



**OLDHAM SAFEGUARDING
ADULTS BOARD**

Safeguarding Adults Review - Michael

Overview Report

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1. Executive Summary

1.1 Background and context for the review

The Oldham Safeguarding Adults Board (OSAB) commissioned this Safeguarding Adult Review (SAR) in February 2026 to better understand the care and support provided to an adult man in the year before he sadly passed away. During this time, he experienced multiple physical/medical and mental health crises. This involved urgent medical responses including hospital admissions, which sometimes overlapped with the support he received from community and hospital mental health services. He primarily received medical care from Northern Care Alliance NHS Foundation Trust hospitals in Oldham and Bury and Pennine Care NHS Foundation Trust mental health services in Tameside, Oldham and Bury.

The adult man at the centre of the review process is a White British man, called Michael for the purposes of this review. Very sadly he died in May 2023 aged just 54. The preliminary medical cause of his death was 1a) Cardiorespiratory Arrest b) Pathophysiological Stress of an incident on 20-21 May 2023 in combination with Ranolazine Toxicity and Ischaemic Heart Disease. A Coroner's Inquiry into Michael's death will further investigate the wider possible causes and circumstances of his death.

A SAR referral was originally made by a designated safeguarding professional at Greater Manchester Integrated Care Board (ICB) Oldham due to concerns around the care of patients experiencing health crises involving their physical or mental health, or both. Michael died whilst detained under a s.136 arrangement under the Mental Health Act (MHA) (2025). This allows the Police to detain adults for their own safety and for onward mental health assessment. Michael was believed to have taken a significant intentional overdose of medication meant for the treatment of chronic stable angina. He was transported to the hospital but experienced high levels of stress and agitation before and after arrival in hospital, which required the use of physical restraint.

Whilst under detention in the s.136 suite (a designated space within a hospital emergency department where an adult experiencing a mental health crisis can be safely and securely cared for) Michael is said to have experienced two non-epileptic seizures; two episodes of vomiting and he complained of chest pain. He is said to have refused normal medical observations, and it was not clear if the seizures were responded to. He sadly passed away whilst under detention.

Although a screening meeting was convened in October 2023 to review the SAR referral, this process was paused because an Independent Office for Police Conduct (IOPC) investigation had to be concluded before a recommendation could be made to the Oldham Safeguarding Adults Board (OSAB) Independent Chair about whether the SAR criteria had been met. Following the conclusion of the IOPC investigation, the screening meeting was reconvened in January 2026 and it was agreed that the

SAR criteria had been met. This included a reasonable cause to believe that Michael may have experienced abuse or neglect, including acts of omission by services, before his death. These considerations resulted in this SAR being commissioned, particularly with a view to understanding how Michael's co-occurring acute mental and physical health challenges and his wider vulnerabilities were supported and co-ordinated by services at a system level.

The author was commissioned to lead and undertake the SAR process and analysis, as an independent person with a background in health and adult social care, but with no connection to Michael or the services involved in providing his care.

Michael's health, social and family context

One of the key questions for the review has been to what extent Michael was understood as a potentially vulnerable adult, potentially with formal care and support needs, in the year before he died. Michael's mental and physical health certainly seemed to deteriorate across 2022 and 2023, based on the number of emergency attendances to hospital and hospital in-patient admissions for both physical and mental health conditions.

He had a long-established history of cardiac health problems and had previously experienced several heart attacks. During the time period of this review, Michael appears to have experienced two heart attacks (diagnosed as non-ST elevation myocardial infarction or 'NSTEMI') one in August 2022 and again in May 2023, alongside numerous other emergency presentations to hospitals for chest pain, which were attributed to factors including angina or chronic obstructive pulmonary disease (COPD) on investigation. He also received emergency treatment for a blood clot in his leg in May 2023 following surgery, which could also have been linked to his underlying cardiac health issues. Michael was also diagnosed with type 2 diabetes.

In contrast Michael did not have a long-term background of mental health issues that were known to services, in fact his mental health challenges only began to emerge from March 2022 but continued until his death in May 2023, and across this period he seemed to experience ongoing active and passive suicidal ideation. Prior to this, Michael had one admission to an inpatient mental health ward in January 2003 where he was diagnosed with mixed anxiety and depressive disorder on discharge. However, his GP reported that he was not prescribed any mental health-related medication.

During the review period, Michael was admitted to mental health wards on both a voluntary and formal basis in March 2022, October – December 2022 and January 2023. In December 2022, on discharge from the mental health ward, he was diagnosed with Adjustment Disorder and Emotionally Unstable Personality Disorder (EUPD) was documented on his subsequent discharge in January 2023.

The other specific health issue that is documented across the chronology by different services is non-epileptic attack disorder (NEAD)ⁱ. The review was told that NEAD is a psychological health issue which is often triggered by overwhelming stress, which in turn causes the brain to temporarily shut down and might be compared to a safety valve being activated. It cannot be treated with medication, but therapeutic psychological support may have some benefit in identifying what triggers a NEAD event for an individual and might therefore help to manage the symptoms. Multiple NEAD events occurred and were investigated as a form of seizure in January 2023 and again in May 2023.

Alongside his health issues Michael appeared to be experiencing several social stressors. These included:

- A relatively recent marital breakdown (probably during 2021) that led directly to him becoming homeless
- The recent deaths of two siblings (both reported by Michael to have been at the end of 2022)
- His new partner experiencing periods of mental and physical ill-health for which Michael appeared to be supporting her, based on the accounts of practitioners and the chronology of partner agency involvement that has informed the review process
- Numerous incidents of suspected exploitation by people he was staying with, or people associated with them, allegedly including his adult children, their friends and the daughter of his new partner. He also appeared to be vulnerable to theft and potential exploitation by people who befriended him, whilst in hospital and in temporary homeless accommodation
- Not being physically well enough to work continuously and being temporarily 'signed off' work by his GP several times over the review period. Also not being able to work periodically due to being formally sectioned under the Mental Health Act on several occasions

SAR timeframe and focus

This review scope covers around a 14-month period prior to Michael's death, from March 2022 to May 2023 when he passed away. The review has considered Michael's recent personal history, his relationships and the risk of exploitation that arose from some of these relationships, his housing arrangements, contact with different services and how his health, care and support needs were understood, supported and co-ordinated by services.

