of April 2024, Sanctuary Trust could have flagged up the fact that Joe was receiving very limited support. In their contribution to the SAR, the Sanctuary Trust acknowledge that Joe's Sanctuary Trust support worker appeared to have become the only consistent point of contact. On 16th April 2024 they raised concerns with FCHO that Joe was not receiving the support anticipated and emailed Probation and FCHO on 18th July 2024 to advise of difficulty in engaging with Joe and to advise that they were considering case closure.

5.46 The Sanctuary Trust takes the view that during the months prior to Joe's death, when he became increasingly isolated from services, they could have formally flagged the lack of multi-agency support to Joe through a safeguarding referral, requested a Care Act assessment or by instigating a multi-agency discussion.

Recommendation 8

That the Sanctuary Trust review their policy for formally raising concerns when an adult they support becomes isolated from services and, as a result, the risks to that adult escalate markedly.

5.47 OSAB partners have produced guidance on "where the individual or family are not engaging with services" which addresses the issue of case closure where an individual is unwilling or unable to engage with services. The OSAB guidance repeatedly stresses the importance of not closing the case prematurely and states that risk assessments should be routinely completed when a case is to be closed because of a failure to co-operate/engage or keep clinical appointments. The guidance states that it is a requirement to actively check with other partner agencies known to be in contact with the individual.

5.48 In Joe's case, Probation did not close his case but applied a nationally mandated operational change which limited their further contact with him and the EIT closed his case because they no longer considered him to be eligible for support from their service. The GP practice's action in removing Joe from their patient list without "actively checking" with partner agencies does not appear to be consistent with the OSAB partners guidance, although, as previously stated, GP practices follow GMC guidance. However, the change in policy the GP practice has introduced

as a result of their learning from this case goes some way towards achieving consistency with the OSAB partners guidance.

5.49 From July 2024 Joe's contact with agencies indicated that he was either "in crisis" or approaching that state. He frequently expressed suicidal ideation; he appeared desperate to be admitted to hospital primarily in respect of his mental health but also in relation to his physical health; he appeared to be struggling with money and implied that his benefits had been restricted or that money had been stolen from him and became involved in shoplifting groceries accompanied by violence and the threat of violence; he became violent at the job centre when a hardship payment could not be paid by that particular job centre and used violence at his mother's address which brought him into conflict with the criminal justice system and when accessing support in the community were discussed with him he appeared to be too overwhelmed and distressed to avail himself of these services or agree to any referral.

5.50 During this period there was some effective partnership working. The DWP contacted Joe via the Sanctuary Trust worker's phone and obtained Joe's consent for a Focused Care Practitioner to carry out a joint visit with the DWP outreach navigator to attempt to re-register Joe with a GP practice. Sadly, Joe died before this planned joint visit could take place. As previously stated the Sanctuary Trust worker liaised with Probation and the DWP and was attempting to obtain a replacement phone for Joe during the week prior to his death. Joe's arrest following the domestic abuse incident at his mother's address on 27th July 2024 led to a referral to the GMMH Criminal Justice Liaison and Diversion Team for possible help and support with his mental health; Joe declined a screening by the team.

5.51 However, silo working and an absence of single agency escalation was also strongly in evidence during this period from July 2024. For example:

- Joe made two unscheduled visits to Probation on 11th and 18th July 2024 when the duty officer was concerned about his presentation. Probation has advised the SAR that the second of these visits should have led to an immediate crisis response.
- GMP did not complete a care plan after Joe was found after an earlier missing person report.
- FCHO served a "notice to quit" on Joe, although they have advised the SAR that they took this action primarily to encourage him to make contact with them.

5.52 Joe presented at the ROH on 10th July, 19th August and on 8th, 9th, 11th and 12th September 2024. He was seen by the PCFT LMHT on 10th July, 19th August and 8th and 13th September 2024. Joe was no longer registered with a GP practice, but this issue does not appear to have been disclosed by Joe or identified by any of the practitioners involved in his care during these hospital attendances or LMHT assessments. Following the 10th July 2024 assessment the LMHT requested Joe's GP to consider support from the Focused Care practitioner if available in the surgery. It is unclear if the LMHT wrote to Joe's GP following the 19th August 2024

assessment as their notes document that Joe “refused a referral to his GP to look at his medication” as Joe “had not had medication for some months”. The fact that Joe said that he had not been taking prescribed medication for some time could have prompted professional curiosity over whether he was currently registered with a GP practice. Following the 8th September 2024 LMHT assessment the letter to Joe’s GP had no GP address shown and so it is assumed that the letter was not sent. Following LMHT’s interaction with Joe on 13th September 2024, a GP letter was generated although it does not appear to have been shared with a GP as there is a note to indicate that Joe was not registered with GP. It is assumed that Joe’s attendances in ROH A&E would have automatically generated a GP letter.

5.53 It is of concern that Joe’s multiple presentations at hospital A&E and assessments by the hospital LMHT, during which the information he shared indicated safeguarding concerns did not apparently lead to clarity that he was not registered with a GP practice or if it was recognised, any action to encourage him to register with a GP practice. Where letters were sent (electronically) to Joe’s last GP practice, the SAR has been advised that such letters are ‘automatically returned’ or forwarded to the patient’s new GP practice. When GP letters are automatically returned to ROH A&E or the PCFT LMHT, there appears to be no process for reviewing the situation and thereafter contacting Joe to encourage him to register with a GP.

