



**OLDHAM SAFEGUARDING
ADULTS BOARD**

Safeguarding Adult Review: 'Ruth'

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1. PEN PORTRAIT OF RUTH

- 1.1 Ruth¹ was a White British female who was 47 years old at the time of her death following an intentional overdose of prescription medication. She lived in a ground floor flat which was social housing provided by First Choice Homes Oldham. Ruth had a complex range of comorbid physical and mental health conditions, with formal diagnoses of Bipolar Disorder (BPD), Emotionally Unstable Personality Disorder (EUPD), Complex Post Traumatic Stress Disorder (C-PTSD), Raynaud's Disease, Arthritis and Chronic Obstructive Pulmonary Disease (COPD). These conditions contributed to chronic pain and fluctuating mobility; at times Ruth was able to mobilise using crutches, at other times she needed a wheelchair and was at risk of falls.
- 1.2 Faith was very important to Ruth. Some agency records associate her with the Church of Jesus Christ of Latter-day Saints, a Church of England Priest performed the last rites before she died, and she was also known to have attended a non-denominational online Christian Church regularly. In February 2024, Ruth told a mental health professional that she "prays to God every day", and that although people had abused her all her life, she still had faith in God. Ruth said that she had some good friends and was able to forgive all who have harmed her.
- 1.3 Professionals who worked with Ruth understood that her two cats meant a lot to her. They described her as "quite the character"; she was funny, generous and able to strike up conversation with people wherever she went, although her relationship with family was strained and they were not close. Professionals also knew that Ruth lacked confidence at times, needing reassurance and validation. She struggled with chronic pain but was determined to maintain her home and her independence.
- 1.4 Ruth's friend, Tina¹, provided informal support to her for around two years before she died. Tina said that Ruth needed help to understand what happened in meetings and wrote notes of what was discussed to go over with Ruth afterwards, as she would often get confused or misunderstand information.
- 1.5 Tina told the Author that "on a good day, Ruth would be the life and soul of the party". She described Ruth as a "very caring, very loving person" who liked helping people, although this also made her vulnerable to being taken advantage of by others at times. She recalled that there would be times when they both had tears rolling down their faces with laughter and that Ruth would get food that Tina liked in for their tea when she visited. Tina remembers Ruth as "a lovely lady and a lovely friend".
- 1.6 The Author, Oldham Safeguarding Adults Board and its partner agencies offer their sincere condolences to Ruth's family and friends for their loss.

2. INTRODUCTION

2.1 Background

- 2.1.1 Ruth was an adult with care and support needs (see paragraph 1.1) living in Oldham. She had a history of mental health difficulties, physical health needs, substance use, vulnerability to exploitation, and repeated episodes of self-harm by overdose. These factors sat alongside a significant history of domestic abuse. From 2019, Ruth was in a relationship with a man, P, who was abusive towards her. Agencies received repeated reports of assaults, coercive and controlling behaviour and non-fatal strangulation. Following a serious assault in November 2022, Ruth took an overdose of prescription medication and was admitted informally to hospital². She was recognised as a high-risk victim of domestic abuse, referred to MARAC³,

¹ Names changed to maintain anonymity (both Ruth and Tina)

² An informal admission to hospital refers to a patient who enters hospital or a mental health unit voluntarily, without being legally detained under the Mental Health Act.

³ MARAC (Multi Agency Risk Assessment Conference) – regular coordinated meetings between statutory and voluntary agencies to share information and create safety plans for victims of high-risk domestic abuse.

and was subject to a safeguarding enquiry under s.42 of the Care Act 2014 (Care Act)⁴. She also spent a short period in refuge accommodation. As her partner had also acted as her carer, formal care arrangements were put in place by Oldham Council Adult Social Care (ASC) when protective legal measures restricted his contact with her. During this period, agencies worked with Ruth through the Team Around the Adult (TAA) framework⁵. The relationship ended around the end of 2022.

- 2.1.2 In June 2023, Ruth was admitted to hospital after a further intentional overdose. She was subsequently detained under s.2 Mental Health Act 1983 (MHA), later regraded to s.3 for treatment. On discharge, Ruth was entitled to s117 aftercare⁶. However, there was disagreement and a lack of clarity between Pennine Care NHS Foundation Trust (PCFT) and ASC about responsibility for assessing and coordinating her community support. Ruth was discharged with support from ASC, routine Home Treatment Team (HTT) follow-up, outpatient psychiatric care, a package of four care calls per day and floating support from KeyRing. KeyRing provides community-based support to adults with care and support needs and is not responsible for administering medication.
- 2.1.3 A central feature of Ruth's care was the management of risk associated with prescribed medication. Ruth had a significant medication regime and was known to be at high risk of overdose. A plan was agreed that her medication would be stored in a safe in her living room, with the key kept in an external key safe so carers could administer medication. In practice, this arrangement became a recurring source of anxiety, frustration and risk. Difficulties included missed or mistimed care calls, medication being left unsupervised or supervised by others, Ruth not always being at home when carers attended, and the key safe code being shared with external professionals. Ruth also reported concerns about carers, whilst domiciliary care providers reported difficulties meeting her needs. Over the review period, the package of care was delivered by five different domiciliary care providers.
- 2.1.4 The arrangements around Ruth's care were further complicated by the absence of a clearly identified lead professional. Much day-to-day liaison took place between third sector floating support and private care agencies. Multi-disciplinary meetings were held, but not all relevant professionals were consistently involved, and a TAA was not re-established. Ruth was later placed on the waiting list for CMHT assessment in January 2024 and allocated a care coordinator. During this period, concerns also emerged about the prescribing and review of her psychiatric medication, including duplication of Aripiprazole prescribing and later identification that she was overmedicated and receiving high-dose antipsychotic therapy.
- 2.1.5 Ruth's mental and physical health fluctuated during the review period. At times she presented with symptoms including elation, disinhibition, disorientation and grandiosity, consistent with manic features of BPD. She also experienced chronic pain linked to physical health conditions, resulting in ambulance call-outs and attendances at A&E. Across the timeline, several agencies and individuals became aware that Ruth knew the code to the key safe, creating a foreseeable risk that she could access her medication. Responses to this risk were inconsistent.
- 2.1.6 On 8th August 2024, Ruth attended A&E with a bag of medication from home, reporting difficulties with her mood and stating that she felt her medication needed reviewing. She was assessed by the Mental Health Liaison Team (MHLT) and discharged with planned follow-up

⁴ A safeguarding enquiry under s.42 of the Care Act is a legal duty placed on local authorities to investigate or instigate actions when an adult with care and support needs is experiencing, or is at risk of, abuse or neglect, and is unable to protect themselves.

⁵ Team Around the Adult (TAA) is the multiagency forum used to coordinate information-sharing, risk assessment and support planning for an adult experiencing complex or escalating risk. It is part of Oldham's Tiered Risk Assessment and Management (TRAM) Protocol. Available from [OSAB TRAM Protocol](#)

⁶ Under MHA, s.2 permits a compulsory hospital admission for up to 28 days for psychiatric assessment, whilst s.3 authorises an admission for medical treatment for up to 6 months (which is renewable). Following detention under s.3, s.117 imposes a joint duty on health and social services to provide free, multidisciplinary 'aftercare' services to support the patient's recovery and prevent re-admission.

from her CMHT care coordinator. Later that day, her medication was returned to her home and handed to a carer to place in the medication safe. The following day, a carer was unable to access Ruth's property because the front door key and medication safe key were no longer in the key safe. Police forced entry and Ruth was found having taken a significant overdose of multiple medications. She was admitted to intensive care in a critical condition and died two days later.

2.2 Legal Basis for the Review

- 2.2.1 This Safeguarding Adult Review (SAR) is commissioned under s.44 of the Care Act, which places a statutory duty on Oldham Safeguarding Adults Board (OSAB) to arrange a review of cases in its area where an adult with care and support needs dies as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the individual, or the adult is still alive but experienced serious abuse or neglect. This is known as a mandatory review.
- 2.2.2 The aim of a SAR is to learn from individual cases to produce evidence-based findings and recommendations which are applicable to the local system. The purpose of the review is not to investigate the circumstances of an individual's death or apportion blame, but to identify learning that can strengthen multiagency safeguarding practice and system effectiveness.
- 2.2.3 Ruth's case was referred to OSAB by PCFT on 11th December 2024 and considered at OSAB's Safeguarding Review, Audit and Quality Assurance subgroup on 30th January 2025. The panel agreed that the case involved an adult in Oldham with care and support needs. It was acknowledged that Ruth had died by suspected suicide (pending confirmation of cause of death by the Coroner) and that there were acts of omission by involved agencies and weaknesses in the system around care coordination, medication management and collaborative support of people with complex mental and physical health needs, that contributed towards her death. Therefore, it was agreed that the statutory criteria for a mandatory review were met.
- 2.2.4 OSAB liaised with Oldham Community Safety Partnership (CSP) for advice on whether Ruth's case also met the statutory criteria for a Domestic Abuse Related Death Review (DARDR) under s.9 Domestic Violence, Crime and Victims Act 2004. A representative from the CSP attended the initial panel meeting for this SAR on 25th February 2026 and determined that the statutory criteria were not met as, although there is evidence to support that Ruth was in an intimate relationship which was abusive, there is no evidence to suggest that the abuse was a causal factor in her death. Information held by partners was reviewed and there is a significant amount of information relating to mental ill health, self-harm and suicidal ideation predating the relationship. Ruth's ex-partner died in March 2024 and there was no evidence that there had been any contact since the relationship ended in 2022. Oldham CSP also extend their sincere sympathies to those who knew Ruth and recommended that domestic abuse be included as a Key Line of Enquiry in the SAR so that any relevant learning or good practice could still be identified.

3. TERMS OF REFERENCE AND METHODOLOGY

3.1 Scoping Period

- 3.1.1 The review examines agency involvement with Ruth from **1st May 2022**, when high-risk domestic abuse concerns led to a multiagency safeguarding response, Ruth taking an intentional overdose resulting in hospitalisation, discharge planning and changes in care arrangements, through to **8th August 2024** where she was found unresponsive following an intentional overdose and subsequently died. This timeframe has been selected to capture key decision-making points across mental health, ASC and wider services, including hospital admissions under the MHA, discharge planning, CMHT eligibility decisions, medication management arrangements, multiagency coordination and risk management in the community.

3.2 Independent Author and Review Panel Membership

- 3.2.1 The Author commissioned to conduct this review is Kirsty Findlay. She is a registered social worker with a background in forensic practice with both children and adults. She also has five years of experience as a senior safeguarding practitioner in an NHS mental health Trust. Kirsty holds statutory review related qualifications, including the Certificate in Chairing a Domestic Homicide Review, and Significant Incident Learning Process (SILP) Lead Reviewer Accreditation. She has also completed the Social Care Institute of Excellence (SCIE) SAR Reviewer training programme. Kirsty is fully independent and does not have current connections with any agencies, organisations or individuals involved in this review or the Oldham/Greater Manchester area.
- 3.2.2 Alongside the Author, a review panel was formed. The purpose of the review panel is to provide independent multiagency oversight, scrutiny and challenge throughout the review. The panel supports the Author by sharing relevant information, identifying key learning, testing emerging findings, and agreeing recommendations to improve future safeguarding practice. The review panel for this SAR consists of senior representation from the following agencies:
- Oldham Safeguarding Adults Board (OSAB)
 - Oldham Council Adult Social Care (ASC)
 - Cera Care (representing Care Quality Services and Premier Care)
 - Greater Manchester Police (GMP)
 - KeyRing
 - Northern Care Alliance NHS Foundation Trust (NCA)
 - Pennine Care NHS Foundation Trust (PCFT)
 - NHS Greater Manchester Integrated Care Board (ICB)
 - Turning Point
 - Oldham Council Independent Domestic Violence Advisor (IDVA) Service
 - First Choice Homes Oldham (FCHO)
 - Oldham Council Housing Options
- 3.2.3 Although OSAB agreed in January 2025 that the criteria for a mandatory SAR were met, the review was postponed until after the conclusion of the GMP investigation into Ruth's death, as outlined in paragraph 3.6.2. The review panel met on 25th February 2026, 29th April 2026 and 9th July 2026 with the aim of conducting the review in a timely and proportionate manner. Following final panel agreement on the overview report, including its findings and recommendations, the report was then presented to OSAB on 3rd August 2026 for formal sign-off.

3.3 Methodology

- 3.3.1 This SAR is conducted in line with the principles laid out in paragraph 14.167 of the Care and Support Statutory Guidance. The methodology is based on the understanding that SARs are intended to support learning and improvement across the safeguarding system. Therefore, the SAR has been approached with the following principles in mind:
- It is assumed that the case provides a fair and reflective representation of practice
 - It is assumed that evidence provided to the Author was contemporaneously recorded and provides an accurate account of events
 - Practitioner reflections are understood as personal subjective recollections of practice at the time
 - Practitioners are generally understood to have been working with the intention of supporting Ruth, whilst recognising that individual practice is shaped by the wider system, including organisational pressures, pathways and thresholds
 - SAR learning is most effective when it moves beyond the facts of one case to identify learning that has wider relevance for multiagency safeguarding practice and system improvement

- 3.3.2 Given the complexity of Ruth's needs, a traditional SAR methodology was considered proportionate to the scope of the review, and capable of generating robust, actionable learning for OSAB.
- 3.3.3 Agencies with significant involvement during the review period were required to complete full Individual Management Reviews (IMRs), providing a detailed narrative chronology and analytical response to a set of KLOE. Agencies whose involvement was more limited or peripheral, completed a proportionate summary report with a focused chronology and concise analytical reflection relevant to the agency's role. All contributing agencies, whether completing an IMR or summary report, were expected to prioritise analysis over description and to reflect openly on learning and systemic influences on practice.