Whilst the events that immediately led up to Michael's death in May 2023 are important, they are not the sole or primary focus of this review, as the chronology clearly shows that Michael's physical and mental health problems sharply escalated

across 2022 and 2023. The focus for the review has therefore been to understand how these multiple, often acute, health events were understood holistically between medical (physical) and mental health services and whether there were opportunities to join-up his healthcare or respond sooner with psychiatric support for his mental health challenges.

At the beginning of the period under review, in March 2022, it appears to be significant that Michael formally presented to homelessness services for the first time, although it seems very likely that he had experienced housing insecurity for at least 6 months before this and had been staying short-term with friends and relatives without having a stable base. How his homelessness impacted him, including the degree to which it increased his risk of financial exploitation, is a theme the review has considered.

The findings and learning from this SAR are particularly relevant to services involved in supporting adults who:

- Experience a relatively sudden escalation of co-occurring acute physical and mental health problems, especially where there has been no significant history of mental health problems or suicidal ideation in the past
- Experience multiple significant life events and/or sudden changes to their social or family circumstances such as relationship breakdown, bereavement and loss and homelessness, which might indicate or lead to increased psychological vulnerability

The review may also be of interest to and contain relevant insight for services that use or are considering using biopsychosocial assessment to holistically support adults whose health and care needs appear to be driven by intersecting physical, psychological and social factors.

1.2 The review process

The review process was based around a relatively typical methodology for a SAR, consulting widely with practitioners, service leads and an oversight panel of representatives from many of the agencies involved in Michael's care and support. The contributions of family members was discussed by the SAR panel, and included contacting someone thought to be Michael's sibling, however it was considered not to be appropriate to contact Michael's closest family members because some had made unverified allegations against him, whilst others were alleged to have been involved in financially exploiting him.

The SAR was conducted over an approximately 5-month period between February – July 2026 and consisted of the following elements:

- Provision of a case chronology which documented service contacts with Michael and summary case notes from relevant agencies over a roughly 14-

month period prior to his death, from which the independent reviewer developed key lines of enquiry (KLOE) as the basis and focus for the review

- Also shared with the review were the findings of a Patient Safety Incident Review led by Pennine Care NHS Foundation Trust, conducted in the months following Michael's death. This looked specifically at the care provided around his mental health care and needs and was concluded in September 2023. This report has been considered alongside other evidence from the review process
- An initial multi-agency panel meeting to agree/adapt the KLOE and the review process
- Individual agency meetings between the Independent Author and representatives from agencies, to discuss the KLOE and verify agency information
- A multi-agency Practitioner Learning Event where representatives who worked in the services that Michael had used were able to share their perspectives and insights
- Production of an initial analysis report, discussed at a multi-professional SAR Panel meeting
- Production of a final analysis report with recommendations for comment by the SAR Panel, followed by presentation to the Oldham Safeguarding Adults Board for final review

An important aim of the review process is to understand who Michael was and his circumstances, through the eyes of those who knew him well and the practitioners that worked with him.

Establishing a more personal account of Michael has been challenging, because of the time that has elapsed between the original events and this SAR, and because of the barriers to family involvement.

Only one of the practitioners attending the Practitioner Learning Event had met Michael in person, but their recollections suggested that although Michael could appear vulnerable because of his mental health difficulties and regular attendance at hospital Emergency Departments (ED), this was not always the case and there were occasions, especially when he was supporting others, that he appeared to be calm and rational in his thinking and approach.

There was a strong sense from the Practitioner event and the chronology that Michael lacked stability in his life, which included sometimes volatile and unpredictable relationships. Having stable, trusted relationships and a home are often protective factors in times of difficulty and Michael did not seem to have any of these in the final year of his life, which may have undermined his resilience and ability to cope. This lack of protective factors could therefore have compounded his

vulnerability, his anxiety about his health, his suicidal thoughts and the intent to end his life.

However, the events that surrounded Michael do not always appear to be of his own creation and may have reflected the lives and circumstances of the people he spent time with e.g. his partner, his own and his partner's children and their friends and associates. Agency case notes across the chronology occasionally document that Michael said that he was experiencing anxiety and depression and feelings of unease, largely prompted by the behaviours of the people around him, including his ex-wife and his then current partner.

It was noted that on the day that Michael passed away in hospital, his behaviour had been markedly different, and he had presented as uncharacteristically erratic and aggressive, based on the practitioner's previous experience of Michael.

1.3 Overview of the case and care scenario

Across March 2022 Michael appeared to experience several mental health crises, resulting in him being detained under s.136 Police powers under the Mental Health Act 2025 at the start of the month, and culminating in him being formally admitted (under section) to a mental health ward in Tameside following a large overdose of (presumed prescription) medication taken over two days later in March. These events appeared to coincide with anti-social behaviour linked to his son's property where he had been staying and which resulted in him being unable to return to live with his son, due to the conditions of the Anti-Social Behavioural Order imposed by his son's social landlord, First Choice Homes Oldham.

Before leaving the mental health ward in Tameside, Michael made a formal online homelessness application and was given temporary homelessness accommodation in Oldham. In his homelessness assessment he reported that he had already been street-homeless for several days but had nonetheless returned to work.

During April, housing move-on options were discussed with Michael, however, later in the month the temporary housing provider reported concerns that someone 'impersonating' Michael been using the temporary accommodation. Michael reported that the keys to the accommodation had gone missing after visiting his son's house and he was unsure how to report this but had contacted the Police. The person using the supported accommodation was known to his son.

Following these events the temporary homelessness accommodation was withdrawn, and Michael appeared to resume staying short-term with friends/family. When re-contacting the housing options service in May 2022 to explore accommodation options with his partner, who was being discharged from hospital after a stroke, Michael is recorded as saying he had '*been living here, there and everywhere*'. Later in May Michael sent a letter advising that he had found short-term accommodation with friends and family and no longer needed temporary accommodation.