Recommendation 9

That the Northern Care Alliance and Pennine Care NHS Foundation Trusts consider what action it is proportionate to take when a patient is repeatedly presenting at the ROH A&E and repeatedly being assessed by the LMHT and letters to the patient’s GP are being returned because the patient is no longer registered with that GP practice.

5.54 As stated, during his July, August and September 2024 LMHT assessments Joe shared information which indicated safeguarding concerns. PCFT has advised the SAR that a safeguarding referral should have been made under the category of financial abuse on 10th July 2024, that a safeguarding referral in respect of financial abuse could have been considered on 8th September 2024 and the LMHT did not seek advice from the Trust’s safeguarding team. Had safeguarding referrals been made the fact that Joe had become unmoored from services, particularly from primary care and was no longer receiving medication in respect of his mental health would have become apparent.

Recommendation 10

That Pennine Care NHS Foundation Trust review the ROH LMHT responses to Joe and consider why safeguarding referrals were not made and implement any necessary changes to professional practice and advise Oldham Safeguarding Adults Board of the outcome.

Recommendation 11

That the Probation Service review their responses to Joe's unscheduled visits to Probation on 11th and 18th July 2024 and consider why safeguarding referrals were not made and implement any necessary changes to professional practice and advise Oldham Safeguarding Adults Board of the outcome.

5.55 After Joe self-discharged from the ROH A&E on 13th September 2024 the ward sister was concerned for his welfare as he had expressed suicidal thoughts but left before being seen by the LMHT. The ward sister attempted to arrange for a welfare check to be carried out on Joe but was unable to achieve this despite determined efforts. She initially phoned GMP who advised her that she should contact NWS who advised her to recontact GMP as they were responsible for carrying out welfare checks. The ward sister then contacted the PCFT 24 hour helpline and was advised that they were unable to reach out to Joe in the community and suggested that she contact Joe directly. The ward sister then attempted to phone Joe but was unable to obtain any response.

5.56 GMP has shared the Right Care, Right Person (RCRP) 'Walkout from healthcare – adults' policy with the SAR. 'Walkout from healthcare' relates to adults who walk out of acute hospitals, hospital emergency departments, GP surgeries, medical clinics, and mental health establishments, as well as any other NHS facility where a patient may have attended for treatment, whether medical or psychological. RCRP regards someone who has walked out of a healthcare facility as a 'concern for welfare incident.' Such people are not considered missing in the first instance and GMP will initially respond to incidents only where there is an immediate risk to life or of serious harm or the definition of a high risk missing person has been met. GMP's expectation is that the healthcare agency will make reasonable enquiries to locate the person. GMP may conduct a joint home visit if there are safety concerns for partner agencies. SAR Panel members said that partner agencies were aware of the RCRP 'Walkout' policy and had taken steps such as putting up signs in hospital A&E stating that if someone wanted to leave the premises they would need to inform a member of staff so it can be marked that they were not missing. However, the Panel felt that it was not realistic for hospital staff to carry out address checks. Overall, the SAR panel felt that the policy left a gap, where patients such as Joe left the hospital and presented a risk to themselves and to others but were not an immediate risk, for which there was no obvious solution.

5.57 There were several acts of kindness from professionals who became concerned about Joe's presentation such as the Probation duty officer who arranged for a "gas and electric loan" and the delivery of a food bank parcel and the ROH A&E staff who provided Joe with food to take with him when he left the hospital on 8th September 2024

Explore the extent to which Joe's mental capacity was appropriately considered.

5.58 There is no indication that Joe's mental capacity was formally assessed. There were several interactions with practitioners when Joe's presentation could have led practitioners to question his capacity, including:

- In September 2023 Turning Point found it difficult to assess if Joe was oriented to time, place and person and noted that that his judgement appeared “limited” as evidenced by his “inability to problem solve and understand the consequences of his actions”.
- In October 2023 a mental health assessment in prison noted Joe to be “struggling to maintain attention, mixing words up and experiencing difficulty forming sentences”.
- In March 2024 the Probation referral to Turning Point stated that Joe’s use of Crack Cocaine was impacting his ability to function, his decision making and his ability to manage his finances appropriately.
- In the 16th April 2024 EIT referral requesting support from ASC, the referral stated that Joe “appeared unable to retain information”.
- During an PCFT LMHT assessment of Joe on 10th July 2024 the practitioner concluded that Joe “demonstrated capacity to make decisions in his own best interests and insight into his current circumstances” but also “expressed thoughts of feeling overwhelmed and unsure where to go for help”.
- When Joe made an unplanned visit to Probation on 18th July 2024, the duty officer noted that Joe was “unable to finish his sentences or explain what he was thinking or feeling” and noted a “strong sense of confusion”.
- On 19th August 2024 the assumption by the PCFT LMHT practitioner that Joe had mental capacity was documented to be a barrier to acceding to his request for a MHA assessment.

5.59 It is clear that assessing Joe’s capacity was not a straightforward task due to the challenges practitioners often experienced in engaging with Joe, his abusive behaviour and his alcohol and drug use.