IMRs	Summary Reports
ASC	North West Ambulance Service (NWAS)
Cera Care	Oldham Housing Options
GMP	
KeyRing	
NCA	
PCFT	
Primary Care (GP)	
IDVA Service	
FCHO	
Turning Point	

- 3.3.4 In addition to IMRs and Review Panel scrutiny, a facilitated multiagency practitioner learning event (PLE) was held on 6th May 2026 to support shared reflection discussion in a psychologically safe and learning-focused way. There was representation from all agencies who had direct contact with Ruth, except for the IDVA service. The PLE provided an opportunity for practitioners involved in Ruth's care and support to discuss key events, consider the multiagency response, and reflect on the factors that supported or hindered effective practice. Themes from the PLE have informed the analysis and learning within this report. The Author would like to thank all those who participated for their honest and open engagement.
- 3.3.5 Input from Ruth's family and friends was also sought in order to gain their perspectives, ensure transparency and incorporate understanding of lived experience into the review. Ruth's mother was approached on two occasions by the allocated Senior Investigating Officer (SIO) from GMP but did not feel able to directly contribute to the review. Ruth's friend, Tina, did agree to participate. Tina knew Ruth for approximately two years before she died, and Ruth had designated Tina as next-of-kin in her health records. The Author had several telephone conversations with Tina and met her once face-to-face in the process of conducting this SAR. Her contribution has also been considered within the analysis. The Author and OSAB extend their gratitude to Tina for her time and input into Ruth's review.

3.4 Key Lines of Enquiry (KLOE)

- 3.4.1 The review has been structured around a set of ten KLOE. These were developed to focus information gathering and scrutiny on the most relevant areas of multi-agency practice, decision-making and potential for new learning that has not yet been identified in other local reviews. The KLOE informed the IMRs, Review Panel discussions and practitioner reflection. The analysis that follows is organised around broader thematic areas using the Five Domains

framework⁷ that cuts across the KLOE, rather than addressing each one in isolation. The KLOE set by the Author and agreed by the Review Panel were:

- 3.4.2 **KLOE 1** – How were Ruth’s mental health needs, physical health conditions and vulnerability to exploitation understood across agencies, and how did this understanding influence risk assessment, care planning and inter-agency working over time?
- 3.4.3 **KLOE 2** – How were patterns of domestic abuse, coercive control and associated risk identified, assessed and responded to across agencies, and how did Ruth’s vulnerabilities and circumstances influence professional understanding and intervention?
- 3.4.4 **KLOE 3** – In what ways were local mental health pathways and eligibility criteria applied in Ruth’s case, including decisions regarding referrals to and acceptance by CMHT, and how did service thresholds shape access to ongoing support?
- 3.4.5 **KLOE 4** – How were statutory duties under the Care Act, Human Rights Act 1998/European Convention on Human Rights, MCA, and MHA (including Section 117 aftercare) interpreted and implemented, and how were local Care Programme Approach (CPA) processes applied in practice?
- 3.4.6 **KLOE 5** – How were concerns about deterioration, medication risk or support gaps identified and escalated within and between agencies, and what clarity existed regarding available escalation routes and governance processes?
- 3.4.7 **KLOE 6** – How was responsibility for care coordination and management of risk determined across agencies, including the use (or discontinuation) of multiagency forums such as Team Around the Adult, and what statutory, organisational or procedural frameworks informed clarity regarding the lead professional role?
- 3.4.8 **KLOE 7** – How were Ruth’s medication needs managed across agencies, including prescribing, timely administration, supervision, storage and communication between primary care, secondary mental health services, pharmacy and domiciliary care providers, and how did governance systems support safe and coordinated practice?
- 3.4.9 **KLOE 8** – How did commissioning and care brokerage processes respond to the complexity of Ruth’s mental and physical needs in securing and sustaining her package of care, and how were domiciliary care provider capability, service suitability and risks associated with instability identified, assessed and overseen?
- 3.4.10 **KLOE 9** – How was the impact of trauma, domestic abuse and Ruth’s diagnoses of C-PTSD and EUPD (and associated relational and emotional regulation difficulties) understood and addressed within professional responses, and how did organisational culture, workforce capability and supervision enable or constrain trauma-informed and relational practice?
- 3.4.11 **KLOE 10** – How and to what extent were Ruth’s identity, faith, health conditions and wider social circumstances (including poverty and housing) considered within professional responses, and how did intersecting vulnerabilities influence accessibility of services, professional decision-making and safeguarding responses?

3.5 Equality, Diversity and Inclusion

- 3.5.1 The review has explored the extent to which Ruth’s protected characteristics under the Equality Act 2010, including age, disability and gender, were recognised and understood by agencies. It has also considered whether wider intersecting aspects of Ruth’s identity, vulnerability or

⁷ The SAR Five Domains Good Practice Guidance (2026) was developed following the Second National Analysis of SARs to support more consistent identification and sharing of learning. Available from [Five Domains Good Practice Guidance](#)

experience influenced the response she received, including any barriers to engagement or access to support.

3.6 Parallel Processes

- 3.6.1 The SAR has sought to identify parallel proceedings and ensure appropriate sequencing to avoid prejudicing any ongoing investigations. The following parallel processes have been identified:
- 3.6.2 A **criminal investigation** was conducted by GMP to consider whether the circumstances around Ruth's care and professional actions prior to her death amounted to an offence of wilful neglect under the Criminal Justice and Courts Act 2015, or corporate manslaughter under the Corporate Manslaughter and Corporate Homicide Act 2007. The outcome was that there was insufficient evidence and the investigation was finalised with no further action being taken.
- 3.6.3 A **Coronial Inquest** has been scheduled to take place from 14th to 16th October 2026. The Coroner is aware of the SAR and will have access to the overview report. OSAB has liaised with the Coroner's Office, and it has been agreed that the Independent Chair of OSAB can attend the hearing if required, to speak to the report and the subsequent work to implement its recommendations.
- 3.6.4 The criteria for a **DARDR** was considered as discussed in paragraph 2.2.4.
- 3.6.5 PCFT completed a **Patient Safety Incident Investigation (PSII)** under the NHS Patient Safety Incident Response Framework (PSIRF)⁸ into Ruth's mental health care in the preceding six months before her death. Relevant findings from the PSII were incorporated into PCFT's IMR to inform this SAR.

4. COMBINED NARRATIVE CHRONOLOGY: MAY 2022 – AUGUST 2024

- 4.1 Ruth was in a relationship with P between 2019 and 2022. Shortly before the scoping period, in April 2022, GMP received reports from Ruth and a third party alleging domestic abuse, including use of weapons, threats to kill, assault and physical injury. Ruth was also presenting with apparent mental distress. The incidents on 13th and 14th April 2022 were recorded as concerns for welfare rather than domestic abuse, and a DASH risk assessment⁹ was not completed. During the 14th April attendance, officers also noted a stockpile of untaken medication in Ruth's property, but this information was not shared with other agencies.
- 4.2 On 15th April 2022, Ruth took an overdose and was taken to A&E. She made further disclosures of domestic abuse to hospital staff and was assessed by the MHLT. Given repeated recent contact with mental health services, increased risk to self, domestic abuse concerns and uncertainty about her safety at home, Ruth was offered an informal mental health admission. Due to bed availability, she was initially admitted out of area to an independent unit before being repatriated to an acute mental health ward at Royal Oldham Hospital (ROH) in mid-May.
- 4.3 During this admission, Ruth's overdose was understood as linked to her experience of domestic abuse and wanting to escape rather than wanting to die. Ruth did not return from agreed leave and was located at home by police. As she was an informal patient and did not wish to return to hospital, she was discharged and referred to the HTT, who subsequently identified no further role.

⁸ PSIRF is the NHS's system for managing patient safety incidents and a PSII is a deep, system-based response to an incident.

⁹ DASH is the Domestic Abuse, Stalking and Honour Based Violence risk checklist. It is used to help identify the level of risk in domestic abuse cases and inform safety planning, safeguarding responses and referral to MARAC where appropriate.

- 4.4 Later in May 2022, further domestic abuse concerns were reported. Ruth told police that P had been banging on her door and that she wanted time away from him. This was recorded as a medium-risk domestic abuse incident, and a referral was made to ASC. On 25th May 2022, Ruth fled to a women's refuge out of area, where she disclosed further abuse. Following contact with GMP, the earlier April incidents were reopened, P was arrested, a DASH was completed and graded high risk, and a MARAC referral was made.
- 4.5 Ruth returned to Oldham after P was bailed with conditions not to contact her, although refuge workers encouraged her to remain in refuge until P's bail address could be clarified, she left before this was confirmed. The refuge notified GMP and Oldham Multi Agency Safeguarding Hub (MASH), and an 'at risk' marker was added to Ruth's address. As P had previously provided informal care, ASC completed a Care Act needs assessment and commissioned support from KeyRing, the community support organisation. On 27th June 2022, a one-year non-molestation order was granted, prohibiting P from contacting Ruth or being within 100 metres of her address. Police records indicate that P breached the order repeatedly between October and December 2022, including attending Ruth's address, banging on the door, demanding access and refusing to leave.
- 4.6 Due to ongoing domestic abuse, a safeguarding enquiry under s.42 Care Act 2014 was started. At an initial strategy meeting on 31st October 2022, agencies noted that Ruth was fearful of P and struggled to refuse him access to her property. A plan was made for professionals to visit Ruth when P was attending probation appointments so that safety planning could be discussed with her.
- 4.7 On 5th November 2022, Ruth reported that P had broken into her home and assaulted her. Ruth acted protectively by injuring P, who then left the address. Ruth contacted GMP and disclosed that she had taken a significant quantity of medication. Police transported her to hospital, where she was reviewed by the MHLT once medically fit. P was arrested and another DASH was completed, which scored 17 and led to a second MARAC referral. Due to the escalating risks, the TAA lead professional from ASC discussed whether the case should be referred to the Adults Complex and High Risk Panel (CaHRP) under the TRAM protocol with their service manager, but it was agreed the case should continue to be managed under TAA. The TAA lead professional also escalated their concerns about repeated breaches of bail to the vulnerability lead at GMP. However, no further action was taken in relation to the breaches following the Crown Prosecution Service (CPS) charging decision.
- 4.8 Ruth was assessed by the HTT two days later and significant ongoing risk to self was identified. She was offered, and consented to, a second admission to the same mental health unit during the scoping period. During this admission, Ruth disclosed non-recent sexual and physical abuse by family members during childhood, discussed the domestic abuse she had experienced from P, and was open about her cannabis and alcohol use. Staff supported her to self-refer to Turning Point and, as the safeguarding enquiry was still open, it was decided that a TAA approach under the TRAM protocol would be taken for multiagency risk assessment and management.
- 4.9 On one occasion whilst having time off the ward, Ruth took another intentional overdose. When she returned and ward staff became aware of this, holding powers under s.5(2) MHA¹⁰ were used so a MHA assessment could be facilitated, however Ruth was deemed not detainable.
- 4.10 A second MARAC meeting took place during Ruth's admission, but PCFT were not invited. PCFT had also not been included in earlier TAA meetings. The ward sought advice from PCFT safeguarding team, and contact details were shared with the TAA lead professional so that the ward could be included in future multiagency meetings. A TAA meeting took place on 1st December 2022, and a shared action plan was developed, including seeking feedback from MARAC, referring Ruth to CMHT, updating her Care Act assessment, liaising with housing, and

¹⁰ s.5(2) MHA is a doctor's holding power that allows an informal hospital inpatient to be detained temporarily for up to 72 hours so that a MHA assessment can be arranged where they appear to need detention and are seeking or likely to leave hospital.

exploring disruption and enforcement options in relation to P. Escalation to Adults CaHRP was considered but deemed unnecessary at the time as the case was being heard at MARAC and Ruth was in a place of safety in a mental health unit.