Across June to August 2022 Michael presented to the Royal Oldham Hospital on numerous occasions, both self-presenting and by ambulance. Most of these events were linked to suspected heart attack/chest pain or collapse. Michael did not wait to be seen on one occasion, self-discharged on 2 occasions and was admitted briefly in July and August. The August admission seems to have been due to a confirmed heart attack.

Michael's GP followed up on these incidents and his self-discharge. Michael advised that he had an upcoming cardiology appointment and said that he had self-discharged in July because of this. However, Michael did not attend a vascular surgery outpatient appointment on 25 August, and when this was again followed up by the GP, Michael said that it was because he had just left hospital following a heart attack.

Across September and October, Michael made contact with the ambulance service and the Police relating to different issues, a medical issue for himself and another relating to his partner. However, on 10 October he called for an ambulance, initially linked to heart palpitations but then reported feeling very unsettled to the ambulance crew and also disclosed that he had been experiencing suicidal thoughts.

He was taken to the Royal Oldham Hospital and subsequently referred into the Home Treatment Team or HTT (a short-term support service for adults experiencing a mental health crisis). The day before his scheduled appointment with the HTT, Michael reported not being able to keep himself safe and asked to be admitted to hospital. He was advised to attend his appointment the following day for further support, but whilst at the HTT appointment he suffered a suspected heart attack and was transferred to Fairfield Hospital emergency department (ED).

On medical discharge from Fairfield Hospital, Michael was reviewed by the Bury Mental Health Liaison Team (MHLT) who requested an informal admission to a mental health ward. This seems to have been in part due to concerns about Michael's homelessness and poor nutritional intake, as Michael reported to a dietician that he had not eaten properly for days and had no money.

This informal admission was to a private mental health ward at the Priory in Darlington from 20/21 October 2022 and was for several weeks. It seems likely that Michael returned to Greater Manchester around 12 December 2022 under Section 2 of the Mental Health Act due to ongoing suicidal ideation. Whilst in hospital under section, Pennine Care reported that Michael was involved in multiple events and absconsions and he is also said to have assaulted staff. These events and Michael's focus on addressing his housing situation along with his request to be discharged, led to temporary homeless accommodation being arranged through the Oldham Housing Options service from 22 December 2022. On discharge, Michael received a diagnosis of Adjustment Disorder and a follow up by the HTT and a biopsychosocial risk assessment was scheduled.

Although HTT initially found it challenging to contact Michael, he did attend an appointment on 29 Dec and reported that he felt much better. Michael is reported to have told the HTT that he had suffered a heart attack/stroke prior to the mental

health admission, and although there is no medical evidence to confirm this, the fact that he reported this may suggest that he did believe this to be the case.

In early January 2023, there were further calls to the Police and ambulance service, one linked to his partner who was experiencing a mental health crisis, and another a few days later due to Michael experiencing chest pain and seizure-like activity. The day after this call, on 8 January, Michael took an overdose (said to be 3 months of prescription medication) and was again transported to Royal Oldham Hospital. Due to an ongoing intent to end his life, he was then admitted informally to a mental health ward at Fairfield Hospital in Bury.

Whilst on the mental health ward, Michael experienced another seizure-like event and was taken to the emergency department for investigation. It was concluded that he had experienced a non-epileptic event. He was then discharged back to the mental health ward on 10 January where he then remained, however, on 27 January an ambulance was again called due to Michael experiencing chest pain. He was transported to ED but no abnormalities were found. During this mental health admission, a diagnosis of Emotionally Unstable Personality Disorder (EUPD) was concluded and the likelihood of NEAD was also referenced.

Whilst still on the mental health ward, on 1 and 2 February two events of possible financial exploitation of Michael were reported to ward staff (perpetrated by a peer on the ward). The ward reported the matter to the Police, but Michael did not respond to Police enquiries to confirm/deny the events, however, he later reported the same crime himself direct to the Police but again did not respond to follow-ups. On 2 February Michael was discharged from Fairfield Hospital with temporary accommodation provided and the chronology documented:

Seventy-two hour and seven-day follow-up appointments were arranged. A six-week outpatient appointment with the community mental health team was arranged. A safeguarding referral was requested for potential vulnerability to financial exploitation in the community. The rationale for discharge was documented as: 'No evidence of depression, has future plans, admission was more geared around accommodation.... Full capacity to make decision.'

On 4 February, the 72 hr HTT follow-up appointment went ahead and a risk assessment was completed. Michael was then discharged with an outpatient appointment with the Community Mental Health Team (CMHT) arranged for the end of April, which Michael did not attend. The appointment was rearranged for July 2023.

In late February Michael called for an ambulance reporting multiple symptoms and was transported to the Royal Oldham Hospital where he was treated for acute coronary syndrome (ACS) and had gastroenterology investigations. He was medically admitted until 10 March. On discharge, a referral to the heart failure clinic was also made.

Across March there appears to have been likely financial exploitation by a family member, reported by Michael's bank to the Police, however, Michael said that he did not wish to report/pursue a crime. Later in the month Michael called the Police to

request an escort to recover his property from his partner's address. He reported that his partner's daughter kept asking for money before she would allow him to collect his belongings. In early April, Michael again called the Police stating that another resident in his temporary accommodation had been invited into his room and had taken his mobile phone whilst there. This event was recorded as a crime.

Across March and early April, the GP attempted to contact Michael several times, and he was seen face to face on two occasions. At the second of these face-to-face consultations, the GP recommended a phased return to work as Michael reported feeling well with no symptoms.

However, on 25 April Michael called an ambulance due to fears about sudden pain in his leg. He was transported and admitted to Royal Oldham Hospital and subsequently treated for left lower limb blood clot on 26 April and it was recorded that Michael had a further heart attack during his admission. He was discharged from the Coronary Care Unit on 2 May. However, 2 days later Michael again called an ambulance with concerns about a loss of pulse in his left foot. He was admitted and investigations identified numerous issues linked to his heart condition and the previous procedure. During this admission, Michael also experienced multiple seizure-like events. This was investigated and it was concluded that it was likely to be Non-Epileptic attack Disorder (NEAD). He was discharged on 18 May.

On 19 May, Michael experienced further NEAD events and an ambulance was called by his family, but he refused to be transported to hospital.

