OLDHAM SAFEGUARDING ADULTS BOARD

RAPID REVIEW REPORT

1. Safeguarding Adult Review Details

Pseudonym of the Adult at Risk:	'John'
Year of Birth:	1955
Date of Safeguarding Adult Review Referral:	04/12/2024
Chair:	Michelle Grant
Date of Rapid Review Meeting:	10/06/2025
Date of Practitioner Learning Event:	25/06/2025
Date of Final Review Panel Meeting:	10/07/2025
Presentation to Oldham Safeguarding Adults Board:	08/08/2025

2. Introduction

Oldham Safeguarding Adult Board (OSAB) has a statutory duty under the Care Act 2014 to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the Safeguarding Adults Board (SAB) knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult.

SAR Review Panel members must cooperate in and contribute to the review with a view to identifying the lessons to be learned and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work together and independently, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

A referral for consideration of a case for a SAR was sent to OSAB by Northern Care Alliance NHS Foundation Trust in December 2024 in relation to 'John'. John was a white British man who was 69 years old when he died at Royal Oldham Hospital (ROH) in November 2024. It was understood that John was heterosexual; his religion was unknown to partner agencies involved.

The referral was discussed at the OSAB Safeguarding Review, Audit and Quality Assurance Subgroup on 11 March 2025. It was agreed that the criteria for a SAR were met as John had mental and physical health needs including challenges with his mobility; it was recognised that there had been missed opportunities for partner agencies to manage and monitor his needs more effectively; and although a natural cause of death was found, it was suspected that self-neglect and neglect may have been contributing factors. The Subgroup agreed that a 'Rapid Review' methodology should be utilised considering the period from February 2023 until John's death.

The Independent Author for this SAR is Michelle Grant who is an Independent SAR author. Michelle has a health background working in acute hospitals for 20 years and latterly for 10 years in a Clinical Commissioning Group (CCG) and an Integrated Care Board (ICB) as the Designated Nurse for Adult Safeguarding and Mental Capacity Act (MCA) Lead. She has undertaken SAR author training and has since authored several Safeguarding Adult Reviews across the Country. The Independent Author has no links to the OSAB or any of its partner agencies.

3. Contributing Agencies

Agency/Role	Screening Report/ Chronology Submitted?	Attended Rapid Review Meeting?
Detective Constable, Serious Case Review Team, Greater Manchester Police	Y	Y
Safeguarding Practitioner, North West Ambulance Service NHS Trust	Y	N
Therapeutic Services Director and Adult Safeguarding Lead, Tameside, Oldham and Glossop Mind	Y	Y
Head of Service for Discharge and Early Intervention, Adult Social Care, Oldham Council	Y	Y
Designated Professional Safeguarding Adults, Oldham Place Team NHS Greater Manchester Integrated Care Board	Y	Y
Named Nurse Safeguarding Adults, Northern Care Alliance NHS Foundation Trust	Y	Y
Safeguarding Families Specialist Practitioner, Pennine Care NHS Foundation Trust	Y	Y
Service Manager, Housing Options, Oldham Council	Y	N
Safeguarding Operational Lead, Mastercall Healthcare	Y	N
Specialist Nurse, Adult Safeguarding, Northern Care Alliance NHS Foundation Trust	Y	Y
Chief Executive Officer, Age UK Oldham	Y	Y

4. The Report

4.1 Facts about the case from SAR referral and Agency Summaries of Involvement (Step 1)

As stated above, John was a white British man who was 69 years old when he was admitted onto ward F7 at Royal Oldham Hospital on 3 October 2024 following a decline in both his physical and mental health. An adult safeguarding referral was completed by staff in the Emergency Department (ED) on 4 October 2024 following a disclosure that John lived in a house with five other people who were alcoholics and intravenous (IV) drug users, he did not feel safe in his home. John had lived there for fourteen years but told staff he felt unsafe to return due to ongoing health issues.

During his inpatient stay, John was diagnosed and treated for a urinary tract infection and acute kidney injury. He was found to be malnourished with a Body Mass Index (BMI) of 15. Normal range for a male is between 18.5–24.9. He was started on nutritional supplements after being seen by a dietician. He was also seen by the Mental Health Liaison Team (MHLT) due to his low mood. The Tissue Viability Team reviewed John as he had a pressure ulcer, and the Integrated Therapy team also saw John offering a stairs assessment and equipment for his home including a commode. John was referred to both the Community Dietitians and Community Therapy team as part of his discharge plan.