- 4.11 Ruth asked to be discharged from the ward on 12th December 2022 but was encouraged to stay until a safer discharge plan could be arranged. She said she wanted to go back to her flat and that she felt safer on the first floor, despite difficulty physically managing the stairs. She was discharged a week later with HTT and CMHT support. A discharge ward round took place on 16th December 2022. There are different agency perspectives about the extent of multiagency involvement in this meeting, PCFT advised that partner agencies were invited but did not attend, however the ASC IMR records concerns that TAA professionals were not present and that this affected the ability to plan discharge safely. In any case, discharge planning was experienced by ASC as urgent and pressured, with ASC updating Ruth's care and support plan and commissioned a domiciliary care package from the first domiciliary care provider, Amber Care, as an emergency rather than a planned way. A key safe was fitted so carers could access Ruth's flat. Ruth was discharged on 20th December 2022 and a TAA meeting took place on the same day with relevant agencies in attendance. Whilst ASC expressed concern that the speed of arranging care contributed to an unsafe discharge, PCFT explained that, as Ruth was an informal patient, she could not be kept in hospital without her consent.
- 4.12 Ruth had a joint HTT and CMHT assessment on 28th December 2022. She was distressed due to difficulty accessing newly prescribed medication, and HTT staff liaised with the pharmacy, domiciliary carers and the community support organisation so that her medication could be collected. Ruth was tearful because of pain, but no suicidal intent was identified. It was agreed that CMHT would complete a short intervention with Ruth.
- 4.13 The following day, the community support organisation supported Ruth to see her GP for a medication review. Ruth was experiencing significant pain and difficulty walking. Given her history of overdose, the GP advised that a medication safe should be ordered. The community support organisation shared this with ASC, who arranged a medication safe and advised that only carers should have the key code. Ruth agreed to this plan.
- 4.14 In February 2023, professionals became concerned about a friendship Ruth had formed with a man whose behaviour appeared controlling and potentially exploitative. Concerns included him discouraging Ruth from taking medication, supplying cannabis, influencing what food she bought, and staying in her property late at night. These concerns were discussed within TAA and a Domestic Violence Disclosure Scheme (DVDS, also known as 'Clare's Law')¹¹ application was made.
- 4.15 After CMHT completed a short-term piece of work, Ruth was transferred to their Care Management and Review Team (CMRT)¹². She had been seen once face to face by CMHT in early January. Further face-to-face contact was offered but declined by Ruth, as she felt she was receiving appropriate support from other services. The remaining contacts, including the discharge appointment, took place by telephone without a full review of needs in line with PCFT policy. It does not appear that partner agencies were informed of her discharge from mental health services. In March 2023, the community support organisation became aware that Ruth could access the medication safe and emailed CMHT. There is no evidence that this information was responded to and she was not open to them at the time.

¹¹ The Domestic Violence Disclosure Scheme (DVDS), often referred to as Clare's Law, is a police information-sharing process that allows a person to ask whether a current or former partner has a history of abusive behaviour ('right to ask') and allows police to proactively disclose relevant information where this is necessary to protect someone from domestic abuse ('right to know').

¹² Case Management and Review Teams (now de-commissioned) were a CMHT function providing assessment and review for people with mental health diagnoses who required ongoing psychiatric input and commissioned care, including reviewing whether placements continued to meet their needs and informing local authority funding decisions.

- 4.16 In April 2023, the s.42 enquiry and TAA meetings ended as the risks from P had reduced. There should have been a case conference to agree to the safeguarding enquiry being closed and whether TAA meetings needed to continue, but this did not happen.
- 4.17 In June 2023, Ruth took an intentional overdose of her prescription medication and was admitted to the Acute Medical Unit at ROH. There was liaison between NCA and PCFT regarding her physical and mental health needs. Ruth was assessed under the MHA whilst inpatient on a physical health ward due to indicators of relapse of BPD symptoms and was detained under s.2 to the same ward until a bed became available on the mental health unit at ROH. A urine drug screen was positive for opioids, benzodiazepines, methamphetamines and THC¹³. Ruth also told staff that P had been stalking her but this was not risk assessed further through the completion of a DASH, although the information was shared with Oldham MASH, who advised Ruth was only open to the duty team at that time. Ward staff contacted the duty team to share details for Ruth's ward rounds. The community support organisation indicated at this time that they did not believe there had been any recent contact by P.
- 4.18 Ruth was transferred to the mental health unit on 24th July 2023 and, following further MHA assessment, was regraded from s.2 to s.3 for treatment, making her eligible for s.117 aftercare on discharge. Amber Care informed ASC that they no longer felt able to support Ruth in the community following her overdose and were uncomfortable dispensing medication because it was unclear what medication Ruth could access outside care calls. The care package was terminated.
- 4.19 During Ruth's admission, the mental health unit and the community support organisation liaised regularly. Concerns were raised that Ruth had picked the lock on the medication safe to access medication before taking the overdose. Ward staff liaised with ASC so that Ruth's community needs could be reassessed and a new care package arranged as part of discharge planning. There was disagreement about which agency was responsible for assessing Ruth's care and support needs. Ruth was also reviewed by medical staff in relation to possible menopause, due to some of her reported physical and psychological symptoms. A referral was made to CMHT but this was then retracted as it was deemed by a senior clinician on the ward that Ruth did not meet the criteria for CMHT input.
- 4.20 During the admission there were also concerns that Ruth was using illicit substances whilst on s.17 leave, which led to leave being reviewed and at times rescinded. Ruth self-referred again to Turning Point in August 2023, reporting high levels of alcohol and cannabis use. She was assessed by Turning Point via telephone a week later and said she wanted to move out of her flat due to having "*terrible memories*" of the abuse she suffered there from P. She explained that he had nearly murdered her and broke her ribs. Ruth was accepted for treatment, but Turning Point were unsuccessful in making further contact with her, so the referral was closed the following month. Attempts to contact Ruth did not include reaching out directly to the mental health unit she was detained to for support in facilitating engagement.
- 4.21 By September 2023, Ruth's mental health had stabilised and acute admission was no longer required, but discharge was delayed whilst a community care package was sourced. Ruth continued to report poorly controlled pain. PCFT explored a referral to the pain clinic, but this needed to be made by her GP. PCFT wrote to Ruth's GP to request this, but a referral was not actioned.
- 4.22 The mental health unit re-referred Ruth to CMHT in preparation for discharge on 20th September. The referral was triaged and declined as Ruth was deemed not to have CMHT needs. The referral was then discussed between the CMHT manager and ward nurse-consultant. The clinical view was that Ruth did not meet the criteria for CMHT intervention, as her presentation was understood to relate primarily to physical health needs, substance use and the management of her care package. The referral was also understood to have been made in the context of Ruth's s.117 aftercare and the need for CMRT to manage the package of care. Following liaison

¹³ THC – Tetrahydrocannabinol – the primary psychoactive component found in cannabis.

between the ward, CMHT and ASC, it was decided that Ruth would remain open to ASC for a six-week period, before transferring her case to CMRT, without CMHT assessment.

- 4.23 By October 2023, ASC had sourced a new care package from the second domiciliary care provider, Nobilis Care, funded through s.117 aftercare. This consisted of four daily care calls and eight hours of weekly floating support from the community support organisation. A medication concordance document stated that Ruth's medication should be secured in a locked box to reduce overdose risk and administered by carers. Ruth had also been offered a ground floor flat due to physical disability and trauma linked to her previous address. Ruth was discharged on 23rd October 2023 with the agreed care package and routine 72-hour HTT follow-up.
- 4.24 After discharge, Ruth continued to express concerns about carers not attending at the agreed times and difficulties with medication administration. These included delays arising from her GP not yet receiving the hospital discharge summary, prescriptions defaulting to her pre-admission regime, and carers being reluctant to administer medication where it was not provided in blister packs. Nobilis Care told MHLT that they had not been made aware of the complexity of Ruth's needs when accepting the package, that some carers were unwilling to support her because of how she spoke to them, and that they had struggled to contact the allocated social worker.
- 4.25 Ruth's concerns about missed or mistimed care calls continued, and she began cancelling visits. The community support organisation made a safeguarding referral, which led to a care review involving Ruth, the community support organisation, ASC and Nobilis Care. Ruth said a carer had given the medication safe code to her cleaner so medication could be administered when carers were unable to attend at the scheduled time. There was disagreement between Ruth and Nobilis Care about who had cancelled visits, and the domiciliary care provider said Ruth contacted them repeatedly to express dissatisfaction.
- 4.26 Ruth moved to a new ground floor flat with FCHO as a managed move on 23rd November 2023. Due to the move, she was no longer in the catchment area for Nobilis Care so she received short-term support from the third domiciliary care provider, Enablement, until a new domiciliary care provider was sourced, moving to Premier Care (fourth domiciliary care provider). Although Ruth was initially positive about Premier Care, similar difficulties quickly emerged regarding care calls and medication management. Premier Care documented an occasion when Ruth requested medication again after it had already been administered and became argumentative when the carer declined.
- 4.27 ASC shared their six-week review update with CMHT via email, so that oversight could be transferred to the CMRT as planned (per paragraph 4.22). However, the CMHT manager advised they would not usually transfer care when there is an open safeguarding enquiry. The ASC social worker clarified that this was related to a previous domiciliary care provider and things had improved under the current one. ASC also stated that some sort of CMHT input was required as they were having difficulty managing Ruth's complex needs. It is unclear what the outcome of these discussions were as there is no documentation from the internal pathway meeting, but in any case, a referral was not made to CMRT.
- 4.28 In December 2023, Ruth contacted GMP reporting a burglary and stating that someone had taken her cats. Officers noted that her property was very untidy and that Ruth appeared agitated and distressed. Around the same time, Premier Care and the community support organisation raised escalating concerns with ASC that Ruth was refusing visits and medication, her flat had been "*trashed*" and faeces smeared on the walls, there was also an unknown male in the property, and Ruth had gained access to her medication because the safe had been left unlocked. ASC contacted CMHT to request mental health support and a joint assessment was agreed. The community support organisation continued to express concern that Ruth had access to her medication, but ASC indicated that the safeguarding threshold was not met because Ruth had not misused the medication on that occasion. The domiciliary care provider was to be reminded that the medication safe should be locked when not in use.

- 4.29 Also in December 2023, Ruth reported concerns about a specific male carer. She said the carer had left her medication safe open over the weekend for her to take medication unsupervised, had taken drinks from her fridge, and had thrown tablets at her on one occasion. A safeguarding referral was made, although Ruth did not want to take the matter further. Ruth also requested female-only carers due to her past experiences of domestic abuse.
- 4.30 During the same month, Ruth changed pharmacy, but the new pharmacy did not provide blister packs. This created further difficulty for the domiciliary care provider due to the volume of Ruth's medication. During liaison about the medication issues, Premier Care gave the community support organisation the code to the medication safe so Ruth could be supported to check what medication was missing.
- 4.31 In January 2024, the community support organisation asked ASC whether Ruth's medication risk assessment needed updating in light of recent events. ASC acknowledged the risk and advised that mental health support had been requested, whilst also noting the limits of professional intervention where a person has mental capacity and makes unsafe choices. A new care plan was created, but Premier Care did not receive it until three weeks later. It was also identified that documentation about Ruth's medication was inaccurate and did not match her prescriptions. A referral was made to CMHT, which was accepted and Ruth was placed on the waiting list for assessment.
- 4.32 Ruth was reviewed in outpatient clinic by a psychiatrist in January 2024 and her medication for symptoms associated with BPD and EUPD were increased. The psychiatrist issued the new prescription and asked for it to be collected and delivered to Ruth by a CMHT duty worker. When the worker arrived, Premier Care gave them the medication safe code so the prescription could be placed inside. Premier Care advised that they would remove medication no longer needed at the next care call.
- 4.33 In February 2024, the community support organisation became concerned about Ruth's mental state and contacted her social worker for advice, describing feeling overwhelmed by the situation. Ruth's medication supply remained problematic due to difficulties with pharmacy provision, including lack of blister packs and a period when Ruth removed herself from one pharmacy without transferring to another. Professional liaison between Premier Care, the GP and pharmacies eventually resolved this, although Ruth went without some medication during this period.
- 4.34 Ruth contacted 111 and disclosed that she was overspending and lending money, so she had no funds to buy food or fix her wheelchair. This was shared with ASC and her GP. She also told CMHT that she was still paying bills for her previous accommodation and was receiving bailiff/court letters.
- 4.35 On 5th February 2024, it was identified that Ruth had been overmedicated with Aripiprazole. Her GP had prescribed a repeat dose of 20mg, whilst secondary mental health services had separately prescribed 30mg, resulting in Ruth taking 50mg daily when the maximum dose should have been 30mg. The GP had not been aware of the psychiatrist's prescription so they liaised with secondary mental health services and it was agreed that Aripiprazole would be prescribed by PCFT rather than Primary Care going forward.
- 4.36 Ruth was assessed by CMHT in February 2024. She was anxious about her medication and unclear about the roles of Premier Care and the community support organisation. Ruth said she could not continue as things were, that her medication was not right, and that she was unhappy with her carers. At a multidisciplinary meeting on 13th February 2024, CMHT, the community support organisation and Premier Care discussed medication and pharmacy difficulties. CMHT noted that Ruth should have been allocated a care coordinator on discharge from hospital. The domiciliary care provider asked whether medication could be left out if Ruth was not at home, but CMHT advised that, given overdose risk, it would be safer for Ruth to miss a dose than to have medication left unsupervised.