On 20 May a family member called for an ambulance due to concerns that Michael was taking steps to end his life by taking an overdose of his prescription medication. NWAS attended and requested Police attendance to gain entry to Michael's temporary accommodation. Michael was restrained due to aggressive behaviour and the ambulance crew determined that he lacked capacity to make decision to be transported to hospital and a decision was made in his Best Interests. Michael also admitted to taking an overdose.

Although it was reported that he remained calm during the ambulance transport to Royal Oldham Hospital, he again became aggressive and violent in the ED. Due to this, he was restrained and detained under Police s.136 powers and moved to the s.136 suite. In line with procedure, the Mental Health Liaison Team (MHLT) advised that they would assess Michael after the 12-hour (poisoning) observation period had elapsed. Michael is said to have refused clinical observations and remained aggressive. It seems likely based on observations made by the Police, that Michael experienced a further NEAD event whilst restrained and then appeared to have stopped breathing. Despite attempts to resuscitate him, he sadly passed away.

1.4 The key issues under consideration

Initial key lines of enquiry (KLOEs) were developed by the independent reviewer based around the chronology and were then discussed and agreed with the SAR

Panel. The KLOEs have been applied across the review to explore with agencies and practitioners how Michael's health care and housing needs were understood and communicated, especially between mental health and physical health services.

These were:

1. For adults who have a history of experiencing acute mental health crises alongside acute physical health crises, how would this normally be managed e.g. who would have clinical oversight, how would mental health and physical health professionals communicate with each other regarding care/management?
2. Were any mental health diagnoses established/known before the review period and if so, how were they being treated/managed? Was Michael being actively treated for anxiety e.g. with medication and/or therapeutic support?
3. How is continuity of care and oversight maintained for Oldham residents who have experienced repeat acute mental health episodes?
4. Michael was referred to the Oldham CMHT in February 2023 – were there opportunities to refer him earlier given his repeated mental health crises?
5. How was non-epileptic attack disorder (NEAD) understood and treated in Michael's case?
6. Is it possible/likely that the regular NEAD events were a stress response linked to Michael's repeated cardiovascular events and a deep anxiety/fear about his physical health?
7. How could the repeated mental health-related events that Michael experienced, have been joined up so that each event was seen as part of a wider pattern of need/behaviour?
8. For an adult who has a history of suicidal ideation and non-fatal suicide through an overdose of prescribed medication, how is this risk communicated and managed between services?
9. What was known to the homelessness team around Michael's wider vulnerabilities across this period e.g. suicidal ideation and risk of exploitation
10. How could Michael's vulnerability to exploitation by others have been recognised sooner and action taken?
11. How were the reasons for his vulnerability to exploitation fully explored?
12. How can safeguarding in the context of acute health events be improved?
13. A Care Act assessment / safeguarding enquiries could have helped professionals to see the cyclical patterns of need and crises for Michael. What were the barriers to professionals making these referrals?
14. What can we learn from this SAR about how to support adults experiencing co-occurring mental and physical health crises?

Based on these initial KLOEs and discussion with the agency leads in the first stage of the review, 3 key themes of interest were generated by the independent reviewer with sub-themes added to address the most important emerging issues from the review process. These are:

Co-ordinating care for adults experiencing co-occurring and re-occurring mental and physical health crises

- a. Information sharing between physical and mental health services
- b. Medication management for adults at risk of suicide

Responding to multiple vulnerabilities

- a. Suicide risk
- b. Problematic anxiety and health anxiety
- c. Exploitation
- d. Homelessness

Safeguarding in rapidly evolving crisis scenarios

1.5 Good practice learning points

The review has highlighted a series of good practice points from different agencies who supported Michael across the final year of his life. These were predominantly secondary healthcare services, primary healthcare and homelessness services.

It is worth noting that the evidence from the review overall points towards expected practice. For example, Michael's mental and physical health needs were identified, assessed and treated, often with onward referrals being made for additional support from other services, especially in the mental health arena. He was promptly admitted to hospital for medical treatment on numerous occasions between March 2022 and May 2023, which involved him undergoing several surgical procedures. There is evidence that cardiology and other follow-up appointments were arranged and communicated to Michael's GP. Statutory homelessness provision was also made available to him in Oldham on two separate occasions.

Within this picture of expected practice, the most notable good practice examples are highlighted here:

- Oldham's statutory homelessness service had a good overview of Michael's social and mental health circumstances, gathered through their three contacts with him during homelessness enquiries / assessments. They appear to have remained flexible with him despite issues with his first placement in temporary accommodation

- His second longer-term stay in temporary homelessness accommodation lasted for nearly 5 months and included low level support from the accommodation provider
- There are several examples of temporary homelessness accommodation being arranged for Michael prior to discharge from mental health wards
- On medical discharge from Fairfield Hospital in October 2022, Michael was reviewed by the Bury Mental Health Liaison Team (MHLT) who requested an informal admission to a mental health ward due to concerns about his homelessness and levels of self-care. This shows good continuity of mental health care as directly prior to the medical admission, Michael had been under the care of the Oldham Home Treatment Team
- The seizure-like activity Michael experienced whilst admitted to both medical and mental health wards (in Oldham and Bury) was investigated and diagnosed as non-epileptic attack disorder (NEAD)
- Michael's GP directly followed up with him after his medical admissions to discuss the circumstances and explore the reasons for missed outpatient appointments
- The Home Treatment Team (HTT) were flexible with Michael and took steps to engage him if he missed appointments
- The staff on the mental health ward at Fairfield Hospital showed awareness of and professional curiosity around financial exploitation when it appeared that Michael had been financially exploited by a peer on the ward and an acquaintance. This incident was appropriately reported to the Police and raised as a safeguarding concern

1.6 Summarising commentary

This SAR has highlighted a specific set of circumstances in which an adult man, Michael, experienced an acute onset of social, physical and mental health challenges in the c.18+ months before he sadly passed away. A change in his personal circumstances, which led to housing insecurity and exposure to financial exploitation, two recent close family bereavements, alongside established cardiac health problems and other co-morbidities, in combination seem to have precipitated an ongoing crisis in his mental health. This manifested as problematic anxiety, health anxiety, multiple episodes of non-epileptic attack disorder, suicidal ideation and several overdoses of prescription medication with suicidal intent.