During his hospital admission, John had requested to be rehoused and to receive a package of care although in a conversation with staff from the Integrated Therapy team it was documented that John was informed his housing application was unlikely to be accepted. Possibly as a result of this information, John then agreed to return to his current accommodation with support from Age UK Oldham. He also declined the stairs assessment and equipment including the commode which had been suggested to manage his continence as he had stated that he struggled to access the communal bathroom which was in a poor state of repair and required him to climb a set of stairs. The risks of returning to his current residence were explained to him. It was felt by staff that he had the mental capacity to make the decision to return to his home with only support from Age UK Oldham.

John was discharged home on Friday 18 October 2024 with the above support; a food package was supplied. It is understood that the safeguarding concern raised by ED was not investigated by Adult Social Care (ASC) under safeguarding procedures following the referral made on 4 October 2024; it was felt that this would be more appropriately managed as a needs assessment, the threshold for safeguarding not being met. ASC asked the Transfer of Care Nurse to complete a Discharge to Assess document that they could review.

Following his discharge, John was contacted via telephone by the Community Rehabilitation and Falls Team on 24 October 2024 and again the following day, John's mobile phone was found to be switched off. Consequently, he was contacted via letter on 28 October 2024 requesting he contact the team if he still needed their input. The letter informed him if no contact was made, he would be discharged from their service.

No agency saw John following his discharge from hospital until he was readmitted to Royal Oldham Hospital on 5 November 2024 following a visit from his daughter who called an ambulance. A further safeguarding adult referral was raised by staff. At this time, John reported he was homeless, living in a homeless shelter (which was not correct, he was still living in his home) and had been unable to look after himself. He was found to be in a very poor state of health with several pressure ulcers, covered in faeces and significantly malnourished.

John reported he had been unable to mobilise due to pain in his legs resulting in him becoming doubly incontinent. It was documented that John had maggots in wounds to his legs. He sadly died on 7 November 2024.

John was seen by several GPs during the review timeframe. He had been referred into secondary care on a two week wait pathway for suspected cancer. He did not see the same professional on each occasion, which is not unusual across Primary Care nationally.

4.2 Case Discussion

4.2a About the adult & their lived experience (Step 2)

At the Rapid Review meeting attended by representatives of the agencies involved in John's case, attendees shared what was known about John and his lived experience:

- John had lived in a Home of Multiple Occupancy (HMO) for the last fourteen years, with five other male residents who he described as IV drug users and alcoholics. He appeared to have infrequent contact with his ex-partner and their daughter. He did have friends in the local area that he used to see but over the years, his friendship group became much smaller. The Covid-19 lockdowns had a negative impact on him, he did not want to spend time with the other people he lived with and so gradually spent more and more time alone in his bedroom.
- His poor mobility due to vascular problems in his lower legs and emphysema limited his ability to go food shopping. The communal kitchen was in poor condition with no functioning cooker and no microwave.
- He had been under recent investigation for unexplained weight loss, cancer was ruled out following appropriate investigations. It was noted in his healthcare record that he had struggled with the preparation for a colonoscopy due to his ability to obtain laxative medication and the accessibility of the toilet at his home.

4.2b Views of family/carers

The review has not been able to engage the family of John for the purposes of the review; he had no carers.

4.2c Views of frontline professionals

The views of frontline professionals were gathered at a Practitioner Learning Event attended by those who worked directly with John:

- Policies and procedures were followed, including process by ASC for responding to referrals, by the hospital in respect of discharge protocols and by statutory agencies in line with the Care Act (2014), the Mental Health Act (1983) and the Mental Capacity Act (2005).
- ASC did not proceed with a safeguarding enquiry following the safeguarding referral made by the ED staff at the Royal Oldham Hospital on 4 October 2024. The referral stated that he lived in a HMO with IV drug users and alcoholics and did not feel safe there. It was felt that it was not inappropriate for the staff from the Integrated Discharge Team (IDT), social workers based at the hospital, to request a hospital Transfer of Care Nurse to complete a discharge to assess referral form during the first admission.
- ASC staff reflected that the three earlier referrals to them made by John's daughter, ex-partner and North West Ambulance NHS Trust (NWAS) during 2023/24 did not result in the requested needs

assessments being undertaken. Referrals were made instead to Mind and Age UK Oldham. Mind never managed to engage John and closed him to their service without seeing him. No further action.