5.60 However, practitioners generally assumed Joe to have capacity even though his capacitated decisions, such as the decision to live independently and frequently decline support placed him at risk.

5.61 What was not evident in Joe’s case was ongoing, trauma-informed consideration and review of capacity in individuals who chronically disengage from support whilst experiencing cumulative harm. Nor was there any consideration of whether his prior trauma, substance misuse and emotional dysregulation may have obscured indications of executive functioning.

5.62 The OSAB TRAM protocol stresses that understanding mental capacity is key to any risk management process and the need to balance the capacity to understand immediate risk alongside wider patterns of behaviour in order to understand an individual’s executive functioning.

5.63 OSAB has responded to learning from previous SARs by offering multi-agency MCA training on a rolling programme and developed extensive MCA guidance which

is on the OSAB website. In this case a range of agencies missed opportunities to fully consider Joe's mental capacity including Turning Point, HMP Lancaster, Probation, the EIT and the PCFT LMHT. There may therefore be value in evaluating take-up of the OSAB MCA training and promoting it to the agencies involved in this SAR. Bespoke MCA "putting theory into practice" training is currently being delivered to ASC, Children's Social Care and PCFT and the Oldham Council MCA lead provides support, guidance and mentoring to practitioners. However, the SAR Panel felt that providing further MCA training was not necessarily the answer. For example, TRAM training explores the intersections between trauma, substance misuse, ACEs and executive functioning highlighted in previous SARs. However, it was felt that the following recommendation was merited.

Recommendation 12

That when Oldham Safeguarding Adults Board disseminates the learning from this Safeguarding Adult Review, the need to consider formal Mental Capacity Assessments when a person refuses essential support or disengages, especially where there is evidence of impaired executive functioning is highlighted.

5.64 The SAR Panel also discussed the extent to which the MCA Code of Practice remains fit for purpose. It was acknowledged that much more is known about mental capacity than when the MCA Code of Practice was published in 2006 including in relation to executive functioning, the impact of trauma, alcohol, and Adverse Childhood Experiences (ACEs). Government consultation on revisions to the MCA Code of Practice closed in 2022 but no changes have been implemented as yet. Following discussion, the SAR Panel felt that this was an issue which may merit escalation using the National SAR Escalation Protocol and invites OSAB to consider this course of action.

Explore professional responses to queried autism.

5.65 On 29th November 2022 Joe's new GP practice made a referral to the Mental Health single point of access in which the GP stated that Joe was "likely autistic as he has a lot of traits although masks it well and I am looking to refer him to Learning Assessment and Neurocare Centre (LANC UK) for a formal assessment would be grateful if he could be reviewed".

5.66 The SAR understands that at some later date, possibly In January 2023, an application was made to LANC UK for an autism assessment of Joe. There is no indication that such an assessment was completed. Joe's aunt has contributed to this SAR and shared a copy of an email she sent to LANC UK on 23rd February 2023 to enquire about a questionnaire completed by Joe and sent to LANC UK on 9th January 2023. She received no reply to this email.

5.67 It is not known why the autism assessment was not completed although the SAR has been advised that the provider LANC UK no longer exists and that there had been concerns about the quality of service provided at that time.

5.68 Several agencies became aware of Joe's autistic traits and mistakenly assumed that his autism assessment was ongoing. Several agencies made reasonable adjustments for Joe's suspected autism.

5.69 Probation and Changing Futures held a meeting in January 2023 at which they agreed a number of adjustments to the manner in which they were working with Joe including weekly appointments at the same fixed time and day, a visual calendar of appointments, no group appointments and Probation expectations were to be sent out in bullet point easy read format. This was good practice. Additionally, Turning Point has advised the SAR that awareness of Joe's autistic traits informed their assessment of Joe.

5.70 However, several key agencies were unaware of Joe's autistic traits including FCHO and GMP and so it is assumed that the issue was not included in the Housing Options assessment of Joe. Joe was arrested by the Police on several occasions. The Autistic Society provides detailed guidance to assist the Police in making reasonable adjustments for neurodivergent people¹³ including the need for an Appropriate Adult to safeguard the interests, rights, entitlements and welfare of a child or vulnerable adult who are suspected of a criminal offence.

5.71 Joe's suspected autism may have contributed to the difficulties practitioners frequently experienced when attempting to engage with Joe. Worrying about uncertainty (also called "intolerance of uncertainty), having unexpected changes in routine, sensory overload and being challenged by social settings are commonplace occurrences for many autistic people¹⁴. Joe frequently articulated feeling overwhelmed, particularly during the last few months of his life when he appeared to be "in crisis".

5.72 Joe's former GP practice has advised the SAR that the systems and pathways for adult autism assessment are often difficult to manage in a timely manner, especially when the individual is not consistently engaged with services. The SAR has been advised that currently adult patients are screened by their GP and are then referred for a full assessment but there is a very significant waiting period. This is a national issue. Patients have the right to choose and in Greater Manchester, they can choose from clinically led providers, who have a good or above Care Quality Commission (CQC) rating. The patient advises the GP they want to be assessed by a provider who has an NHS standard contract with an ICB in the UK and is clinically led and the GP must refer into that service. However, because spending on ADHD and Autism has risen sharply in Greater Manchester (and nationally) – from £5 million three years ago to £31 million in 2025/2026 - from 1st September 2025 new non-urgent ADHD and Autism Spectrum Condition assessment bookings with right to choose providers are being temporarily held back in Greater Manchester. This means patients will have to wait longer for an Autism Spectrum Condition assessment.