In turn, these circumstances have exposed some known weaknesses and limitations in the way that health care services respond in a co-ordinated way to adults like Michael who are experiencing co-occurring physical/medical emergency health issues and mental health crises.

Some of these issues originate in what would be accurately described as system limitations. For example, technical challenges in synthesising an individuals' health care information and making it available to all health care professionals; some issues were associated with the way secondary and emergency health care is organised and delivered and the inherent limitations in this, and others are linked to high demand on limited resources, particularly in the mental health arena.

For example, the review heard that:

- Medical and mental health professionals working in emergency and secondary health care cannot currently routinely access the full medical histories and current care needs of patients
- Emergency and secondary health care, in both medical and mental health disciplines, therefore relies considerably on accurate and comprehensive patient disclosure to understand co-occurring mental and physical health conditions / episodes of care
- Although an individual's risk of suicide can be 'flagged' on some patient record systems e.g. in Primary Care, this information may not be available to practitioners in different health care settings
- There is currently variable guidance across Greater Manchester, specifically for prescribers of medication on how to manage prescribing where an adult has a known risk of suicide using prescription medication
- The pathways of support for adults *without* a diagnosed severe and enduring mental health condition (an SMI) who are experiencing ongoing or acute mental health problems, suicidal ideation or active suicidal intent are often unclear
- Similarly, there is often a gap in mental health support for adults diagnosed with Emotionally Unstable Personality Disorder (EUPD)
- Mixed social, health and housing vulnerabilities in adulthood, which may also increase the risk of self-harm or harm from others, are more challenging to identify when an adult is mainly accessing secondary and emergency healthcare or when the adult is not well-known to primary or community health care services

However, contributors to the review agreed that it is not uncommon for adults to present across health care services (e.g. in primary care, community health care, secondary care and emergency care) experiencing concurrent mental health crises and acute medical health issues. Michael's situation is therefore potentially not a unique set of circumstances and whilst the reviewer and SAR panel recognised that there is not an easy solution to the various system problems that undermined the ability of practitioners to join-up the care that Michael received, the findings of the SAR help to highlight and raise awareness about these challenges.

Many of the recommendations therefore focus on clarifying for colleagues working across health care, social care and homelessness support what it is already possible to utilise or build on - within existing legislation, policies, guidance and resources - to reduce the risk of a similar issue arising in the future. There is a particular focus on suicide prevention and clarifying the availability and flexibility of mental health support for adults experiencing mental health crises, who would not normally meet the criteria for formal community mental health services.

1.7 Recommendations

The recommendations from this Safeguarding Adult Review aim to follow the evidence from the review process. They are organised under the 3 primary themes of interest for this safeguarding adult review and seek to directly address the learning and follow-up actions that the review has identified.

In line with the analysis in the summarising commentary, the review has highlighted numerous practice challenges in joining up information and care in emergency and secondary health care settings when an individual is experiencing both acute physical and mental health problems. There was a recognition of these system-level challenges throughout the review, however, some are outside of the scope of this SAR and the Oldham Safeguarding Adult Board to address. The recommendations therefore focus on feasible local (or Greater Manchester level) improvements around information sharing, co-ordination and care delivery.

Co-ordinating care for adults experiencing co-occurring and re-occurring mental and physical health crises

1. The Oldham SAB (OSAB) should consider how to improve holistic care for adults experiencing mental and physical health issues. This may involve:
 - Appropriate health care agencies describing and promoting relevant care pathways and services
 - OSAB seeking assurance that targeted training and guidance is available within each health care agency / setting
 - Promotion of the Greater Manchester Health Record to residents and health and social care employees
2. The Oldham SAB in collaboration with the Oldham Suicide Prevention Partnership should:
 - consider the learning from this review around the role of physical prescription medication in suicide

- develop or highlight existing best practice guidance for prescribers, which aims to reduce the risk of suicide by prescription medication for adults who are at a known risk of suicide
- seek assurance from relevant partners that anyone managing or administering an individual's medication in the community e.g. a care agency, uses a medication management policy that recognises suicide risk and how to manage this risk

Responding to multiple vulnerabilities

3. The Oldham SAB and the Oldham Suicide Prevention Partnership, should task mental health commissioners and services with mapping, describing and promoting mental health support pathways for adults experiencing suicidal ideation (primarily for a target audience of health and social care practitioners and professionals)
4. Pennine Care NHS Foundation Trust should clarify for other professionals how adults who are diagnosed with Emotionally Unstable Personality Disorder (EUPD) and who are experiencing ongoing mental health crises, can be supported within universal and specialist mental health services
5. The Oldham SAB should task partners representing physical and mental health perspectives, supported by relevant specialist expertise, with determining how to raise awareness about Non-Epileptic Attack Disorder (NEAD), including how it should be understood, treated and supported
6. The Oldham SAB should discuss with its partners how to improve identification of acute health anxiety and problematic anxiety, so that adults can be supported in a timely way with appropriate interventions and treatments
7. The Oldham SAB should seek assurance that partners have in place practice guidance or relevant processes that recognise financial abuse and exploitation as an all-age safeguarding risk
8. The Oldham SAB and its partners, including the Oldham Housing Options service, should discuss how it may be possible to raise awareness of vulnerabilities linked to housing insecurity, specifically, the impact on an individual's mental wellbeing and resilience, and the increase in adult men experiencing housing insecurity due to relationship breakdown and divorce in late adulthood

9. The Oldham SAB should seek assurance from Pennine Care NHS Foundation Trust that new Care Act Assessment/referral and/or existing contact with Adult Social Care is routinely considered for adults who:
- are being discharged from an inpatient mental health ward
 - on standard 7-day follow-up after discharge
 - on referral to the Home Treatment Team
 - following detention under s.136 Police powers under the Mental Health Act 2005 and/or being cared on a 's.136 suite'

Safeguarding in rapidly evolving crisis scenarios

10. The Oldham SAB and safeguarding partners should discuss options and appropriate routes for responding to safeguarding concerns raised about adults experiencing recurrent mental health crises, including the application of the TRAM (Tiered Risk Assessment and Management) protocol
11. The SAB should seek assurance from Pennine Care NHS Foundation Trust that its risk assessment processes and practices for adults at risk of suicide are in line with NHS England's 'Staying Safe from Suicide' best practice guidance for safety assessment, formulation and management

2. Analysis by the key issues explored in the review

2.1 Co-ordinating care for adults experiencing co-occurring and re-occurring mental and physical health crises

The review has tried to understand how typical Michael's circumstances were – specifically how common it is for an adult to experience frequent, acute mental and physical health episodes in parallel over an extended period. Several of these events also happened while Michael was seen in person or was receiving treatment e.g.