- There are good connections with the Housing Options team at Oldham Council. There was potentially a missed opportunity to involve them in addressing whether the landlord who owned the property could have been made to address the poor living conditions at the property. Practitioners reflected that poor living conditions can sometimes result in feelings of shame about someone's circumstances. It was felt that John could have experienced this or that having practitioners knock on the door of the property to visit John might have made relationships with others in the property 'difficult'. It was noted that on one occasion when NWAS were called to attend John at home, he was waiting outside the property, and they were not allowed inside.
- Those working directly with John while he was in hospital reflected that he often changed his mind about decisions during the time he spent on the ward as an inpatient. Staff felt that they had no reason to question his mental capacity to make the decisions he was making.
- The Integrated Therapy Team staff member documented a conversation in which the Transfer of Care staff member discussed with John the unlikelihood of him being rehoused given the current housing challenges in the Oldham area. This communication was regarded as realistic under the circumstances. The information provided may have influenced John to reconsider the level of care he initially indicated he required, particularly in light of his recent decline in physical health.
- John was referred to the Tissue Viability Nurse for an existing pressure ulcer, the dietician for his malnutrition and the Occupational Therapist (OT) which was appropriate.
- Once he knew his rehousing application was unlikely to be progressed, he stated he would go home instead. He then refused a stairs assessment as noted previously the bathroom at his home was on the first floor. He also refused the commode that was suggested by the OT. The risks of these decisions were discussed with John, and he demonstrated the mental capacity to be able to understand the risk he was placing himself at.
- In planning his discharge, health staff were not aware of the poor living conditions at his property, John did not volunteer this information to staff during his hospital admission. People who live in a HMO may have challenges such as access to their post. Letters were sent to John’s home address, which, during the review process, the GP was able to identify had just a single letterbox and there was evidence that John was sometimes late responding to, or did not respond to, written correspondence.
- The mental health practitioner who assessed John when he was an inpatient was clear that he did not have a mental health condition that required treatment. He was able to communicate what support he felt he needed and this was clearly documented in his healthcare record.
- The discharge from hospital was on a Friday afternoon and Age UK Oldham were contacted to support him on discharge. Clarification was sought by the service about whether he needed to be seen straight away, they were informed 'no' and that he would be discharged home with a food package. It was later realised that John would not have been able to prepare the food provided due to his lack of cooking facilities at his home.
- The GP safeguarding lead for the practice that John was registered with felt that the hospital discharge summary that they received was limited in sharing appropriate information about John's care by the ward team despite him being treated for pneumonia and after being seen by the MHLT. They had received a discharge letter from the MHLT following their contact with John in hospital, the letter indicated that John was still an inpatient at this point. Usual practice is for GPs to act when they have the hospital discharge summary which would then indicate any further action the GP was required to take on discharge.

- The practice staff were not aware of the other problems John was having with access to bathroom facilities, hot water and being able to obtain and cook food. The information shared by other practitioners as part of this review was new information to the GP. They felt that had they had a copy of the transfer of care document that was completed this would have provided a more holistic view of the challenges John faced. The discharge summary mentioned 'safeguarding' which the GP took to mean this was being actioned. The practice would but a 'flag' on a patient's electronic record if vulnerabilities were brought to their attention.

4.2d Immediate thoughts/observations (Step 3)

At the Rapid Review meeting, attendees shared their initial thoughts and observations about the case:

- Was John's housing a barrier to him accepting support and allowing practitioners in?
- Were other residents putting pressure on John not to have external agencies in the building?
- No needs assessment by ASC, referred to Mind due to concerns around his mental health.
- Heavy reliance on people having telephone contact with services and having access to mobile telephones.
- What family support was available?
- How was John discharged without being seen by ASC following the safeguarding referral made by ED staff?
- How was the information John shared with the MHLT shared with ward staff? Is there an issue with information sharing if the information is only written in the healthcare record?
- Could not contact John. Could it have been agreed with family that ASC contact them to arrange a time to visit John?
- John was not seen by a social worker during his first admission. The IDT worker asked the Transfer of Care Nurse to complete a Discharge to Assess document.
- In March 2023, was it appropriate for ASC to refer John to an Age UK Oldham PIP worker for support with housing when this service does not provide this support? A referral to Housing Options would have been more appropriate.
- Mind received a referral from the ASC Adult Referral Contact Centre (ARCC) which indicated that John suffered from anxiety and depression due to his home circumstances. Several attempts were made to speak with John and two face to face appointments were made; neither of which John attended. Issues with his mobile and the passing on of appointment letters were possible barriers to engagement. There was a delay in contacting the referrer to let them know they were struggling to engage John.
- Was there a missed opportunity to apply professional curiosity by the GP in September 2023 when he disclosed stress about his home circumstances?