¹³ <https://www.autism.org.uk/advice-and-guidance/topics/criminal-justice/criminal-justice/professionals>

¹⁴ <https://reframingautism.org.au/a-professionals-guide-to-supporting-autistic-clients-and-patients/>

Explore the extent to which Joe's presentation as an angry and aggressive male was explored and the extent to which this presentation may have alienated professionals and represented a barrier to accessing services.

5.73 Joe's mother frequently reported domestic abuse incidents in which Joe was regarded as the perpetrator of violence and threats of violence. On one occasion he armed himself with a metal pole. His mother was referred to MARAC on 3 occasions and received support from the IDVA service. Legal protections such as a DVPO, and a Non-Molestation Order were put in place to protect his mother and her younger sons from the risk of domestic abuse from Joe.

5.74 Joe's aunt also provided substantial support to Joe but from June 2023 began discouraging him from visiting her address because she felt intimidated by his behaviour and discussed taking steps to obtain an order to prevent harassment by her nephew.

5.75 Joe also behaved violently and aggressively to practitioners. He allegedly assaulted a nurse when admitted to hospital under the MHA and was convicted of assaults on housing staff. He was also arrested for causing damage at a job centre and for assaulting police officers.

5.76 He often adopted a particularly hostile approach to female practitioners which led to the closure of his case by Changing Futures after his female support worker had been subjected to frequent misogynist abuse. He was often documented to be hostile, accusatory and irritable during meetings with his Probation Officer who also documented that he presented as loud and threatening when his needs were not met.

5.77 Despite the frequency with which Joe presented as aggressive, threatening and hostile, practitioners attempted to work with him as effectively as possible whilst being mindful of their personal safety. Changing Futures only closed his case after providing support over a substantial period. His particular hostility to women made it challenging for exclusively or primarily female staffed agencies to work with him and one lone working service declined a referral because of the risks Joe was assessed as presenting to practitioners.

5.78 Joe's mother and aunt have contributed to this SAR and they both take the view that the defining event in Joe's life was the incident in which he sustained very serious stabbing injuries when young men forced their way into the family home in June 2020. His mother felt that he suffered undiagnosed PTSD and she felt that he appeared "tortured" by the experience. Joe's aunt felt that the stabbing incident and the lack of psychological support he received following the incident led to a deterioration in his mental health and a change in his behaviour which caused problems in the household. Many of the practitioners who subsequently supported Joe became aware of the stabbing incident and appeared to have insight into the potential trauma Joe experienced as a result.

5.79 However, Joe's aggressive and violent behaviour towards practitioners was frequently viewed through a risk management lens. This was understandable as employers owe a duty of care to their staff and are legally obliged to take all

reasonable steps to ensure their safety in the workplace and when they are fulfilling their duties away from the workplace.

5.80 It is unclear to what extent the underlying causes of Joe's presentation were fully explored when opportunities presented themselves such as during assessments when there was greater opportunity to explore issues in depth. During a Turning Point assessment in September 2023 Joe spoke about feeling abandoned and rejected by his mother as he thought she blamed him for a past relationship break-up. He also remembered crying when he found out about a managed move from one secondary school to another. There could have been greater exploration of his feelings towards women, given the apparent difficulty he had working with women and the frequency with which he assaulted them or behaved in a misogynist manner towards them. His mother said that Joe had never had an intimate relationship as far as she was aware and that she had "no idea" about his sexuality and "was confused about it herself".

5.81 Many agencies made reasonable adjustments for Joe's autistic traits but there is less evidence that practitioners explored whether his violence and aggression could have been a response to external issues which are known to cause some autistic people to display distressed behaviour. External issues may include difficulty in processing information; unstructured time; sensory differences; changes in routine; transitions between activities, services or addresses; or physical reasons such as feeling unwell, tired or hungry.

5.82 Without exploration of any underlying causes of Joe's presentation there was the risk of unconscious bias in the way that practitioners made sense of Joe's behaviour. For example his aggression was frequently perceived as stemming from not accepting the consequences of his behaviour and failing to take responsibility for it. The opportunity to reframe Joe's behaviour as a defensive or protective response to past ACEs, trauma and feelings of shame was generally overlooked.

5.83 The SAR has been advised that Lads Like Us¹⁵ were recently commissioned to provide training by OSAB in which issues such as the tendency of men to struggle to internalise trauma and struggle to articulate their thoughts and feelings and present as angry leading to services closing doors to them.

Recommendation 13

That Oldham Safeguarding Adults Board requests partner agencies to review their policies for the management of people who they support who present as angry, violent or aggressive in order that practitioners are trained to explore the underlying causes of the person's presentation, whilst embedding clear safeguards to prioritise practitioner safety, that practitioners are supported through structured reflective supervision frameworks to reflect on this challenging area of work and that consistent organisational learning is promoted.

¹⁵ <https://www.ladslikeus.co.uk/>

Explore professional responses to Joe's suicidal ideation.