- In October 2023, he was attending an appointment with the HTT for his mental health when he experienced a suspected heart attack and was transported for emergency medical treatment at Fairfield Hospital in Bury
- Whilst staying on a mental health ward at Fairfield Hospital in January 2023, he experienced both a seizure-like event and chest pains was again taken to the Fairfield ED for investigation on both occasions
- On a medical admission to the Royal Oldham Hospital in May 2023, Michael experienced numerous NEAD events

Healthcare professionals' views on Michael's acute mental and physical health episodes seemed to suggest that while it is not generally the norm for a patient to experience multiple, frequent *acute* mental health and medical events in parallel, or in sequence, most also said that it was not exceptional, particularly if the adult has established physical co-morbidities alongside mental health issues.

Some professionals also noted the rise in adults with complex physical and mental health issues being seen in services and the challenges for community mental health services in some areas due to high and ever-increasing demand.

a. Information sharing between physical and mental health services

Throughout Michael's experiences with secondary medical or mental health care services, it seems that his care was delivered effectively, but largely in silos, which prevented the various clinicians working with him from seeing his rapidly deteriorating mental and physical health and social situation holistically. However, this reflects how the UK secondary health care system is set up to provide specialist care. The prevailing view from professionals was that consultation between specialist disciplines within secondary care does happen when the patient's conditions specifically indicate it, but this does not happen routinely especially between medical and mental health disciplines.

Contributors to the review readily acknowledged the weaknesses in information sharing between specialist physical and mental health services, largely because the electronic medical records for these services are held on different systems and delivered by different health care agencies. This means that a psychiatric doctor cannot automatically see the physical health records of the person they are treating,

and vice versa, and they may be completely unaware of any relevant wider health issues unless the patient discloses them. This may also have implications for treatment decisions and use of medications.

The review has concluded that the lack of co-ordination seen around Michael's mental and physical secondary health care reflects a systemic problem, which is not unique to this case or the healthcare systems in Oldham and Bury or Greater Manchester more generally. The review tried to explore possible solutions to this and several options were suggested that may help to join-up physical and mental health care in similar cases in the future.

These were:

- Promotion of the Greater Manchester Care Recordii which health and social care professionals across Greater Manchester can access, which provides a high-level summary of an individual patient's current health or care issues, medications, allergies, test results, care plans, social care needs and input from carers. However, it was noted that patient consent is required before professionals can see this information
- Where secondary care clinicians have immediate concerns about a patient or suspect wider potentially serious physical or mental health issues, it is possible to request a summary of health care issues and needs from the GP, in order to inform treatment and decision-making. However, this may not be pragmatic in emergency or out-of-hours care situations
- Creating guidance for secondary care professionals which supports more holistic care for patients experiencing concurrent physical and 'active' problematic mental health problems i.e. where poor mental health significantly impacts on an adult's day-to-day functioning, regardless of whether they have a severe and enduring mental health (SMI) diagnosis

b. Medication management for adults at risk of suicide

By February 2023, Michael had taken 3 separate overdoses of prescription medication with a stated intent to end his life. The review has not been able to identify how Michael's access to prescription medication was managed to mitigate his risk of suicide by this method.

The GP indicated that where a suicide risk is known by the GP, medications are usually restricted to a maximum of 2 weeks. It was also advised at the Practitioner Learning Event that patients are usually discharged from hospital with a maximum of 1 weeks' worth of medication. Whilst the review heard that this is standard practice, it also means that vulnerable patients do not have access to large amounts of medication on discharge. However, practitioners noted that it can be challenging to comprehensively mitigate the risks around misuse of prescription medication as adults may stockpile medication and the risks can often be dynamic and changeable.

An action arising from the SAR will be to understand if there is a recognised local, Greater Manchester or national protocol or good practice for managing medical prescriptions in a scenario where the adult is at a known high risk of suicide, and what is the method for flagging this specific risk to all medical prescribers, regardless of their health care setting. There is already a range of NICE guidance on the topic of suicide prevention through reducing access to methods of suicideⁱⁱⁱ and by implementing safe medication prescribing and dispensing practices^{iv}, which may assist with this.

Recent research^v looking at the role of medication in self-harm and suicidal intent, (which drew on Coroners' Prevention of Future Deaths reports that involved medication, and wider research on the causes of medicine-related suicides), reported that opioids and antidepressants are the forms of medication most involved in suicide.

A distinct and therefore important feature of the learning from this SAR has been Michael's ongoing use of his *physical health medications* with suicidal intent, which should not be overlooked in prescribing practices designed to reduce the risk of suicide involving medication.

2.2 Responding to multiple vulnerabilities

One of the central questions for the SAR has been to what extent Michael's vulnerabilities and risks were recognised by professionals, leading when appropriate, to safeguarding concerns or consideration of referral for Care Act Assessment.

The general sense from the discussions with agencies and practitioners is that Michael did not immediately present as highly vulnerable. Some practitioners said that it was not always clear that he was homeless because he gave a residential address on several occasions, and others believed the fact that he was employed was likely to be viewed as a protective factor, as well as an indication that Michael was functioning reasonably well, despite his mental health problems.

Most professionals said that his suicidal ideation and past overdoses were his most evident vulnerability, but the practitioners at the learning event agreed that his poor mental health would not necessarily trigger a safeguarding concern or lead to an escalation in the safeguarding response, partly because Michael regularly received support from mental health services. It was also suggested by practitioners that safeguarding concerns primarily regarding an adult's mental health would typically result in a referral to the CMHT.