- 4.37 Later in February 2024, a CMHT worker visited Ruth with her Aripiprazole prescription. Ruth said she did not know why her medication was in a safe because she knew the code, and she told the worker what it was. This information was not shared with other agencies. At an outpatient appointment on 27th February 2024, Ruth's medication was reviewed and clarified, with documented rationales for prescribed medications and dosages. This review was delayed as the NHS cancelled the scheduled clinics in November and December 2023, then Ruth did not attend the clinic appointment in January 2024.
- 4.38 In March 2024, Ruth told CMHT that she was struggling with her physical and mental health and would consider moving into a care home with 24-hour support. She also said she would strongly prefer female carers for personal care. CMHT contacted Premier Care, who advised that they could not guarantee female-only carers. Premier Care also told the community support organisation that Ruth knew the code to the medication safe. The community support organisation were already aware and discussed that CMHT also knew, although the relevant chronology entry from Cera Care states that the CMHT support worker did not consider Ruth to be presenting as an overdose risk at that time. Premier Care said they would change the code and indicated this was the fourth time this had been required, although this was not otherwise reflected in the chronology. At this time, the community support organisation documented observing Ruth telling her CMHT community support worker during a telephone call that she would like a personal assistant to take her out when the community support organisation could not support this, although this conversation is not reflected in PCFT records.
- 4.39 In April 2024, carers could not access Ruth's medication safe and emergency prescriptions had to be arranged. A short supply of medication was obtained via 111 and left on top of a kitchen cupboard. Around this time Ruth was exhibiting signs of disinhibition, disorientation and grandiosity. She refused to attend A&E, and the community support organisation contacted Tina, Ruth's next of kin, for support. Tina arranged a new key-controlled medication safe and a separate key safe for the medication safe key.
- 4.40 In April 2024, Ruth was also concerned about weight loss and possible financial exploitation after giving bank details to someone who had called her from America. Two days later, she was conveyed to A&E by NWS after contacting GMP reporting significant pain. She was found with double incontinence, confusion and drowsiness, and had abnormal observations. Once medically optimised, she was assessed by the MHLT, a safety plan was completed, information was shared with her GP and CMHT, and she was discharged. NCA completed a safeguarding referral to ASC.
- 4.41 Ruth was seen face-to-face by CMHT a week later. She was angry and upset, said she had "*had enough*" and did not want to carry on anymore, and described frustration at being dependent on others for daily living tasks. She again said she would prefer a personal assistant and requested a medication review. Her CMHT assessment period ended, and she was allocated a care coordinator on 17th April 2024.
- 4.42 The care coordinator first visited Ruth on 25 April 2024. Ruth described ongoing issues with the domiciliary care provider, including concerns about male carers, the timing of evening medication, and support with continence care. She said one male carer gave her evening medication too early, making her drowsy and causing her to go to bed earlier than she wanted. She also said he did not help her change her pads correctly, was rude and abrupt, and made her feel uncomfortable in her own home. The care coordinator agreed to contact Premier Care, but no further actions were recorded. During this CMHT referral episode, no Mental State Examination¹⁴ or risk review was documented.
- 4.43 In May 2024, Ruth was triaged by a community dietician and identified as being at high risk of malnutrition. She was later prescribed nutritional supplement drinks, and a plan was made to

¹⁴ Mental State Examination (MSE) is a structured clinical assessment of a person's presentation at a point in time, including areas such as appearance, behaviour, mood, thought processes, perception, cognition, insight and risk.

fortify her diet. She continued to report significant pain. In the same month, a carer contacted their manager after identifying that Ruth's medication had been left out by another carer the previous evening for Ruth to take herself, but Ruth had forgotten to take it. The manager advised the carer to contact 111 for advice on the missing dose.

- 4.44 Ruth subsequently told her care coordinator that having carers administer her medication was too restrictive because she had to remain at home around their call schedule. She said she wanted to manage her own medication and understood the risks of overdose or missed doses. The care coordinator suggested this be discussed with a psychiatrist before any decision was made. At an outpatient appointment three weeks later, the psychiatrist agreed Ruth could self-administer some of her evening medications, namely Zopiclone, Promethazine and Melatonin, subject to review and Ruth remaining safe. The domiciliary care provider was informed which medications Ruth could self-administer and which required continued carer administration, and was asked to ensure all carers working with Ruth were made aware.
- 4.45 Also in May 2024, Ruth experienced a further change of domiciliary care provider, from Premier Care to the fifth and final domiciliary care provider, Care Quality Services. Outstanding safeguarding enquiries were closed because the domiciliary care provider had changed and the risk was considered resolved, although the parent company of the fourth and fifth domiciliary care provider remained the same (Cera Care).
- 4.46 In June 2024, Care Quality Services liaised with the pharmacy and GP when repeat prescriptions had not been issued in time, resolving this without direct impact on Ruth. During a care coordinator visit on 10th June, a carer arrived for the tea-time call at 15:15. The care coordinator explained the medication timeframe and the importance of medication being given after food not before. The domiciliary care provider later raised concerns about carers staying beyond allocated time, Ruth not always being home for calls, wanting carers to undertake additional tasks and trying to prevent them from leaving. The domiciliary care provider indicated they did not wish to continue providing care and wanted to serve seven days' notice. The community support organisation also raised concerns with Ruth's CMHT care coordinator about the quality of care being provided, based on information Ruth had shared with them.
- 4.47 In late June 2024, the domiciliary care provider emailed Ruth's GP asking whether medication could be left out for Ruth to take herself. However, this decision had been made by a PCFT psychiatrist and had previously been communicated to the domiciliary care provider (see paragraph 4.44). In July 2024, Ruth attended an outpatient psychiatry appointment where her medication was reviewed. It was identified that she was overmedicated and receiving High Dose Antipsychotic Therapy (HDAT)¹⁵, which had not previously been recognised. Haloperidol and Procyclidine were stopped, and a Diazepam reduction was started. No "CPA"¹⁶ documentation was completed.
- 4.48 In July 2024, there were further difficulties with repeat prescriptions not being requested or issued in time. Ruth also had an outpatient appointment in the colorectal clinic, which she said was secondary to the domestic abuse she experienced, where she sustained multiple injuries. She was booked in for a colonoscopy and an ultrasound scan.
- 4.49 On 1st August 2024, the community support organisation made a safeguarding referral after Ruth said her neighbours knew the key safe code, could access her property, and were taking advantage of her. Ruth said she was paying for drugs and alcohol for them, could not say no, and needed help. She told the community support organisation it was not safe for the worker to enter the property but did not explain why. The community support organisation shared this with Ruth's care coordinator, and they agreed a joint cold-call visit. When they attended the following

¹⁵ High Dose Antipsychotic Therapy is when a patient is prescribed a daily dose of a single antipsychotic, or a combination of multiple antipsychotics, that exceeds the maximum recommended limits defined by standard references such as the British National Formulary.

¹⁶ Care Programme Approach (CPA) was the former framework for coordinating community mental health care for people with complex needs. By 2024, CPA had been superseded in England by the Community Mental Health Framework, although CPA terminology still appears in some records or local practice.

day, Ruth was at home by herself and later denied feeling at risk. She did express frustration that her medication was being reduced.

- 4.50 On 8th August 2024, Ruth contacted 111 in distress and said she wanted to attend A&E, though the reason was difficult to establish. She also had a telephone GP consultation for a mental health review and was advised to attend A&E if concerned about suicidal thoughts. Ruth attended hospital at lunchtime, saying her mental health was declining and that she wanted her medication reviewed. She arrived with a bag containing a large quantity of medication, which she had removed from the medication safe. She struggled to concentrate during triage and said she was God.
- 4.51 Ruth was referred to the MHLT, who liaised with her care coordinator. The care coordinator emphasised that Ruth should not be discharged with the quantity of medication she had brought with her, given her history of overdose. Ruth was discharged, and the MHLT transported her medication back to her home separately, handing it to a carer and asking them to secure it in the medication safe. Ruth was last seen at approximately 21:30 that evening.
- 4.52 On the morning of 9th August 2024, a carer attended for a routine call but could not access Ruth's home because the front door key was not in the key safe, and Ruth did not answer her phone. A neighbour told the carer they had heard shouting and a commotion the previous night involving male and female voices. The carer contacted GMP to report a concern for welfare. Police attended and gained entry. Ruth was found unresponsive on her bed, surrounded by a significant amount of medication.
- 4.53 Ruth was taken to hospital and admitted to intensive care. It was recorded that she had taken unknown quantities of several medications, including Zopiclone, Phenalgin, Melatonin, Co-codamol, Omeprazole, Naproxen and Diazepam. Ruth died in the Intensive Care Unit at ROH on 11th August 2024.

5. ANALYSIS AND FINDINGS

5.1 Analytical Framework

- 5.1.1 The ten KLOEs identified within the terms of reference were used to guide agency IMRs, practitioner discussion, family/friend engagement and analysis of the chronology. In practice, the evidence gathered does not fall neatly into ten separate areas. Many of the KLOE overlap, reflecting the complexity of Ruth's circumstances and the way in which mental and physical health, domestic abuse, trauma, medication management, care provision and social context interacted over time.
- 5.1.2 To present the learning in a more accessible and structured way, the analysis has been organised using the SAR Five Domains framework into the following themes:
- Direct Work
 - Inter-agency Teams Around the Adult
 - Organisational Support for Practice
 - Governance
 - National Context
- 5.1.3 The framework enables the review to move from individual lines of enquiry to wider system learning, whilst still ensuring that the original KLOE are addressed. Issues relating to suicide risk, domestic abuse, trauma-informed practice, equality and Ruth's lived experience are considered within and across the domains rather than treated as isolated topics, because they influenced how risk was understood, responded to and escalated throughout the review period.
- 5.1.4 A table has been included at Appendix A that maps the KLOE for this review to the five domains.

5.2 Domain 1: Direct Work

5.2.1 Domestic Abuse Response

- 5.2.2 Ruth's lived experience, vulnerabilities and identity intersected in ways that required holistic assessment and trauma-informed responses. She had long-standing mental health difficulties, with records referring to diagnoses including BPD, EUPD and C-PTSD, and had first been detained under s.3 MHA in Oldham in 2017. She also experienced chronic pain linked to physical health difficulties. Ruth had been in a relationship with P since 2019 and, by 2022, the abuse had escalated to high-risk physical and emotional abuse, coercive and controlling behaviour, use of weapons, threats to kill, non-fatal strangulation, false imprisonment, stalking and harassment.
- 5.2.3 Although the relationship is believed to have ended, with no further direct contact by early 2023, the impact of abuse continued to affect Ruth's mental and physical wellbeing. The Senior Investigating Officer (SIO) from GMP (for the investigation into Ruth's death) told the Author of an occasion in 2024 when Ruth contacted police in a distressed state because she believed she had seen P near her home, although this call was made after P's death. Ruth told CMHT during an assessment in February 2024 that P was the reason for her current mental and physical health problems, and that she felt "*abandoned, lost, used and humiliated*". The need for specialist colorectal input some 18 months after contact with P ended is a stark indication of the enduring physical consequences associated with the abuse she endured. This demonstrates the long-term fear, hypervigilance, trauma and physical harm that can remain for victims of domestic abuse long after direct contact with the perpetrator has ended. Domestic abuse should therefore not be understood as a discrete episode in Ruth's history, but as significant context shaping trauma, relational safety, trust and ongoing risk.
- 5.2.4 Professional responses to domestic abuse concerns in Ruth's case varied in effectiveness. There were two police callouts in April 2022 where domestic abuse was reported and Ruth presented in a distressed state. During one of these incidents, Ruth was detained under s.136 MHA and conveyed to a health-based place of safety¹⁷. In the other April incident, Ruth was seen with bruising to her arms, she said she had been assaulted but P said he had to restrain her to prevent her from leaving the house as he was concerned about her mental state. Both incidents were treated as concern for welfare in the context of mental ill health rather than domestic abuse related incidents. As a result, P was not arrested and DASHs were not completed, delaying identification and specialist support.
- 5.2.5 This is significant because mental ill health and distress can both be a consequence of domestic abuse and a factor that obscures professional recognition of abuse¹⁸. Research indicates that victims' trauma responses may be pathologised, with the abuse overlooked and behaviour interpreted as primarily disordered¹⁹. This risk can be reinforced where perpetrators use DARVO tactics²⁰ to capitalise on the victim's distress and undermine their credibility.
- 5.2.6 The GMP IMR author identified that the police response in April 2022 was not aligned with expected practice. Following a coronial investigation related to a different case, a Chief Constable's Order (2020/38) was put in place, directing officers to submit a care plan wherever GMP responded to a person presenting with mental health concerns. Due to Ruth's

¹⁷ Under s.136 MHA, police may remove a person in a public mental health crisis to a "place of safety". A health-based place of safety (HBPoS) is a designated NHS clinical facility, rather than a police cell, where the individual can be detained for up to 24 hours for a formal assessment under the MHA.

¹⁸ Lohmann et al (2023) The Trauma and Mental Health Impacts of Coercive Control: A Systematic Review and Meta-Analysis. *Trauma, Violence & Abuse*, 25(1) 630-647. Available from [The Trauma and Mental Health Impacts of Coercive Control: A Systematic Review](#)

¹⁹ Women's Aid (2021) *Mental health and domestic abuse: A review of the literature*. Available from [Mental health and domestic abuse: A review of the literature](#)

²⁰ Harsey and Freyd (2020) Deny, Attack, and Reverse Victim and Offender (DARVO): What Is the Influence on Perceived Perpetrator and Victim Credibility. *Journal of Aggression, Maltreatment & Trauma*, 29(8) 897-916. Available from [Deny, Attack, and Reverse Victim and Offender \(DARVO\)](#)

vulnerability, care plans should have been submitted. It was good practice that stockpiling of medication was documented, but no onward referrals were made because it was assumed that this would be addressed by health services when Ruth was taken to hospital. Across the scoping period, there were five missed opportunities for officers to submit a care plan or make appropriate onward referrals to partner agencies.