5.84 When Joe was assessed by the Mental Health Access Team or the PCFT LMHT he was generally perceived to articulate suicidal thoughts which had not progressed to a specific plan which he intended to carry out.

5.85 An exception occurred in September 2022 when he was said to have bought a rope and bucket from a DIY chain with the intention of hanging himself. At that time Joe had been experiencing accommodation instability including rough sleeping and sleeping in a tent in the garden of his family home and elsewhere in cold weather conditions. There were an estimated 741 deaths of homeless people registered in England and Wales in 2021. 99 of those deaths were attributed to suicide (13.4% compared to around 1% of deaths by suicide per year in the general population). Most homeless deaths registered in 2021 were amongst men (87.3%) (3)

5.86 On other occasions Joe said that he wished he had a rope or a noose to hang himself.

5.87 There was some self-harming behaviour such as a reference to stabbing himself in the foot multiple times with a broken mop handle in July 2023 and he fractured his leg after apparently kicking the wall of his flat. Self-harm is a known antecedent of suicide.

5.88 However, he often shared feelings which could have given an indirect indication of suicide risk such as stating that he was feeling "empty, hopeless, having no meaning or purpose in life, low self-worth and low confidence" during a September 2023 Turning Point assessment and not infrequently saying that "sometimes he did not want to be around". He frequently spoke of "feeling overwhelmed" during the LMHT assessments completed between July and September 2024 and wishing to be "sectioned" in order to "have a break".

5.89 Joe's suicidal ideation tended to be recorded by the individual agency to which he disclosed it and was generally not the subject of multi-agency discussion. For example suicidal ideation was not included in the otherwise comprehensive discussion of the risks to which Joe was exposed at the 16th April 2024 professionals meeting. And when Joe began regularly presenting at the ROH with suicidal thoughts from July 2024 onwards, he was referred to the LMHT whose assessments were shared only with primary care from which Joe had been de-registered by that stage.

5.90 The PCFT LMHT assessments generally assessed him as "feeling suicidal in the context of his social situation". However, his "social situation" contained many known antecedents of suicide such as isolation from family and disengagement from services and he was experiencing financial worries. It is unclear whether known antecedents of suicide informed professional responses to Joe's suicidal ideation.

5.91 Following these later LMHT assessments there could have been a stronger focus on safety planning particularly when Joe voiced that he was "ready to die" during the LMHT assessment carried out on 10th July 2024.

5.92 However, Joe's presentation was complex and his fluctuating suicidal ideation occurred in the context of substance misuse, emotional dysregulation, possible neurodivergence, past trauma and a challenging interpersonal style that may have masked underlying distress and limited opportunities for deeper exploration of intent, planning and any protective factors.

5.93 In April 2025 NHS England published *Staying Safe from Suicide* (4), which is best practice guidance on the assessment, formulation and management of suicide risk. *Staying Safe from Suicide* urges a shift away from the use of static risk stratification (e.g. low, medium or high risk) because suicidal impulses are highly changeable and can shift in minutes. *Staying Safe from Suicide* noted that 17 people die by suicide each day in the UK. Of those 5 are in contact with mental health services and 4 of those 5 were assessed as low or no risk of suicide at their last contact.

5.94 *Staying Safe from Suicide* promotes a more holistic, person centred approach in which practitioners explore risks collaboratively, understand changeable safety factors and co-produce safety plans. *Staying Safe* envisages the regular review and refinement of safety planning rather than the reactive approach to crises which became evident in Joe's case. This approach could have been followed if a TAA approach had been adopted following the professionals meeting in April 2024.

5.95 *Staying Safe from Suicide* also promotes evidence-based practice, drawing on the latest research and understanding of population-level risk trends. In Joe's case this could have led to a stronger focus on the known antecedents of suicide which were present in his life.

Recommendation 14

That Oldham Safeguarding Adults Board shares the learning from this Safeguarding Adult Review with those responsible for the Oldham Suicide Prevention Strategy, particularly:

- *The need for practitioners to reframe violent and aggressive behaviour as a defensive or protective response to past ACEs, trauma and feelings of shame.*
- *The need for practitioners to respond to indirect indications of suicide risk, especially where individuals have complex needs.*
- *The need for practitioners to be supported to confidently approach discussions about suicide risk, which can often be anxiety provoking.*
- *That Oldham Safeguarding Adults Board should be formally consulted on the safeguarding aspects arising from the implementation of Staying Safe from Suicide.*

Explore the professional responses to indications of potential exploitation following reports of cuckooing, fraud, a lack of money/food/gas/electricity and presentations at hospital involving Joe's rectal area.

Joe experienced multiple exclusion homelessness. Explore the way that the risks arising from homelessness interact with people who may be at risk of exploitation.

5.96 Joe sustained a suspected fractured eye socket in August 2022, the cause of which is not known.

5.97 Concerns that Joe may be being financially exploited by people he lived adjacent to or who visited his accommodation first arose in July 2023 when the PCFT LMHT noted that Joe was receiving threats from two men at his accommodation although they were both due to move out. In September 2023 Joe's aunt raised concerns about his phones being stolen and "people going into his room". Also in September 2023 Joe reported being threatened with a knife by a peer to Turning Point.