4.2e Analysis Tree: Cause and Effect – factors that may have influenced the incident and individual or/and agency practice (Step 4)

At the Rapid Review meeting, attendees identified the following areas of concern and continued to further analyse the causes and subsequent effects of them on practice.

<u>Lack of Care Act Assessments on someone with care and support needs</u>

- Cause: The three referrals to ASC in 2023 and 2024 by family and NWAS did not result in ASC carrying out a formal needs assessment on John. Alternative routes were taken, the rationale for which do not appear to have been explored further with John into why he did not feel he needed support when others clearly thought he did. There was no consideration of asking John if he gave his consent for ASC to contact his GP to share information and to establish what his health needs were. John was not seen by ASC during his first hospital admission, no needs assessment was carried out, a discharge to assess

document was requested instead. When John refused to see the social worker, this was respected and no further attempt was made to try and engage John to explore the reason why.
- Effect: There were four potential missed opportunities to fully assess John's care needs. The holistic view of John's needs was only established following his readmission to hospital in November 2024, by which time his physical health had declined to terminal levels.

<u>Failure to revisit the information documented in the healthcare record of John following the contact the MHLT had with him during his hospital admission</u>
- Cause: The information documented by the MHLT does not appear to have been revisited as part of his discharge planning.
- Effect: There was a missed opportunity to revisit with John his decision about his discharge given the risks he was exposing himself to.

<u>The lack of context around the vulnerabilities of John when referring to Age UK Oldham</u>
- Cause: Quality and timing of the referral made to Age UK Oldham. The referral made by telephone contact with the service on a Friday afternoon did not reflect the level of detail about John's vulnerabilities that if known, would potentially have led to more assertive action when contact with him was unsuccessful. The telephone referral was made on the same afternoon that John was discharged and not earlier.
- Effect: Age UK Oldham had to contact the referrer on Friday afternoon to establish whether John needed support that day. They were assured that he was being sent home with food and he did not need to be seen until after the weekend. Due to lack of information about John's vulnerabilities at the point of referral, Age UK Oldham did not raise any further concerns about John when they were unable to contact him after his discharge, therefore health and social care staff were not aware that he was not responding to care calls.

<u>The lack of holistic information about John's hospital treatment and discharge plan in the summary sent to the GP</u>
- Cause: Lack of information about the vulnerabilities of John in his hospital discharge summary which was very clinically based, and made no reference to the review undertaken by the MHLT or what the outcome of the safeguarding referral was prior to discharge.
- Effect: Missed opportunity to follow up on the safeguarding concern and place a 'flag' on John's GP electronic record.

<u>Housing availability in Oldham</u>
- Cause: Lack of availability of suitable housing options in Oldham.
- Effect: John appeared to change his mind about the support he had felt he needed with rehousing due to the decline in his physical health as part of his discharge planning when he was informed that it was highly unlikely that he would be rehoused in more suitable accommodation.

4.2f What are professionals worried about? (Step 5)

Attendees at the Rapid Review meeting and Practitioner Learning Event shared what they were worried about:
- Updating referrers about the inability to engage with John and establishing if other agencies are supporting.
- The request for a needs assessment in 2023 had a good level of detail in it, John was spoken to and stated he was managing and had some support. There was no professional curiosity applied to asking John to expand on what he meant. The information shared with ARCC contradicted his response.

- Consent is required for contact with family if the person is going to have difficulty engaging with services and contact is difficult.
- Care planning at point of hospital discharge.
- Decision making when a safeguarding referral is received by ASC: Is policy followed when processing the referral as a 'needs assessment' versus a Section 42 enquiry (both under the Care Act 2014)?
- The responses to John's disclosed housing issues by partner agencies. Could the Housing Options team have offered further support?
- Improving the quality of referrals, record keeping and information sharing. More detail about John's vulnerabilities might have prompted escalation as a result of 'no contact'.
- Challenges with 'stepping up and down' utilising prevention services and statutory services.
- Mental Capacity – Responses to unwise decisions.
- Engagement with family. Were they informed of the date John was being discharged?