Other commentators noted that as health care professionals in crisis response services are increasingly working with very vulnerable adults with multiple complex needs, this may lead to desensitisation and risk-factors being normalised.

a. *Suicide risk*

The response to Michael's suicide risk appeared to be managed through multiple informal/social admissions to mental health wards, formal MHA admissions under section and Home Treatment Team (HTT) follow-up and risk assessment. However, it appears that each individual mental health episode was treated as an isolated event, rather than being seen as part of an ongoing and escalating pattern of need. The review heard that Michael was not under the care of a psychiatric clinician e.g. as a mental health outpatient or through the CMHT, so there was no ongoing clinical oversight of his care needs.

A Pennine Care internal patient safety review considered risk assessment practices by the various mental health teams involved in Michael's care and found that whilst policy had been followed in most cases, staff reported administrative issues with the completion of risk assessment templates and safety/risk management plans, and in the case of the latter, there were different approaches to when a risk management plan would be completed. Some staff also reported that the risk assessment format could be confusing. It was not clear if a biopsychosocial risk assessment is used as standard across the mental health services that Michael had contact with.

In addition, while risk assessment prior to discharge from the HTT is referenced in the chronology, it is not clear if these risk assessments were holistic and detailed. Based on the Pennine Care NHS FT internal review, it seems more likely that the focus of the risk assessment was to maintain Michael's safety with a safety plan, rather than address the underlying causes of his suicidal thoughts and feelings.

The chronology suggests that Michael had numerous mental health diagnoses e.g. December 2022 the diagnosis on discharge was Adjustment Disorder; in January 2023 there is a case note referencing diagnosed EUPD (Emotionally Unstable Personality Disorder) and there were also broader references to his suicidal ideation being associated with '*emotional dysregulation in response to psychosocial stress*'.

After the diagnosis of EUPD was made, whilst Michael was on a mental health ward at Fairfield Hospital in January 2023, he was then referred into Oldham outpatient mental health services, which could have resulted in a fuller assessment and possible support from the CMHT.

In its internal patient safety review, Pennine Care NHS FT considered whether Michael was eligible for any mental health pathways that may have given him ongoing support for his mental health, beyond the response to each individual event involving suicide ideation or medication overdoses with an intent to end his life. It was conceded that a referral into outpatient mental health services / the CMHT could potentially have been considered earlier given the extent of Michael's contact with mental health services in crisis. However, it was noted that these decisions were made by individual practitioners in different locations, based on their first-hand understanding of Michael's circumstances at the time, what information he disclosed

and his willingness to accept support. Most of those practitioner decisions at the time concluded that Michael would not have been eligible for support from the CMHT.

In a contact with mental health services in October 2022, Michael was also referred for counselling and provided with a month's pass for the Safe Haven, a therapeutic service provided from 5pm to 8am where people experiencing a mental health crisis can access support. However, this seems to be the only other mental health support offered to Michael.

The main question for the review remains whether mental health services had the ability to join-up Michael's many separate contacts with services earlier and potentially provide ongoing mental health support and clinical oversight by the CMHT. The barriers to this appear to have been:

- Most mental health staff who had contact with Michael did not consider a referral to the CMHT, probably because they anticipated that Michael would not be eligible for CMHT support based on sustained suicidal ideation
- The mental health risk assessment process may have focused on managing immediate presenting risks and safety planning i.e. suicidal ideation, rather than identifying the factors underlying Michael's ongoing suicidal ideation and overdoses i.e. his precarious physical health and unstable social and housing circumstances
- There is a reported gap in community-based mental health support for adults diagnosed with Emotionally Unstable Personality Disorder (EUPD)

b. Problematic anxiety and healthy anxiety

An unexpected outcome of the review is that given Michael's evidently high state of anxiety - linked to his physical health and multiple social stressors, and strongly indicated by the increasing occurrence of NEAD events from January 2023 until the time of his death in May 2023 - the review has found very little documented recognition by professionals that he was suffering from acute and problematic levels of anxiety. It is also possible that Michael did not have insight into the nature and causes of his anxiety.

There is a note in the chronology where one of Michael's family members refers to his poor mental health '*making him think he was unwell*'. In another note, this was referred to as 'hypochondria' by his partner's daughter. These interpretations seem unfair given Michael's long history of heart problems and the number of genuine cardiac events seen across the chronology. However, they do point towards Michael experiencing frequent, but probably justified, fears about his physical health, some of which do appear to have resulted in 'false alarm' calls for an ambulance for chest pain. Equally, Michael also made several completely justified emergency calls to seek help for life threatening cardiovascular problems.

The review has found no evidence that acute health anxiety, linked to his physical health, was considered by professionals as one of the possible factors driving Michael's poor mental health. Given that several suspected acute medical episodes occurred whilst Michael was admitted to a mental health ward or under the care of the HTT, it is not unreasonable to expect mental health professionals to have shown some curiosity about these medical events.

The multiple, witnessed NEAD episodes were a strong indicator that Michael was experiencing sustained, problematic anxiety. Whilst it is positive that a physical cause of Michael's seizures was ruled out and NEAD was diagnosed, unfortunately this diagnosis does not seem to have been explored further to determine its root cause. The emotional and psychological causes of Michael's NEAD episodes appear to have been overlooked on both mental health and medical wards. Practitioners noted that NEAD episodes in older adult men are not common, which could indicate that Michael was experiencing a significant and unmanageable level of psychosocial distress.

Most contributors to the review felt that NEAD is not widely recognised or understood and this SAR presents an opportunity to promote better awareness of the condition and how it should be interpreted e.g. as a psychological, nervous system response to overwhelming emotional or physical pressure.

c. Exploitation

Each time Michael was discharged from hospital, or 'befriended' by others, there were typically allegations/incidences of suspected financial exploitation by peers, family members and associates of family members. Across the chronology it appears that Michael was very susceptible to financial manipulation by others and being 'taken advantage of' more generally.

Although most organisations were not aware of this risk, in discussion with Greater Manchester Police it was acknowledged that the reports of repeated financial exploitation of Michael to Police were not adequately followed up as a safeguarding issue. At the time of the events there was a lack of understanding about financial abuse and exploitation, especially affecting middle-aged and older adult victims. This has since been addressed and guidance is now available for Police officers, as it was recognised as a gap by a senior Police leaders.