5.98 On 4th April 2024 Probation became concerned about two males staying in Joe's flat which suggested possible evidence of cuckooing. It was decided to share these concerns with FCHO. FCHO has advised the SAR that they have thoroughly checked their records and found nothing to suggest that they were aware of potential cuckooing. Potential cuckooing was one of the risks to Joe which was discussed at the 16th April 2024 professionals meeting and the issue was included in the EIT referral for support sent to the ARCC. However, the wording in the referral sent to the ARCC may have minimised the concern slightly by stating that Joe "reports he has people in his flat that he can't get rid of - unknown who".

5.99 When he was assessed by the PCFT LMHT on 10th July 2024 Joe stated that he had been "scammed for his benefits" which he said he had reported to the Police, his bank and "benefits agencies". There is no indication that Joe had made any such reports to the Police or the DWP. PCFT has advised the SAR that a safeguarding referral in respect of financial abuse could have been made. During one of Joe's unplanned visits to Probation the following day, Joe said that his UC had been "taken from his account" and that he had reported this to the Police. Again, there is no indication that Joe had reported the matter to the Police. During his second unplanned visit to Probation (on 18th July 2024) Joe said that he had been arrested "trying to report someone being in his flat" and that he did not feel safe at home. Probation has advised the SAR that this and other concerns shared by Joe on 18th July 2024 should have led to an immediate crisis response.

5.100 When he attended the ROH A&E on 19th August 2024 he reported feeling suicidal "due to having no money" which had been "going on for 3 months". No explanation of why he had no money appears to have been documented. When he was later seen by the LMHT, Joe said that he was having "financial difficulties that he attributed to fraudulent behaviour of others" which he said had been reported to the Police. There is no indication that he had reported the matter to the Police. When he was seen by the LMHT on 8th September 2024, Joe said that his bank account had been "frauded 3 times".

5.101 The DWP have advised that during the months prior to his death, Joe was in receipt of his benefits although his rent including arrears was being paid directly to FCHO and Court fines were being deducted. Additionally a sanction was imposed in June 2024 for not attending meetings but when lifted a hardship payment was made. However, the application of the sanction seems likely to have caused Joe financial hardship as he received no UC in June 2024 and around half of the usual UC amount in July 2024.

5.102 Joe received PIP (enhanced rate for daily living and mobility needs) from late 2023. The independent reviewer is aware of recipients of PIP being regarded as targets of criminal exploitation because they are perceived as being comparatively “better off” than many of their peers who are not eligible for PIP.

5.103 Oldham had a Complex Safeguarding and Exploitation Strategy 2022-2024 (revised Strategy for 2024-2027 now in place) although this appeared to have a stronger focus on the exploitation of children and adults up to the age of 25. The strategy stated that adult safeguarding cases are considered “complex” where exploitation is combined with risk factors which include, but are not limited to, previous trauma, drug and alcohol misuse, mental health issues, learning disabilities, dementia, acquired brain injury, domestic abuse, and homelessness. Joe appeared to meet the criteria for “complex safeguarding” and concerns arose over cuckooing and financial abuse. Generally practitioners were insufficiently professionally curious when Joe disclosed information which suggested financial abuse and did not appear to view these indications of financial abuse through the lens of “complex safeguarding”. The SAR has been advised of substantial efforts to raise practitioner awareness of complex safeguarding including an all-age training package offered every quarter to all Oldham practitioners. The Oldham Children's Complex Safeguarding team also offers training. OSAB partner agencies are working with partner agencies across Greater Manchester to develop further training to support practitioners making referrals to the National Referral Mechanism (NRM)¹⁶. GMP advised that they have a cuckooing policy and a Protecting Vulnerable People tactical steering group that meets every six weeks. As previously discussed the SAR Panel questioned the extent to which cuckooing is widely understood (Paragraph 5.11). The SAR has been advised that OSAB has produced a 7 minute briefing on cuckooing and an excellent OSAB presentation entitled “Cuckooing, County Lines and Beyond” has been shared with the SAR.

Recommendation 15

That Oldham Safeguarding Adults Board considers the further steps required to build on the programme of work already underway to raise professional awareness of complex safeguarding and exploitation including cuckooing across the range of partner agencies who may become aware of the sometimes quite subtle indications of these categories of abuse.

Explore the application of Care Act eligibility by Adult Social Care (ASC) and the opportunities for appropriate professional challenge to ASC decisions by partner agencies.

5.104 The application of Care Act eligibility by ASC has been addressed earlier in this report. As has the absence of professional challenge to ASC decisions.

Explore the extent to which practice was trauma informed (including case closure decision making), took account of any adverse childhood experiences

¹⁶ The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.

(ACEs) and took account of feelings of shame which may affect a person's access to services.

5.105 Practitioners who worked with Joe, particularly those who worked with him quite intensively such as Changing Futures, the Sanctuary Trust and his Probation Officer, adopted a sensitive and empathetic response where possible.