4.2g What has worked well? (Step 6)

Attendees at the Rapid Review meeting and Practitioner Learning Event discussed what had worked well:

- A cold call was made by two Age UK Oldham workers to John's home on 21 October 2024, following unanswered calls. They waited at the property for thirty minutes to see if they could get engagement and shouted though a window to see if they could get a response. Appropriate signposting was left at the address for their service and also for Housing Options and how to make a housing application. This was deemed really positive practice.
- Mental Capacity Act (2005) was followed in respect of unwise decisions which were accepted once John had given his view on decisions he was being asked to make.
- Care Act (2014) was followed following the referrals made to ASC. The ASC Operating Model allows for four different responses dependent upon the level of need an individual has.
- John was seen by the out of hours GP service on 3 October 2024, consent to speak with daughter and a detailed assessment was recorded, and appropriate hospital admission was arranged.

4.2h Learning that has/should be shared

Attendees at the Rapid Review meeting and Practitioner Learning Event identified learning that had been shared and should be shared:

- There were some missed opportunities to consider 'safeguarding' and 'duty of care' in the discharge plans for John. Historically, ASC had been made aware of the issues with the property John was living in. A Care Act assessment at his first admission in October 2024 could have explored how he was going to be able to meet his hygiene needs when back at home with no access to hot water; how he was going to be able to obtain food and cook for himself against a background of loss of weight in the longer term; how he was going to manage to keep warm with no central heating; and how he was going to manage his toileting needs when he struggled to get upstairs to the first-floor bathroom.
- John was recorded as refusing to see the Social Worker when he was admitted to hospital on 3 October 2024. As a result the IDT asked the Transfer of Care Nurse to complete a Discharge to Assess document for them to review. There was a missed opportunity for ASC to share with the Transfer of Care Nurse the information they were aware of relating to his home conditions from earlier requests for assessments of John's care and support needs in 2023 and 2024. Had this information been shared

it could have allowed for a more comprehensive Discharge to Assess finding. There is no documentation to support that the IDT requested that the Transfer of Care Nurse that John had agreed to speak to explored what was previously known about his home circumstances and if these remained the same.

- There is a lack of evidence to support that there was sufficient communication between hospital teams when caring for John. It is unclear if medical teams discussed with ward staff if the safeguarding concern was addressed and if discharge was going to be 'safe'. There is a lack of information to support if the dietician considered any alternative nutritional food supplements when John could not tolerate the ones prescribed. How was the documentation recorded by the MHLT in John's record considered by health and ASC when discharge plans were being made?
- There was a heavy reliance on John to state if he did not agree with or would struggle to attend outpatients' appointments after his discharge due to his limited mobility. Greater professional curiosity could have been applied to check how he was going to be able to attend these appointments.
- There was no understanding of the poor housing standards that John was living in. Staff at the hospital were not aware that they were discharging him to a home with no central heating or hot water due to the boiler being broken. They were also unaware that he had no ability to reheat or cook food as there was no functioning microwave, kettle or cooker at the property. John did not share this information himself with ward staff or the Transfer of Care nurse.
- John was admitted to the ward with a low BMI and a high Malnutrition Universal Screening Tool (MUST) score. Ward staff did not complete food charts to establish how many calories John was taking in each day. His care plan did not reflect the support he required with activities of daily living.
- When John was seen by the Dietician, nutritional supplement drinks were prescribed, but John was not able to tolerate these. There does not appear to have been any further action taken as a result of this. It is unclear if the dietician was made aware of this, or if John was visited again during his inpatient stay. There was no documentation on John's hospital discharge summary about the GP having to re-prescribe nutritional support supplement drinks.
- During John's inpatient stay in October 2024, the medical staff recorded that there was a 'safeguarding' referral made for John. There was no further consideration by the medical team to discuss with the nursing team if this has been dealt with prior to John's hospital discharge.
- The MHLT who saw John documented their findings in John's medical records but did not document who they also spoke to on the ward to verbally share this information. This learning point has been shared with staff.
- There could have been liaison with the Housing Options team, Oldham Council, who have a Tenants Relations Service that could have supported John with the issues he was having with the condition of his property, had he agreed to this. John's home circumstances may have made him unwilling to accept the support that could be offered but this opportunity was not advanced.
- The GP who attended the Practitioner Learning Event shared findings from the Health Services Safety Investigation Body (HSSIB), an independent arm's length body of the Department of Health and Social Care, which highlights the risks to people associated with a lack of detailed information on hospital discharge being shared with GPs.
- John could have been referred to the Urgent Care service on discharge which would have provided the opportunity for follow up. The importance of more detailed referrals to other agencies should be highlighted, and if a referral is lacking in detail the receiving agency should seek further information.
- Had there been better information sharing and communication between health and social care about the potential for John to continue to be at risk of self-neglect following his return home and his

ongoing vulnerabilities, a Section 11 (of the Care Act) assessment could have been considered by ASC. It is important to note however that there is a 28 day time frame for reviewing somebody and John might not have been assessed prior to his readmission to hospital.