- 5.2.7 Since the period of this review, GMP's Mental Ill Health, Mental Incapacity and Learning Disabilities Policy and Procedure has been updated (September 2024). This now states that mental health care plans should be referred to partner agencies, even if a person has been taken to a healthcare setting or the case has been transferred to NWS as the more appropriate responding agency. GMP also launched mandatory Domestic Abuse Matters training for frontline officers between November 2022 and March 2023 with a focus on improving consistency in responses to domestic abuse. This training included coercive control, victim blaming and recognition of perpetrator manipulation.
- 5.2.8 There were also proactive system responses to domestic abuse. In April 2022, PCFT holistically considered Ruth's repeated recent contact with mental health services, increased risk to self, domestic abuse concerns and uncertainty about her safety at home and offered her an informal admission, including funding an independent out of area placement for a period of time. Following an assault in May 2022, police spoke to Ruth in refuge, P was arrested, bail conditions were put in place, and the case was referred to MARAC. The refuge shared information appropriately with GMP and Oldham MASH when Ruth decided to return to the area. The IDVA service supported Ruth to obtain a non-molestation order and ASC were responsive in assessing her needs and replacing informal care from P with commissioned support from the community support organisation and domiciliary care agencies. When P began breaching the order, ASC opened an enquiry under s.42 Care Act, recognising the risks posed and the impact of Ruth's care and support needs on her ability to protect herself from abuse. Professionals also demonstrated awareness of the risks associated with post-separation stalking and harassment²¹, recognising that a re-referral to MARAC was warranted.
- 5.2.9 Overall, Ruth's case demonstrates both the importance of recognising domestic abuse where mental health distress is prominent, and the value of coordinated responses where domestic abuse, safeguarding, mental health and care needs are considered together.
- 5.2.10 **Managing suicide risk**
- 5.2.11 An area of direct practice that felt difficult for practitioners to manage was Ruth's risk of overdose and fluctuating mental state. Ruth's lived experiences shaped her suicide risk acutely. The impact of domestic abuse on her mental wellbeing has been discussed above at paragraph 5.2.3; women who experience intimate partner violence are three times more likely to attempt suicide²², and suicide amongst victims of domestic abuse have now surpassed intimate partner homicides²³. Ruth's mental health diagnoses also increased her risk of suicide; 30 – 50% of people with BPD attempt suicide and the rate of suicide completion is higher than all other mental disorders except schizophrenia²⁴. Having a comorbid personality disorder (EUPD) increases the risk even further, with research indicating that personality disorders

²¹ Spearman et al (2022) Post-separation abuse: A concept analysis. *Journal of Advanced Nursing*, 79(4) 1225-1246. Available from [Post-separation abuse: A concept analysis](#)

²² Agenda Alliance (2023) Underexamined and underreported. Available from [Underexamined and underreported](#)

²³ Hoeger et al (2025) *Vulnerability, Knowledge and Practice Programme: Domestic Homicides and Suspected Victim Suicides 2020-2024*. Available from [VKPP Domestic Homicides and Suspected Victim Suicides 2020-2024](#)

²⁴ Monson et al (2021) Assessment of suicide attempt and death in bipolar affective disorder: a combined clinical and genetic approach. *Translational Psychiatry*, 11(1) 379 – 387. Available from [Assessment of suicide attempt and death in bipolar affective disorder](#)

influence suicidality of people with a mood disorder (including BPD) by increasing the amount of time spent in high-risk emotional states²⁵.

- 5.2.12 Physical health can also influence suicidality, with associated chronic pain doubling the risk of suicide, and pain management through opioid use also being associated with a higher risk of suicidal behaviours²⁶.
- 5.2.13 Ruth disclosed having experienced childhood sexual abuse (CSA) from family members, which is a known risk factor for adverse socioeconomic, mental and physical health outcomes²⁷, with CSA survivors being six times more likely to attempt suicide than the general population²⁸.
- 5.2.14 Ruth told PCFT that she was experiencing debt issues; she was overspending and lending people money meaning she could not afford food or repairs to her wheelchair. She was receiving debt repayment demands from bailiffs. This information was also shared with ASC and her GP, although there is no evidence in the chronology or IMRs that this was explored further. Ruth could not work due to her disabilities, which would have impacted on her ability to address these debts. Socioeconomic factors, including long-term unemployment and unmanageable debt, are important risk factors for suicide that are often overlooked in risk assessments²⁹.
- 5.2.15 Professionals working with Ruth were aware that her faith was important to her and evidence in records suggests this was a protective factor. For example, she told CMHT in February 2024 that although people had abused her all her life, she still had faith in God and was able to forgive all who have harmed her. The relationship between religion and suicide is complicated as both are complex constructs; the research in this area is inconclusive, with some studies reporting it to be protective and others finding it to be a risk factor for suicide³⁰.
- 5.2.16 In addition, Ruth's age statistically placed her in the highest age-specific suicide rate for females (45 – 49 years old)³¹ and her gender intersected with her drug and alcohol use, with the suicide mortality rate for both alcohol and opioid use being significantly higher for females, and cannabis use also being significantly associated with increased suicide rates for both genders³².
- 5.2.17 Given the above, Ruth's circumstances indicated that she was at foreseeable risk of continued and repeated suicide risk that was not separate from medication management, trauma, domestic abuse, multiple disadvantage or relational distress, and required a shared and dynamic formulation across agencies. There was some recognition of this within the system, but it was not approached in the nuanced way that was required for the complexity of the situation.

²⁵ Jylhä et al (2016) Personality disorders and suicide attempts in unipolar and bipolar mood disorders. *Journal of Affective Disorders*, 190, 632-639. Available from [Personality disorders and suicide attempts in unipolar and bipolar mood disorders](#)

²⁶ Chincholkar and Blackshaw (2023) Suicidality in chronic pain: assessment and management. *BJA Education*, 23(8) 320-326. Available from [Suicidality in chronic pain: assessment and management](#)

²⁷ Fisher et al (2017) *The impacts of child sexual abuse: A rapid evidence assessment*. Available from [IICSA impacts of CSA](#)

²⁸ Tomasula et al (2012) *The association between sexual assault and suicidal activity in a national sample*. *School Psychology Quarterly*, 27(2) 109-119. Available from <https://pubmed.ncbi.nlm.nih.gov/22774785/>

²⁹ Samaritans (2017) *Dying from inequality: Socioeconomic disadvantage and suicidal behaviour*. Available from [Samaritans Report - Dying from Inequality](#)

³⁰ Lawrence et al (2016) Religion and Suicide Risk: a systematic review. *Archives of Suicide Research*, 20(1) 1-21. Available from [Religion and Suicide Risk: a systematic review](#)

³¹ Office for National Statistics (2025) *Suicides in England and Wales: 1981 to 2024*. Available from [ONS: Suicides in England and Wales](#)

³² Athey et al (2025) Association of substance use with suicide mortality: An updated systemic review and meta-analysis. *Drug and Alcohol Dependence Reports*, 14. Available from [Association of substance use with suicide mortality/ systemic review](#)

- 5.2.18 Ruth required mental health hospital admissions twice in 2022, with both overdoses being in response to domestic abuse from P. Following Ruth's second hospital discharge in December 2022, the community support organisation supported her to attend a medication review with her GP. The GP suggested that a medication safe would be beneficial to reduce the risk of overdose. ASC subsequently ordered a safe with code access and advised that only carers should have the code. This plan was made with Ruth's agreement and was documented in a medication concordance document that accompanied her care plan and was shared with the domiciliary care provider. Ruth was assessed as requiring level three medication management, meaning that her medication was to be managed and administered by carers.
- 5.2.19 There were occasions when the medication concordance arrangements were followed by carers. However, the review identified several occasions when medication was not administered under the level of supervision stipulated in Ruth's care plan. At times, medication was left for Ruth to take herself, left under the supervision of others, or not administered because Ruth was not at home when carers attended. These issues were compounded by concerns about the timing of care calls and that Ruth was known to have access to the key safe code. This meant that the agreed medication safety arrangements were not consistently operating as intended.
- 5.2.20 Across the chronology, several agencies became aware, or appeared to have reason to believe, that Ruth knew the key safe code and could therefore access the medication safe. Responses to this information varied considerably. Some professionals recognised this as a significant change in risk, because the agreed safety measure relied on Ruth not having independent access to large quantities of medication. In these instances, concerns were escalated through safeguarding referrals or discussions with ASC, the domiciliary care provider and health professionals. In other records, the information appears to have been noted but not acted upon or treated as a practical issue about care delivery rather than as evidence that the medication risk management plan was no longer effective.
- 5.2.21 This variation suggests there was no shared understanding across agencies about the significance of Ruth knowing the code, who was responsible for reviewing the arrangement, or what escalation route should be used when a medication safety measure had been compromised. Given Ruth's known overdose risk, any evidence that the medication safety arrangement was no longer reliable should have prompted a coordinated review of the plan.
- 5.2.22 In March 2024, the domiciliary care provider changed the code in response to Ruth knowing what it was. However, this was not effectively communicated to carers, who were then unable to access the safe and permanently disabled it whilst attempting to open it. This led to Ruth not having access to her medication for several days and emergency prescriptions needing to be issued. Ruth's friend, Tina, sourced a replacement medication safe that used a key rather than a code. Tina also ordered a separate key safe for the medication safe key to be stored in. Tina told the Author that her understanding was the key safe containing the new medication safe key would be kept in a cupboard and that Ruth would not know the code for it. However, this appears to have been an informal arrangement between Ruth, Tina and the domiciliary care provider, rather than a formal review of the care plan and medication concordance document involving all relevant agencies.
- 5.2.23 The change of medication safe was not effective in preventing Ruth from accessing medication. On 8th August 2024, Ruth attended A&E with a bag full of medication that she had emptied from the safe and taken with her. It is unclear how this occurred and whose decision it was, but by the point of Ruth taking a fatal overdose, it appears that the key for the medication safe was not stored separately but had been placed in the key safe outside her house alongside her front door key. As part of the police investigation, Ruth was seen on CCTV on the evening of 8th August 2024 taking a key from the key safe and returning inside. This was the last recorded sighting of her alive.
- 5.2.24 There were examples of good practice in relation to medication management. Professionals recognised that Ruth was at heightened risk of overdose and attempted to reduce this risk

through a medication safety plan, including use of a locked medication safe and carer involvement in administration. Some practitioners identified that medication access arrangements were becoming unsafe, particularly when Ruth was known to have the key safe code, and escalated concerns through safeguarding referrals or liaison with ASC, the domiciliary care provider and health professionals. There was also evidence of professionals trying to clarify prescribing arrangements and medication changes across primary care, secondary mental health services and pharmacy. These responses demonstrate that several practitioners understood its significance and took steps to reduce harm.

- 5.2.25 However, the effectiveness of these actions was limited by the absence of a shared multiagency framework for overseeing medication related risk. Medication management involved multiple agencies and several interdependent safeguards: prescribing oversight, pharmacy supply, domiciliary care administration, use of a medication safe, key safe access, and monitoring of overdose risk. No single process brought these elements together into one shared medication safety plan. As a result, concerns such as missed or unsupervised medication, stockpiling, prescribing changes, knowledge of the key safe code and reliability of carer administration were not consistently reviewed or escalated as part of one coordinated risk management process.
- 5.2.26 At the PLE, the Author explored the issue of medication management and what practitioners understood the process should have been. ASC explained that any agencies could request an early annual review³³ which could trigger reassessment of Ruth's care plan and medication concordance document. In principle, this provided a route for updating the medication plan when risks changed. However, in practice this route was not straightforward. Ruth was not considered suitable for routine annual review according to the mental health review team criteria because she was not stable and there was an outstanding safeguarding concern. At the same time, safeguarding concerns about medication were deemed to sit with case management and commissioning rather than requiring a s.42 enquiry. This meant there was no clear route for review; the concerns were serious enough to prevent a routine review but not framed in a way that clearly triggered an alternative coordinated review process.
- 5.2.27 There is also a question about whether ASC was best placed to review medication concordance in circumstances where the core risk related to suicide, overdose, fluctuating mental state, multiple prescribers and medication access. This does not mean ASC should not have been involved. Rather, it suggests that medication safety planning in such complex circumstances required shared clinical, safeguarding and domiciliary care provider input, with clear ownership of the plan and agreed escalation routes when safeguards became unreliable.

Finding 1

Ruth's medication arrangements were intended to reduce a known and foreseeable risk of overdose, but over time they became a complex multiagency risk management issue without a clear shared framework for oversight. Although individual practitioners and agencies recognised and escalated concerns at different points, there was no clear trigger for multiagency review when key safeguards became unreliable, particularly Ruth's knowledge of the medication safe code and later uncertainty about where the safe key was held. This meant that changes in risk did not consistently lead to review, escalation or revision of the medication safety plan.