5.106 However, it is unclear whether Joe's adverse childhood experiences were explored in a structured way. For example it is unclear what attention was paid to Joe's experience as a child living in a household in which there was reported domestic abuse of his mother by her then partner. Joe was regarded as a perpetrator of familial domestic abuse against his mother from 2014 (when Joe was 17 years old) and his brother from 2019 (when Joe was 22 years old). The most common form of child to parent domestic abuse is son on mother. This began when Joe was a child and currently the expectation is that this would generate a safeguarding children response in respect of Joe. There is no indication that Joe's alleged domestic abuse of his mother when he was a child or young adult generated any kind of supportive intervention for Joe at that time although at the practitioner learning event, Joe's former Changing Futures worker said that she later worked with Joe on anger management which had a focus on his role as a perpetrator of familial domestic abuse.

5.107 The SAR has been advised that Talk Listen Change (TLC) now provide services for young people in Oldham including young people who need additional support to develop healthy relationships with others. TLC also work with young people who have witnessed domestic abuse or may be exhibiting unhealthy behaviours in their relationships with parents, carers, siblings and friends. The independent reviewer is aware that in Lancashire the MARAC has adopted a 'Three Me's' approach. The 'Three Me's' are the victim, any children of the victim and the perpetrator.

5.108 The response to the serious stabbing injuries Joe sustained in June 2020 appeared to consist of an exclusive focus on treatment and care to enable Joe to make a good physical recovery from his injuries and a criminal justice response to try and bring the perpetrators to justice. The missing element was any consideration of the trauma experienced by Joe. Joe's then GP was informed of Joe's treatment and follow up by the MRI. His then GP practice has reviewed the correspondence they received from the MRI and note that there is no mention of any enquiry about the psychological impact of Joe's injuries, nor are there any follow up actions requested of the GP practice. No enquiry appears to have been made by the GP practice to establish if there was any psychological impact following the injury. Nor is there any indication that Joe contacted his GP to make an appointment and he was not seen by a clinician at the practice until June 2022 where the psychological impact of his stabbing was explored. There had been a failed contact for a mental health review prior to this in October 2021. GMP has confirmed that a referral to Victim Support was offered to Joe which he declined.

5.107 At the time of Joe's admission to the MRI, the country was responding to the unprecedented demands of the pandemic and acute hospitals had adopted a "discharge to assess" approach which entailed discharging patients from hospital as

soon as they were medically optimised. The expectation was that any assessment of the patient's ongoing needs would take place in the community. Joe was not referred to the MRI LMHT.

5.108 NHS England recognises that many people treated for knife or sharp object injuries will need long-lasting care for both the mental and physical aspects of their trauma and in recent years In-Hospital Violence Reduction Services have been introduced which aim to bring together partner agencies to support the delivery of high-quality care, wellbeing and recovery for people acutely affected by violence. The MRI appears to have had such a service at the time of Joe's admission but it is possible that the service would not have been able to operate in the normal manner during the pandemic.

5.109 Several of the practitioners who worked with Joe over the following years became aware of the stabbing incident and included information about this in some assessments and referrals, although the issue may not have been given the prominence that it deserved.

5.110 The exclusively clinical response to Joe's stabbing injuries represents a missed opportunity to offer support in respect of the trauma he experienced. His family feel strongly that the absence of trauma informed support at that time had a significantly detrimental impact on his life thereafter.

Recommendation 16

That Oldham Safeguarding Adults Board arranges to bring the absence of any consideration of the psychological impact of the stabbing of Joe to the attention of the Manchester University NHS Foundation Trust (as the hospital trust at which Joe was treated) and Oldham Integrated Care Partnership (GP practices in Oldham) in order that both bodies may reflect on the response to the 2020 stabbing of Joe and advise of any steps they plan to take to disseminate learning and enhance service provision.

Understanding shame as a key after effect of trauma

5.110 The SAR Panel discussed the developing understanding that shame is a key emotional after effect of experiences of trauma which can become a significant barrier to successful engagement with services. The SAR was advised of the work of the 'Shame Lab' a team of interdisciplinary researchers, scholars, and trainers who work with organisations to help them to become 'shame competent'. OSAB has recommissioned the "Introduction to Shame Competence" course for March 2026, following an initial session held in October 2025 which was well received by multi-agency practitioners.

6.0 Identify good practice

The following good practice has been identified:

- Children’s social care adopted a “think family” approach when working to safeguard Joe’s younger siblings and his mother from domestic abuse from Joe. They sought to provide Joe with support to leave the family home and access accommodation in order to “break the cycle of abuse’.
- In January 2023 Joe’s new GP actively considered an autism spectrum condition assessment after observing that Joe had “a lot of autistic traits which he masks well” (Paragraph 3.15).
- Also in January 2023 Changing Futures and Probation held a professionals meeting at which a number of reasonable adjustments were implemented to better support Joe given his autistic traits (Paragraph 3.16).
- Joe’s female Changing Futures support worker sought to engage constructively and empathetically with Joe despite encountering persistent aggressive and misogynist abuse.
- Probation engaged effectively with Joe during the early months of 2024, conducting a home visit, referring him to Turning Point and taking responsibility for arranging a professionals meeting in April 2024.
- Joe’s EIT care co-ordinator made persistent attempts to engage with him during the period in which he was a patient of the EIT (January to April 2024) including working closely with Probation.