- John fell at home soon after his hospital discharge and was not able to call for assistance. As a result, he was unable to move for a period of days, developed further pressure ulcers, was found covered in urine and faeces and had evidence of maggots on his lower legs. There was no escalation by staff when they were unable to contact John after his discharge. He had a mobile telephone which often did not work, and his daughter found him at his home and arranged to have him readmitted to hospital.

4.3 Improvements to safeguard and promote the welfare of Adults at Risk

Attendees at the Rapid Review meeting and Practitioner Learning Event identified areas where improvements could be made to safeguard and promote the welfare of adults at risk:

- The hospital discharge summary to the GP was very medically focused with no information related to safeguarding concerns raised by the hospital (although they were regularly referred to by the medical team in his healthcare record during his inpatient stay), his frailty and what support was put in place to assist him following discharge. This did not provide the GP with the opportunity to flag John to the safeguarding lead at the practice or to have a vulnerability 'flag' placed on his GP record.
- Age UK Oldham identified that they should have taken steps to contact the referrer to see if other agencies were involved in supporting John when they were unable to contact John or his daughter.
- Mind reflected that they should have made ASC aware earlier that their attempts to engage John had not been successful. It was four months before they shared that they had not been able to engage John and had closed him to their service.
- Discharge co-ordination and communication at the hospital between ASC and health should be reviewed following the findings of this review to see if the experience of John is a 'one off' event. When an individual is making a series of high-risk decisions there should be consideration of a risk management plan by professionals under the Team Around the Adult (TAA) and Tiered Risk Assessment and Management (TRAM) Protocol framework.

4.4 SMART Actions (Step 7)

Action	Outcome	Lead Team(s)
1. ASC to make the triaging/decision making process more transparent so that partners understand how ASC have made the decision.	Agencies who make referrals into ASC will understand how their referral has been progressed against the ASC operating model.	Oldham Adult Social Care
2. ASC to consider whether repeat referrals for the same person should then lead to a Care Act needs assessment e.g. in this case three referrals resulted in a prevention response.	Repeat referrals for the same person will have enhanced scrutiny with management oversight.	Oldham Adult Social Care
3. ASC to audit cases that have resulted in 'No Further Action' or prevention responses to ensure that decision making is robust.	Enhanced assurance for the OSAB and its partners that the ASC operating model is being used appropriately.	Oldham Adult Social Care

4. Health and Social Care partners that are stakeholders in this SAR to consider the SAR findings and undertake a review of: a) how the 'system' gathers relevant information about a person's vulnerabilities (clinical needs and safeguarding concerns) and any after care when planning hospital discharges and b) how this information is shared appropriately with Primary Care, relevant ASC teams, and all members of the Team Around the Adult at the point of discharge to decide what action/s can be taken to strengthen existing processes. Assurances to be provided to OSAB following completion of this action.	There will be improved information sharing and improved outcomes for vulnerable adults.	Northern Care Alliance NHS Foundation Trust, Pennine Care NHS Foundation Trust, NHS Greater Manchester (Oldham), Oldham Adult Social Care
5. OSAB to raise awareness of the importance of including adequate information about the vulnerabilities of the person they are referring when making referrals to other agencies, such as, in John's case Age UK Oldham and Mind.	There will be improved information sharing with all agencies and improved outcomes for adults at risk of self-neglect due to their vulnerabilities.	OSAB Business Unit/OSAB Policy, Procedure and Workforce Development Subgroup
6. OSAB to produce a 7-Minute Briefing about key considerations for practitioners when discharging a vulnerable person to a HMO.	There will be improved outcomes for vulnerable adults.	OSAB Business Unit/OSAB Policy, Procedure and Workforce Development Subgroup

4.5 Gaps in information/organisation representation

No gaps in information or organisation representation were identified.

5. Parallel Processes

In adherence with local agreements, OSAB have maintained contact with the HM Coroner's office throughout the SAR process. As of 3 July 2025, HM Coroner had closed John's case as a natural cause of death was found. HM Coroner has requested a copy of the SAR Rapid Review Report.