- 5.2.28 A related issue is how practitioners understood the balance between mental capacity, autonomy, human rights and foreseeable suicide risk. Within the chronology, in December 2023, there was email correspondence between the community support organisation and ASC

³³ Under s.27 Care Act an annual review is the statutory requirement for a local authority to re-evaluate a care and support plan at least once every 12 months.

about whether Ruth's pharmacy could be asked not to hand medication over to her due to her overdose risk and the response was *"the difficulty is we have limited powers when a person has capacity and makes unsafe choices, it is a minefield but we have limited powers and need to ensure her human rights are not infringed"*.

- 5.2.29 This issue was also explored in the PLE. Practitioners recognised that the interface between mental capacity, autonomy, human rights and the duty to protect life was difficult to navigate in practice, particularly where a person appeared to have capacity but was at known risk of suicide or overdose. Practitioners said they would welcome clearer guidance on how to balance these considerations, including what lawful and proportionate options are available when risk is foreseeable, but the person is not actively consenting to all protective measures. This indicates that the issue was not simply one practitioner's interpretation, but a wider area where frontline staff would benefit from clearer multiagency guidance and support.
- 5.2.30 This response reflected a valid concern about respecting Ruth's autonomy and avoiding disproportionate interference with her rights. However, it also risked oversimplifying the legal and ethical framework. Principle three of the Mental Capacity Act 2005 (MCA) protects the right of a person with capacity to make decisions that others may consider unwise. However, this does not mean that agencies have no further role where there is a known and foreseeable risk of serious harm or death. Practitioners can still assess whether capacity is decision-specific and fluctuating, consider whether the person is able to use and weigh relevant information at the material time, share information where lawful and proportionate, review care and risk management plans, and consider less restrictive measures to reduce risk.
- 5.2.31 This is particularly significant in the context of suicide risk. The relationship between capacity and suicidal decision-making is complex. Research indicates that the legal responsibilities of professionals working with suicidal patients are not always well understood, particularly at the interface between the MHA and MCA, and that practitioners may struggle to balance autonomy with protection of life³⁴. Where mental disorder may impair a person's ability to take a rational decision to end their life, public bodies may still have duties to take reasonable measures to protect life where there is a real and immediate risk³⁵.
- 5.2.32 There is also a risk that 'having capacity' can be used as a reason for services to step back, rather than as the starting point for thorough, person-centred safety planning. Research describes the harm that can be caused when people experiencing suicidality are told they "have capacity" in a way that feels like abandonment rather than support³⁶. This is relevant to Ruth's case because the issue was not whether all risk could or should have been removed, but rather whether agencies had a shared understanding of what reasonable, lawful and proportionate steps could still be taken when Ruth's overdose risk was known and the medication safety plan was becoming unreliable.
- 5.2.33 NICE guidance on self-harm³⁷ emphasises assessment, care planning, safer prescribing and dispensing, consent, confidentiality and safeguarding across health, social care, criminal justice and third sector settings. NHS England's guidance on staying safe from suicide³⁸ also emphasises holistic, person-centred safety planning rather than relying on risk prediction alone, recognising that suicidal thoughts and risk can change quickly. In Ruth's case, this meant that concerns about medication access, stockpiling, missed or unsupervised

³⁴ Beale et al (2024) Mental capacity in practice part 2: capacity and the suicidal patient. *BJPsych Advances*, 30(1) 11-20. Available from [Mental capacity in practice part 2](#)

³⁵ Ruck Keene (2021) *Capacity and suicide*. Available from www.mentalcapacitylawandpolicy.org.uk/capacity-and-suicide

³⁶ Aves (2022) *"If you are not a patient they like, then you have capacity": Exploring mental health patient and survivor experiences of being told "you have capacity to end your life"*. Available from [If you are not a patient they like then you have capacity](#)

³⁷ NICE (2022) *Guideline NG225. Self-harm: assessment, management and preventing recurrence*. Available from <https://www.nice.org.uk/guidance/ng225>

³⁸ NHSE (2025) *Staying safe from suicide: Best practice guidance for safety assessment, formulation and management*. Available from <https://www.england.nhs.uk/long-read/staying-safe-from-suicide/>

administration and changes in mental state needed to be considered together as part of a dynamic safety plan.

- 5.2.34 In considering the above, it appears that practitioners would have benefitted from clearer support to navigate the uncomfortable space between failing to act and infringing rights. Options could have included a coordinated review of the medication plan, clearer agreement about who could collect medication, safer prescribing or dispensing arrangements, review of the medication safe/key safe arrangements, clinical input into suicide risk, and a shared escalation plan if Ruth sought or obtained access to larger quantities of medication. Rather than viewing these as restrictive measures, they are ways of ensuring that autonomy, dignity and safety are considered together.

Finding 2

Practitioners recognised the difficulty of balancing Ruth's mental capacity, autonomy and human rights with the known and foreseeable risk of suicide or overdose, but there was no clear shared guidance to support decision-making in this area. 'Having capacity' risks being interpreted as limiting the scope for intervention instead of prompting careful consideration of what lawful, proportionate and least restrictive steps could still be taken to reduce risk. Practitioners would benefit from a clear framework to help them navigate the space between respecting autonomy and maintaining an active duty of care in the context of overdose risk.

5.2.35 *Trauma-informed responses and making safeguarding personal*

- 5.2.36 Making Safeguarding Personal³⁹ is a sector led initiative that means that safeguarding responses should be shaped by what matters to the person, not just by what agencies identify as risk. In Ruth's case, this meant understanding how her trauma history, domestic abuse, personal care needs and housing situation affected what helped her feel safe.
- 5.2.37 For the purpose of this review, trauma-informed means practice that recognises how trauma can affect a person's experience of safety, trust, relationships and choice, and seeks to avoid re-traumatisation⁴⁰.
- 5.2.38 There were examples of good practice where Ruth's wishes were listened to and acted on. the community support organisation provided female support workers in response to Ruth's request, which was important given her trauma history and the nature of the abuse she had experienced. The community support organisation also supported her to attend the police station to receive disclosure through DVDS, meaning that difficult information was shared with her in a supported way. Ruth also said that she wanted to move from the flat where she had experienced abuse from P, and FCHO facilitated this in a timely manner through a managed move. This was good evidence of trauma-informed practice, recognising that Ruth's accommodation was connected to traumatic memories and did not feel like a safe place for her. The response supported Ruth's choice and sense of safety, rather than treating the request to move as simply a housing issue.
- 5.2.39 However, Ruth's wishes were not consistently reflected in the care she received. Ruth told both the community support organisation and her CMHT care coordinator that she would prefer female carers, particularly for personal care. Tina told the Author that Ruth found it embarrassing to receive personal care from male carers but that she was worried about being too outspoken with the domiciliary care provider about this because she feared they would stop supporting her, which was understandable given the extent of the domiciliary care

³⁹ [LGA - Making Safeguarding Personal](#)

⁴⁰ Office for Health Improvement & Disparities (2022) *Guidance: Working definition of trauma-informed practice*. Available from [working-definition-of-trauma-informed-practice](#)

provider instability Ruth had experienced during the scoping period. It also means that any apparent agreement to mixed-gender care provision should be understood with caution, because Ruth may not have felt able to object if she thought this could put her care package at risk.

- 5.2.40 Cera Care, as the parent company for Premier Care and Care Quality Services, stated during the second panel meeting for the review that they were not aware of Ruth's trauma history and that female carers were provided for personal care calls. However, this is not clearly reflected in the chronology provided. For example, a December 2023 entry from the community support organisation records that Ruth had spoken to the domiciliary care provider about not wanting a particular male carer to support her anymore. This was shared with the social worker, who contacted the domiciliary care provider and was told that they were unable to facilitate female only carers and would need to give notice if this was insisted upon. Ruth also told CMHT in March 2024 that a male carer completed her evening calls and was involved in personal care, although she would prefer a female carer. With Ruth's agreement, the CMHT worker contacted Premier Care about this and was told that Ruth had been made aware of this when she agreed the package.
- 5.2.41 There is a discrepancy between the domiciliary care provider account given at panel and the chronology evidence available to the review. Therefore, the Author cannot conclude that Ruth's preference for female carers was reliably recorded, understood, planned for and met. Research highlights the importance of gender and trauma informed responses, particularly where women's needs are shaped by abuse, poor mental health, disability and other forms of disadvantage⁴¹. With Ruth's history of domestic and sexual abuse, the gender of carers providing personal care should not have been treated as only a personal preference, it was important to her dignity, sense of safety and ability to accept support. Where a domiciliary care provider cannot meet trauma-informed preferences, this should be openly discussed so that risks, dignity, choice and alternative options can be considered in a planned, transparent and purposeful way.
- 5.2.42 This issue is considered further in Domain 3, as the ability to provide trauma-informed and personalised care was not only dependent on individual practitioner awareness, but also whether commissioned care arrangements could provide consistency, appropriate workforce capability, sufficient flexibility and access to staff who could meet Ruth's trauma-related needs, including her preference for female carers.

Finding 3

There were examples of good trauma-informed and person-centred practice where Ruth's wishes were heard and acted upon, including support from the community support organisation and action to facilitate her move from accommodation associated with abuse. However, Ruth's trauma related preference for female carers, particularly for personal care, was not consistently recorded, communicated or assured across her commissioned care arrangements, including whether the domiciliary care provider had access to staff who could meet this need. This meant that an important aspect of Ruth's dignity, safety and ability to accept support was not reliably reflected in her care planning.

⁴¹ Agenda Alliance (2019) *Breaking Down the Barriers: Findings of the National Commission on Domestic and Sexual Violence and Multiple Disadvantage*. Available from [Breaking Down the Barriers Report.pdf](#)

5.3 Domain 2: Inter-agency Teams Around the Person

5.3.1 *Safeguarding and the use of the TRAM protocol*

- 5.3.2 OSAB's TRAM protocol has been in place since February 2022 and sets out a shared multiagency approach for working with adults with multiple and complex needs who may be at risk of serious harm or death. It is designed to support practitioners where risk sits within, or alongside, statutory safeguarding duties, and it should be read alongside the OSAB Multiagency Adult Safeguarding Policy and Procedures⁴². The protocol does not replace single-agency risk management, safeguarding enquiries or police responsibilities, but it provides a structure for sharing information, coordinating support and escalating risk where single-agency management is not sufficient.
- 5.3.3 TRAM works through a tiered model of risk. At standard risk, individual agencies remain responsible for identifying and assessing whether wider risks require information-sharing or a TAA response. At moderate risk, where wider health or vulnerability risks require input from more than one agency, cases should be managed through TAA arrangements, including local risk huddles, MASH daily risk meetings or frequent attender meetings. Where risks cannot be mitigated through TAA, or escalate further, referral to the Adults CaHRP can be considered. High risk cases may be managed through Adults CaHRP or MARAC where domestic abuse is a factor, and critical risk involves serious and imminent risk of harm or death requiring senior oversight and action beyond usual practice where necessary.
- 5.3.4 In practical terms, the protocol is accessed through multiagency working rather than a single referral form. Any agency can call a TAA meeting, and any professional can chair it. The meeting should bring together relevant agencies on a case-by-case basis, including those currently working with the adult, to share information, understand risks and agree actions to reduce or manage them. The TAA model includes identification of a Lead Professional, usually the practitioner with the strongest relationship or statutory role, and the wider TAA should support that person through shared decision-making, agreed actions and collective ownership of risk.
- 5.3.5 Where risk remains high despite TAA, or where practitioners feel stuck, the protocol provides for escalation to Adults CaHRP. Ideally, a TAA should already be in place before Adults CaHRP referral, although the Chair may consider exceptions. The Lead Professional is expected to escalate concerns within their own agency to a safeguarding lead or senior manager before referral, and Adults CaHRP then provides additional support, challenge and problem-solving rather than taking over case responsibility. The case remains with the TAA, which must continue to meet and keep the risk assessment and action plan updated.
- 5.3.6 In Ruth's case, there was one period where TAA under the TRAM protocol was utilised. This was from Autumn 2022 to Spring 2023, when the combination of high-risk domestic abuse from P, vulnerability to exploitation and intentional overdose risk were key trigger factors. TAA provided a structured forum for agencies to share information, coordinate risk management and agree practical actions around safeguarding, domestic abuse and care provision for Ruth. The TAA meeting on 1st December 2022 resulted in a shared action plan, including seeking feedback from MARAC, referring Ruth to CMHT, updating her Care Act assessment, liaising with housing, and exploring disruption and enforcement options in relation to P. Escalation to Adults CaHRP was considered but deemed unnecessary at that point because the case was being heard at MARAC and Ruth was in a place of safety in hospital.
- 5.3.7 However, not all relevant agencies were initially included in the multiagency processes. PCFT were not invited to the second MARAC meeting during Ruth's admission and had not been included in earlier TAA meetings. The IMRs also identified that other agencies involved with Ruth at the time, including GMP, NCA, Ruth's GP and the commissioned domiciliary care provider, were not included in TAA. In relation to PCFT, this was addressed when the ward

⁴² www.osab.org.uk/professionals/policies/

sought advice from the PCFT safeguarding team and contact details were shared with the TAA lead professional so that the ward could be included in future meetings. This was good practice because it recognised a gap in professional involvement and took steps to improve the TAA membership. However, the wider omission of other agencies demonstrates the importance of having a clear and reliable way to identify who is involved when convening TAA.