7.0 List of Recommendations

Recommendation 1

That Oldham Safeguarding Adults Board reviews the criteria by which it is decided to support adults through the TRAM process to ensure there is

- *clarity over eligibility*
- *whilst retaining room for professionals to use their judgement and*
- *that eligibility criteria do not inadvertently exclude some vulnerable adults*

Recommendation 2

That Oldham Safeguarding Adults Board works with partner agencies to adopt a co-ordinated multi-agency approach to improving the quality of safeguarding referrals including making use of the good practice which already exists in pockets of the whole system.

Recommendation 3

That Oldham Safeguarding Adults Board requests a report on the effectiveness of 'step up step down' arrangements between the ARCC and the MASH, with a specific focus on the process by which requests for support are screened by the ARCC and the extent to which the ARCC has a robust process to identify any safeguarding concerns within requests for support.

Recommendation 4

That Oldham Safeguarding Adults Board ensures that TRAM training is targeted on line management and more senior management in order to raise managerial awareness of the TRAM process and to emphasise the importance of managerial support and encouragement to practitioners to fulfil the TAA lead professional role.

Recommendation 5

That Oldham Integrated Care Partnership shares the revised DNA policy adopted by Joe's GP practice in response to the learning from this SAR with all Oldham GP practices and encourage them to adopt a similar approach where they have commissioned Focused Care and enhance professional enquiry into the circumstances of patients with mental illness and social and economic complexities where the GP practice does not have commissioned Focused Care.

Recommendation 6

That Pennine Care NHS Foundation Trust review the process by which patients are discharged from mental health services to ensure that early contact is made with the patient's GP if it is known that agencies are experiencing difficulties in engaging with that patient.

Recommendation 7

That Pennine Care NHS Foundation Trust review the process by which patients who are discharged from the Early Intervention Service on the grounds that their psychosis is drug induced, and they decline support from substance use services. In particular, Pennine Care are requested to ensure that practitioners explore what may lie behind any refusal of substance use support and that practitioners consider whether patients have the mental capacity to understand the risks they may be exposing themselves to if their drug induced psychosis goes untreated.

Recommendation 8

That the Sanctuary Trust review their policy for formally raising concerns when an adult they support becomes isolated from services and, as a result, the risks to that adult escalate markedly.

Recommendation 9

That the Northern Care Alliance and Pennine Care NHS Foundation Trusts consider what action it is proportionate to take when a patient is repeatedly presenting at the ROH A&E and repeatedly being assessed by the LMHT and letters to the patient's GP are being returned because the patient is no longer registered with that GP practice.

Recommendation 10

That Pennine Care NHS Foundation Trust review the ROH LMHT responses to Joe and consider why safeguarding referrals were not made and implement any necessary changes to professional practice and advise Oldham Safeguarding Adults Board of the outcome.

Recommendation 11

That the Probation Service review their responses to Joe's unscheduled visits to Probation on 11th and 18th July 2024 and consider why safeguarding referrals were not made and implement any necessary changes to professional practice and advise Oldham Safeguarding Adults Board of the outcome.

Recommendation 12

That when Oldham Safeguarding Adults Board disseminates the learning from this Safeguarding Adult Review, the need to consider formal Mental Capacity Assessments when a person refuses essential support or disengages, especially where there is evidence of impaired executive functioning is highlighted.

Recommendation 13

That Oldham Safeguarding Adults Board requests partner agencies to review their policies for the management of people who they support who present as angry, violent or aggressive in order that practitioners are trained to explore the underlying causes of the person's presentation, whilst embedding clear safeguards to prioritise practitioner safety, that practitioners are supported through structured reflective supervision frameworks to reflect on this challenging area of work and that consistent organisational learning is promoted.

Recommendation 14

That Oldham Safeguarding Adults Board shares the learning from this Safeguarding Adult Review with those responsible for the Oldham Suicide Prevention Strategy, particularly

- *The need for practitioners to reframe violent and aggressive behaviour as a defensive or protective response to past ACEs, trauma and feelings of shame.*
- *The need for practitioners to respond to indirect indications of suicide risk, especially where individuals have complex needs.*
- *The need for practitioners to be supported to confidently approach discussions about suicide risk, which can often be anxiety provoking.*

- *That Oldham Safeguarding Adults Board should be formally consulted on the safeguarding aspects arising from the implementation of Staying Safe from Suicide.*

Recommendation 15

That Oldham Safeguarding Adults Board considers the further steps required to build on the programme of work already underway to raise professional awareness of complex safeguarding and exploitation including cuckooing across the range of partner agencies who may become aware of the sometimes quite subtle indications of these categories of abuse.

Recommendation 16

That Oldham Safeguarding Adults Board arranges to bring the absence of any consideration of the psychological impact of the stabbing of Joe to the attention of the Manchester University NHS Foundation Trust (as the hospital trust at which Joe was treated) and Oldham Integrated Care Partnership (GP practices in Oldham) in order that both bodies may reflect on the response to the 2020 stabbing of Joe and advise of any steps they plan to take to disseminate learning and enhance service provision.

References

(1) Retrieved from <https://www.local.gov.uk/sites/default/files/documents/National%20analysis%20of%20SARS%20-%20Stage%202%20%28branded%20and%20proofread%29%20v6-19.pdf>

(2) ibid

(3) Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2021registrations>

(4) Retrieved from <https://www.england.nhs.uk/long-read/staying-safe-from-suicide/>