Unfortunately, although staff on the mental health ward at Fairfield Hospital were vigilant and identified 2 separate concerns about Michael being financially exploited in early 2023, neither of these safeguarding concerns recorded on the ward appeared to result in a formal safeguarding referral being made, although the Police were notified in one instance. The Pennine Care NHS FT internal review could not identify why formal safeguarding referrals were not sent to Bury Adult Social Care and there was no record of these having been received by Adult Social Care.

There were therefore multiple missed opportunities to address the financial exploitation that Michael was experiencing, by numerous family members and acquaintances.

d. Homelessness

Across the chronology, there are various references to 'housing' being a leading concern for Michael. It is probable that his housing insecurity, which appeared to begin around the end of 2021 when he separated from his wife, may have exacerbated the deterioration in his mental and physical health.

He first presented as statutorily homeless in March 2022, following a mental health admission and although he accessed temporary homelessness accommodation twice, his housing arrangements remained unstable between March 2022 and his death in May 2023. Within this period, it seems that Michael stayed with several acquaintances including his new partner, and her daughter who was suspected of financially exploiting him. His reliance on others for accommodation may have increased his risk of financial exploitation, largely by being exposed to people who were ready to capitalise on his vulnerability.

Although some medical and mental health wards were aware of his homeless status and took appropriate action on discharges, including a social admission to a mental health ward in one instance, other health care professionals reported not knowing about Michael's housing insecurity. This may partly explain why he was typically not seen as having vulnerabilities beyond his mental health challenges.

2.3 Safeguarding in rapidly evolving crisis scenarios

Although Michael visited various hospital emergency departments over the 14-month period considered by the SAR, some of which included transportation by ambulance, there is no record of safeguarding concerns being raised by practitioners on any of these attendances. An additional question posed by the SAR panel was why Michael was not referred for Care Act Assessment (CAA) given that he appeared to have needs in relation to some Care Act domains e.g. housing/home environment, family/relationships and community.

The evidence gathered in the review process suggests several likely reasons for this:

- Michael was not seen as vulnerable or likely to have Care Act eligible needs due to some of the issues already described in this report e.g. he reported having a job and living at a residential address and most practitioners were said to have been unaware of his housing insecurity. It was also suggested that Michael's age may have been a barrier to considering possible wider vulnerabilities

- Due to these factors, Michael did not present to practitioners as someone with multiple vulnerabilities, which made it less likely for them to consider him being at risk of abuse or harm, or having care and support needs
- Healthcare services providing a crisis response are primarily concerned with stabilising the situation and dealing with the immediately presenting issues. Whilst the expectation is that crisis/emergency services should still explore an adult's history, this is more reliant on what an adult discloses at the time
- Practitioners working in hospital emergency departments tend to focus more on mental capacity decisions in their assessments, meaning that safeguarding issues and risk is considered to a lesser degree, although there is a prompt to consider safeguarding within the standard paperwork used by the MHLT.

Taken together, these factors provide an explanation for the responses to Michael seen in emergency care situations and the review process found no evidence of acts of omission or oversight.

In reflecting on Michael's case, the mental health liaison practitioner felt that their approach had been in line with usual practice based on the available information at the time. Colleagues representing mental health wards, and the Pennine Care corporate safeguarding team, also said that discharge practices had improved with the introduction of discharge co-ordinators, along with 'formulation' meetings (formulation considers why an individual has a particular mental health problem and the factors that contribute to it). Consideration of Care Act eligible needs and onward referral for Care Act Assessment was said to be more robust because of these new ways of working.

Several agencies observed that Michael was most often seen in emergency and urgent care situations, which do not generally enable practitioners to get to know an adult because of the short-term and focussed nature of the encounter. One instance of this is that the GP noted that there was no indication of Michael's mental health challenges highlighted in the discharge information from Royal Oldham hospital, a few days before Michael died, which suggests that the medical ward were completely unaware of his wider health context.

On balance, a referral into community mental health services would seem to have been the most appropriate pathway to holistically identify, assess and support Michael's escalating social and medical needs, and the apparent combined impact of these factors on his mental health. The frequency and intensity of Michael's mental health episodes, including NEAD events, is perhaps an indication of the depth of his psychological distress and stressors in the final year of this life. However, it is also recognised that a referral into the CMHT may not have been typical practice at the time, due to the eligibility criteria for CMHT support.

ⁱ Northern Care Alliance patient information leaflet explaining NEAD:

<https://www.northerncarealliance.nhs.uk/patient-information/patient-leaflets/neuropsychology-understanding-non-epileptic-attack-disorder-nead?q=%2Fpatient-information%2Fpatient-leaflets%2Fneuropsychology-understanding-non-epileptic-attack-disorder-nead>

Northern Care Alliance Neuropsychology Non-Epileptic Attack Disorder (NEAD) Service information page:

<https://www.northerncarealliance.nhs.uk/patient-information/patient-leaflets/neuropsychology-non-epileptic-attack-disorder-nead-service?q=%2Fpatient-information%2Fpatient-leaflets%2Fneuropsychology-non-epileptic-attack-disorder-nead-service>

ⁱⁱ Information about the GM Care Record <https://gmwearebettertogether.com/>

ⁱⁱⁱ NICE Guideline 105: Preventing Suicide in Community and Custodial Settings

<https://www.nice.org.uk/guidance/ng105/chapter/Recommendations#reducing-access-to-methods-of-suicide>

^{iv} NICE Guideline 225: Self-harm: assessment, management and preventing recurrence

<https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#safer-prescribing-and-dispensing>

^v Anthony G, Aronson JK, Brittain R, Heneghan C, Richards GC. Preventable suicides involving medicines: A systematic case series of coroners' reports in England and Wales. *Public Health Pract (Oxf)*. 2024 Mar 23;7:100491. doi: 10.1016/j.puhip.2024.100491. PMID: 38628605; PMCID: PMC11019265. [Preventable suicides involving medicines: A systematic case series of coroners' reports in England and Wales](#)