- 5.3.8 In April 2023, the s.42 enquiry and TAA meetings ended because the risks from P were assessed to have reduced. However, the chronology indicates that there should have been a case conference to agree closure of the safeguarding enquiry and consider whether TAA meetings needed to continue, but this did not happen. This does not necessarily indicate a gap in the TRAM protocol itself, but it does show the importance of clearly recording decisions to close or step-down multiagency arrangements. A formal closure discussion would have provided an opportunity to agree what residual risks remained, whether any multiagency oversight was still needed, and what should trigger TAA being reconvened if risk changed.
- 5.3.9 Although there is no evidence of further domestic abuse from P after 2022, aside from one unexplored reference from Ruth in June 2023 to having been stalked by P, she continued to have multiple and complex needs. From late 2023, these included concerns about exploitation from neighbours and unidentified male ‘friends’, overdose risk that was not effectively managed, escalating concerns about deteriorating mental state, disclosed debt issues and repeated domiciliary care provider breakdown. These factors appear to have warranted consideration of whether TAA, or another route under TRAM, should be used again.
- 5.3.10 The interface between TAA and other structured safeguarding processes is also relevant. Ruth was open to TAA when the second MARAC referral was made due to persistent breaches of the non-molestation order and post-separation stalking and harassment from P. PCFT were not invited to that MARAC meeting, despite Ruth being an inpatient on one of their wards at the time and had not been included in earlier TAA meetings. PCFT has advised that since that time it is now routinely represented at MARAC. However, Ruth’s case still illustrates the importance of ensuring that information from MARAC is shared into TAA where both processes are operating, and that mental health services and inpatient wards are included in TAA where they are central to the person’s risk management and safety planning.
- 5.3.11 During the scoping period, six safeguarding referrals were made. The only referral that progressed to a safeguarding enquiry resulted in the only TAA taking place. Four referrals across 2023 – 2024 related to concerns about medication management but were deemed not to meet the threshold for s.42 enquiries, as the issues were considered to sit with social care case management and commissioning rather than safeguarding. There is no evidence that TAA was considered as an alternative route to coordinate ongoing risk where safeguarding referrals did not meet the s.42 threshold, even though the TRAM protocol identifies that a TAA approach may be used where care and support needs, risk to others, or situations where *“mainstream safeguarding processes are not appropriate to manage non-engagement and risk of harm or death”*⁴³ are present. If significant risks could not be sufficiently mitigated through TAA, this would also have provided a route for escalation to Adults CaHRP.
- 5.3.12 When it was explored in the PLE why a further TAA was not instigated, it became apparent that awareness of the TRAM protocol was not consistent across agencies. Only approximately half of the practitioners present were familiar with the protocol. It was identified that in 2022, a senior social worker was allocated to Ruth’s case due to the level of complexity, and this practitioner had direct input into the creation of the TRAM protocol. This meant they had a strong understanding of the process. However, when Ruth was later referred to ASC in 2023, the case was allocated to an apprentice social worker. ASC’s IMR author acknowledged that an apprentice should not have been allocated a case of this complexity and that greater management oversight was required. The significance of this is not the individual practitioner’s status, but the organisational decision-making around allocation, supervision and oversight in a complex multiagency risk case.

⁴³ www.osab.org.uk/OSAB-TRAM-Protocol-Flowchart.pdf

- 5.3.13 For practitioners who were aware of the TRAM protocol, there was still some confusion within the PLE about who could instigate a TAA and how. One practitioner said that a referral should be made into Oldham's MASH, who would triage it and set up the TAA; this perception does not accurately reflect the documented process, which states that any agency can call a TAA.
- 5.3.14 Practitioners also identified a practical barrier to using TAA effectively. Although the protocol is clear that any agency can call a TAA, not all agencies have access to systems that identify which partner agencies are working with a person and should therefore be invited. ASC systems may identify commissioned domiciliary care providers, previous MHA assessments indicating mental health involvement, and police contacts shared due to vulnerability concerns. Other agencies, particularly in the non-statutory sector, do not have equivalent access and may rely on information provided by the person, which may not fully reflect the professional network involved. In Ruth's case, several agencies involved with her were not initially included in TAA, and practitioners at the learning event later described the practical difficulty of knowing who else is involved when deciding whether to convene a TAA. Therefore, the issue identified by this review is not the absence of a local risk management framework, but the extent to which that framework is consistently understood, accessible and operationalised across the partnership.

Finding 4

The TRAM protocol provides a useful structure for coordinating complex multiagency risk, and earlier use of TAA in Ruth's case demonstrates how this approach can support effective information sharing, planning and collective risk management. However, the earlier s.42 enquiry and TAA meetings ended without the expected closure discussion, and awareness of TRAM was not consistent among practitioners who attended the learning event. Agencies also identified a practical barrier to initiating TAA where they do not know which other professionals or services are involved. A clearer mechanism to confirm current professional involvement would support fuller participation and reduce the risk of key agencies being omitted.

5.4 Domain 3: Organisational Support for Practice

5.4.1 *Safe medication management*

- 5.4.2 The medication risks discussed in Domain 1 were not only related to direct care practice. They were also shaped by the wider organisational arrangements around prescribing, pharmacy supply, domiciliary care provider administration, communication and review. Ruth's medication management involved several moving parts (see Fig. 1 below), including primary care, secondary mental health services, the acute hospital, pharmacy, the community support organisation, ASC and domiciliary care providers. This level of complexity was not in itself unsafe, but it meant that safe practice depended on clear communication, accurate records, timely updating of prescriptions, and clarity about who was responsible for each part of the medication system. No single agency appeared to hold a complete overview of the whole medication picture over time.

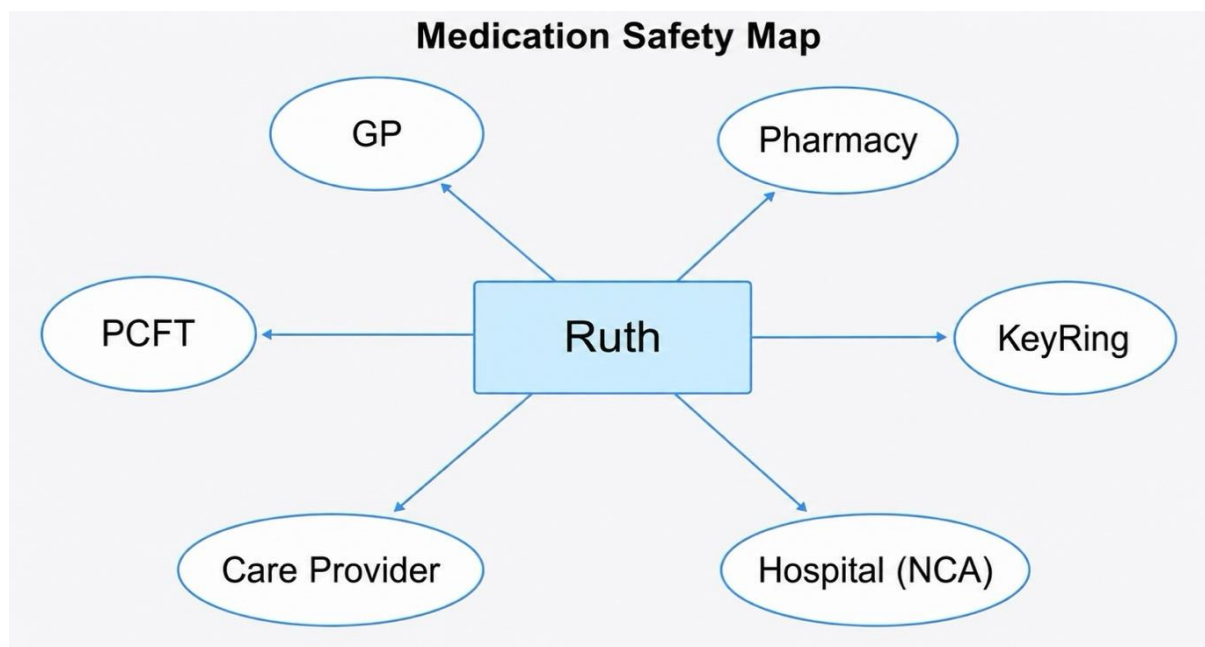


Fig. 1

- 5.4.3 NICE guideline NG67⁴⁴ states that before a social care provider gives medicines support, commissioning and contractual arrangements should be discussed, agreed and recorded as part of the local care planning process, so that it is clear who is responsible and accountable for the decisions being made and which provider will deliver each aspect of medicines support. It also advises that health and social care commissioners and providers should review local governance arrangements to ensure that responsibility and accountability for medicines support is clear.
- 5.4.4 NICE quality standard QS17⁴⁵ states that adults receiving medicines support in the community from a social care provider should have their GP and supplying pharmacy informed that support has started; knowing who is responsible for providing medicines support and who to contact allows prescribers to communicate any changes to medicines to the relevant person. It also states that adults receiving medicines support should have a record of the medicines support they need in their care plan, including their needs and preferences, who to contact about medicines, what support is needed for each medicine, how support will be given and who is responsible for providing it. It states that providers should have robust processes for identifying, reporting, reviewing and learning from medicines-related problems, and that commissioners should ensure services follow such processes.
- 5.4.5 In addition to NICE guidelines, the Care Quality Commission (CQC) also provides guidance for domiciliary care providers⁴⁶. This states that, where medications are stored, there should be safe and appropriate access arrangements that are reviewed at intervals appropriate to the person, particularly where capacity is declining or fluctuating. It also states that care workers should only provide medicines support where this is clearly documented in the care plan, that prescriber directions must be clear, specific and unambiguous, and that home care workers should receive relevant training and support. It notes that leaving out doses for a person to take later should only happen where this has been agreed, risk assessed and recorded in the care plan and medication administration record. CQC guidance⁴⁷ also recommends good

⁴⁴ NICE (2017) *Guideline NG67: Managing medicines for adults receiving social care in the community*. Available from www.nice.org.uk/guidance/ng67

⁴⁵ NICE (2018) *Quality Standard 171: Medicines management for people receiving social care in the community*. Available from www.nice.org.uk/guidance/qs171

⁴⁶ CQC (2022) *Managing medicines: home care providers*. Available from www.cqc.org.uk/guidance-providers/adult-social-care/managing-medicines-home-care-providers

⁴⁷ CQC (2023) *Medicines information for adult social care services*. Available from www.cqc.org.uk/guidance-providers/adult-social-care/medicines-information-adult-social-care-services

governance for adult social care services across areas including medication care plans, working with external healthcare professionals, appropriate use of psychotropic medicines, medicines administration records, training and competence, and multi-compartment compliance aids. These areas were all relevant to Ruth's medication support.

- 5.4.6 One recurring issue was the interface between hospital or outpatient medication changes and ongoing prescribing in Primary Care. When Ruth attended hospital or outpatient clinics and medication changes were made, she could be issued with a short supply of the new medication, with the GP then asked to continue the amended prescription. However, evidence from the chronology and PLE suggests this did not always happen smoothly. On occasions, medication appeared to revert back to an earlier prescription because GP records had not yet been updated. Although clinic letters were reviewed in Primary Care by clinical pharmacists, there was still a time lag in this process. The ICB has advised that the Discharge Medicines Service can support more effective transfer of care between hospital and community pharmacy, where the hospital pharmacy team sends a referral to the patient's community pharmacy through 'PharmOutcomes'. In a case such as Ruth's, where the medication regime was complex and overdose risk was known, delays or inconsistencies in updating prescriptions created avoidable risk, and available transfer-of-care mechanisms needed to be considered as part of the wider medication safety plan.
- 5.4.7 There was also a wider issue about oversight of Ruth's full medication regime. In July 2024, Ruth was identified as being overmedicated and on HDAT. This had not previously been identified, despite her medication being prescribed and reviewed across both Primary Care and secondary mental health services. Whilst it is recognised that not one agency alone should have held responsibility for all aspects of Ruth's medication, the interface between prescribers needed to be stronger, particularly where medication changes were frequent, the medication regime was complex, and Ruth was known to be at risk of overdose.
- 5.4.8 Pharmacy arrangements added another layer of complexity. Blister packs were not always available and, in any event, were not a straightforward solution for Ruth. Frequent medication changes and the nature of her medication regime meant that this method of dispensing may not have been suitable or sustainable. Ruth also changed pharmacy during the scoping period, which created another point where continuity and communication could be disrupted. Pharmacy was not just a dispensing function in Ruth's case, it formed part of the wider medication safety system. Where a person is receiving medicines support in the community, changes in pharmacy arrangements, supply issues or limitations in dispensing methods need to be clearly understood and communicated across the agencies involved. The ICB has advised that community pharmacy commissioning has recently transferred from NHS England to the ICB, and that community pharmacy quality assurance, contractual and regulatory arrangements include safeguarding requirements. However, detailed consideration of community pharmacy involvement was not within the scope of this review, so the Author cannot determine whether there was any specific pharmacy learning in Ruth's case.
- 5.4.9 The importance of stock control and regular medication consolidation is also exemplified by the police investigation following Ruth's death. Officers found a substantial number of empty prescription medication boxes and packets within Ruth's home as listed in Appendix 2. The Author cannot determine from the information shared by GMP when those medications were taken, or whether they reflected historical accumulation, legitimate prescribed use, stockpiling or disposal issues. However, the volume of empty medication packaging reinforces the importance of clear oversight of supply, storage, administration and disposal, especially where access to medication forms part of an overdose risk management plan.
- 5.4.10 In Ruth's case, concerns about medication administration by domiciliary care providers were not always recognised or responded to consistently as potential safeguarding, provider quality or medicines governance issues. Although there were several incidents across time of medication not being administered under the level of supervision set out in Ruth's care plan, being left out to take herself or under the supervision of others, missed medication when Ruth was not at home or carers got locked out of the medication safe, delays linked to care call

times and uncertainty about access to the medication safe, only four safeguarding referrals were made (two by the community support organisation, one by NWS and one by the domiciliary care provider) and none reached the threshold for a s.42 enquiry.

- 5.4.11 OSAB's Multi-Agency Adult Safeguarding Policy and Procedures outline when to consider raising a safeguarding concern following a medication error⁴⁸. This states that all medication errors, including near misses, should be recorded, reviewed and considered in the context of previously recorded errors, because a series of similar incidents may meet the criteria for a safeguarding concern. It identifies that safeguarding should be considered where medication errors cause significant harm or distress, require medical intervention, are deliberate, or form part of a pattern involving the same medication, carer or adult. It also states that where systemic failings in a care provider's medicines management process lead to repeated medication errors, a safeguarding concern should be raised under organisational abuse. Where the issue relates to external factors, including pharmacy, hospital discharge or GP prescribing, services are expected to identify the failing and ensure it is addressed.
- 5.4.12 It would have been better practice if concerns about medication support were considered cumulatively, rather than as isolated incidents. Where repeated concerns arose, there should have been a clear route for review and escalation, including consideration of whether the domiciliary care provider could continue to meet Ruth's needs safely, whether the medication concordance document remained realistic, and whether safeguarding, commissioning or clinical input was required. Without this shared understanding, there was a risk that medication-related concerns were managed as individual care problems, rather than as indicators that the wider medication safety plan was no longer reliable.
- 5.4.13 These medication concerns also link to the wider issue of commissioned care provision. Where medication support is part of a risk management plan, repeated problems with administration, supervision, timing of calls or access to medication should not be seen only as isolated care delivery issues. They should also be treated as domiciliary care provider quality and commissioning intelligence. In Ruth's case, medication-related concerns formed part of a broader pattern of difficulty in sustaining a care package that could safely and consistently meet her needs. This is considered further at paragraphs 5.4.15 – 5.4.25.
- 5.4.14 Recent Health Services Safety Investigations Body (HSSIB) patient safety learning is relevant to this analysis⁴⁹. An investigation into an attempted suicide whilst under community mental health services identified that a change in mental health medication was a potentially vulnerable point, even where the person had a safety plan and planned monitoring in place. The circumstances were different to Ruth's, but the learning is relevant because Ruth's medication arrangements involved known overdose risk, changes in prescribing, community administration, storage controls and multiple agencies needing to understand how medication formed part of her safety plan.

⁴⁸ [OSAB Procedure - When to Consider Raising a Safeguarding Concern Following a Medication Error.pdf](#)

⁴⁹ HSSIB (2026) Investigation Report. Mental Health: attempted suicide while under the care of community services. Available from [mental-health-investigating-under-the-patient-safety-incident-response-framework-psirf/investigation-report/](#)

Finding 5

Ruth's medication support was delivered across a complex network of agencies, but the organisational arrangements needed to hold this system together were not consistently robust. There were delays between medication changes and GP prescribing, pharmacy arrangements were disrupted with some limitations on dispensing, and domiciliary care provider administration concerns were not consistently recognised as safeguarding, quality or commissioning issues, despite an OSAB procedure on when to raise a safeguarding concern following a medication error being in place. This meant that prescribing, dispensing, administration, storage, stock control and escalation did not consistently support a reliable and current medication safety plan.

Detailed consideration of community pharmacy involvement was outside the scope of this review. However, Ruth's case highlights the importance of understanding how pharmacy arrangements contribute to the wider community medication safety system where overdose risk is known, and whether any learning about pharmacy communication or escalation should be reviewed and shared more widely.

5.4.15 *Commissioning and sustaining care for complex needs*

- 5.4.16 Ruth had five different domiciliary care providers during the scoping period. On one occasion, this was related to Ruth moving area, but on other occasions the care package broke down because domiciliary care providers served notice or indicated that they were considering doing so. This level of domiciliary care provider change should have been recognised as significant. In Ruth's case, domiciliary care provider instability was not just a practical issue about sourcing care calls; it was relevant to safeguarding, medication management, relational practice and continuity of support.
- 5.4.17 There were indicators that domiciliary care providers were not always clear about the complexity of Ruth's needs when care packages were accepted. Following Ruth's discharge from hospital in Autumn 2023, Nobilis Care told MHLT that they had not been aware of the complexity of Ruth's needs when accepting the package. In June 2024, Care Quality Services indicated that they were considering serving notice because of difficulties with carers staying longer than planned, Ruth asking carers to complete additional tasks, and trying to prevent carers from leaving. These issues are returned to in the next section in relation to relational and trauma-informed practice. However, they are also relevant to commissioning because they raise questions about whether domiciliary care providers were being given sufficient information, whether they had the capability and support to meet Ruth's needs, and whether repeated domiciliary care provider breakdown was recognised as risk intelligence.
- 5.4.18 The IMR author for ASC was asked about expectations of domiciliary care provider capability, how service suitability is determined, and how risks associated with domiciliary care provider instability are overseen and responded to by Oldham Council as the package of care commissioner. The response from ASC Quality and Commissioning was that domiciliary care providers are expected to know whether they can effectively support a package, but that the needs of the individual must be outlined to enable them to make an informed decision. Their response also identified that domiciliary care providers need to be told when a package is not the "norm", noting that most packages are for older people, so that any special requirements or nuances can be flagged with the domiciliary care provider. If the allocated social worker as a care arranger cannot source a domiciliary care provider, this would be escalated to the Commissioning and Market Management Team (CMM), and it would be up to the care arranger to flag any other issues to CMM.

- 5.4.19 This indicates that, in practice, commissioning oversight was dependent on complexity being recognised and escalated by the allocated worker, care arranger or domiciliary care provider. CMM would not be routinely involved unless they were made aware of concerns or there were difficulties sourcing a domiciliary care provider. This creates a potential gap in cases like Ruth's, where a package can technically be sourced, but may not be sustainable or suitable over time. In these circumstances, the fact that a domiciliary care provider accepts a package should not be taken as sufficient assurance that the domiciliary care provider is equipped to meet the person's needs.
- 5.4.20 Repeated domiciliary care provider breakdown should have triggered consideration of whether the care model remained appropriate. This should have included consideration of why previous domiciliary care providers had struggled, what information was being shared at the point of brokerage, whether the domiciliary care provider had the required skills and training, if additional support or specialist input was needed, and whether the care package was realistic for someone with Ruth's combination of mental health needs, physical health needs, trauma history, medication risk and relational distress.
- 5.4.21 The Author recognises that it is not always possible to commission an ideal domiciliary care provider, and that this is influenced by national challenges within the domiciliary care market as outlined in Domain 5 below. However, repeated domiciliary care provider breakdown should still trigger local oversight and review of whether the package remains suitable, what additional support is required, and whether risks are being escalated appropriately. In Ruth's case, domiciliary care provider instability could have been treated as domiciliary care provider quality and commissioning intelligence, rather than being managed as a series of separate care package breakdowns.
- 5.4.22 Ruth's experience is consistent with wider evidence about commissioning for women experiencing domestic and sexual abuse and multiple disadvantage. Research⁵⁰ identifies that commissioning and funding arrangements can prevent joined-up services, continuity of care and the development of a skilled and secure workforce. It also highlights that commissioning can focus on cost over social value, and that siloed commissioning can make it harder for people experiencing multiple disadvantage to access support because they fall through gaps between services. Although Ruth's domiciliary care package was not a specialist domestic abuse service, the same principle is relevant; people with intersecting needs require care arrangements that are able to respond to complexity, not only deliver time-and-task support.
- 5.4.23 Considering Ruth's intersecting needs formed a significant and ongoing suicide risk as outlined in paragraphs 5.2.11 – 5.2.17, the issue of suicide prevention training is also relevant. ASC confirmed that suicide prevention training is not a core training requirement for domiciliary care providers that they commission. This sits uncomfortably with Oldham's Suicide Prevention Strategy⁵¹, which describes suicide prevention as "*everyone's responsibility*" and states that training should be embedded within workplaces and routinely available, including outside mental health settings. Ruth's domiciliary care providers were not supporting routine low-level care needs, they were supporting someone with known overdose risk, fluctuating mental health, trauma and a medication safety plan that relied partly on carers administering medication safely. This does not mean domiciliary care workers should become mental health specialists, but it does suggest that commissioning arrangements should consider what minimum suicide awareness, escalation knowledge and support are needed where domiciliary care providers are expected to work with people at known risk of self-harm or overdose.
- 5.4.24 This is also consistent with Oldham's Suicide Prevention Strategy, recognising that two thirds of people who die by suicide are not in contact with mental health services and that people receiving safeguarding or social care services may not be under mental health services but still require additional help, risk recognition and pathways into timely intervention. In Ruth's

⁵⁰ Agenda Alliance (2019) *Breaking Down the Barriers: Findings of the National Commission on Domestic and Sexual Violence and Multiple Disadvantage*. Available from [Breaking Down the Barriers Report.pdf](#)

⁵¹ [Oldham Suicide Prevention Strategy](#)

case, this was directly relevant because there were periods when mental health services were not involved yet domiciliary care providers and voluntary sector agencies were still working with her in the community whilst suicide and overdose risk remained foreseeable.

- 5.4.25 Therefore, the review identifies a potential gap in how complex care packages are commissioned, monitored and escalated when domiciliary care provider instability emerges. Ruth's case suggests that the system needs clearer triggers for commissioning or senior oversight where domiciliary care providers repeatedly serve notice, raise concerns about being unable to meet need, or where the care package relies on domiciliary care providers managing risks that go beyond routine domiciliary care. This should include consideration of domiciliary care provider capability, trauma-informed practice, suicide awareness, medication risk, information-sharing and escalation routes.
- 5.4.26 This links to the next section, which considers whether practitioners had the training, supervision and relational understanding needed to work with Ruth's distress, trauma and behaviour in a way that could sustain care safely and compassionately whilst maintaining professional boundaries.

Finding 6

Ruth's repeated changes of domiciliary care provider should have been recognised as an indicator of complexity and risk, not just a brokerage issue. There does not appear to have been a clear trigger for senior commissioning oversight when domiciliary care providers repeatedly served notice, raised concerns about being unable to meet Ruth's needs, or where the package relied on providers managing risks beyond routine domiciliary care. This was particularly relevant because Ruth's care package involved known overdose and suicide risk, but suicide prevention training was not a core requirement for domiciliary care providers. Domiciliary care provider instability was not consistently used as intelligence about whether the commissioned care model was suitable, sustainable or sufficiently supported for Ruth's level of complexity.

5.4.27 *Relational and trauma-informed practice*

- 5.4.28 Ruth's presentation could be difficult for practitioners and carers to understand and respond to consistently. The chronology provides examples of occasions where Ruth contacted services frequently, asked carers to complete additional tasks, became distressed when carers needed to leave, or was perceived as speaking to carers in a challenging way. These actions should not be interpreted as 'difficult behaviour'. In the context of Ruth's trauma history, EUPD, C-PTSD, domestic abuse, abandonment, pain and fear of care breakdown, they also needed to be understood as communication of distress, fear, need and relational insecurity.
- 5.4.29 National guidance supports this approach. NICE guidance on working with people with borderline personality disorder⁵² (a different term for EUPD) states that services should work in an atmosphere of hope and optimism, recognising that many people will have experienced rejection, abuse and trauma, and encountered stigma. NICE also emphasises the importance of comprehensive care planning, clear roles and responsibilities, crisis planning, and risk management that takes account of changes in personal relationships, including therapeutic relationships. Although Ruth's domiciliary care providers were not specialist mental health services, these principles are relevant because they highlight the importance of consistency, boundaries, shared understanding and relational work where a person's distress is expressed through relationships with professionals.

⁵² NICE (2009) *Guideline CG78: Borderline personality disorder – recognition and management*. Available from www.nice.org.uk/guidance/cg78

- 5.4.30 Other best practice guidance for working effectively to support people with personality disorder in the community⁵³ highlights that working with people with personality difficulties can have an emotional impact on staff, and that staff need psychologically informed supervision, support and time to reflect. It also explains that behaviour experienced as challenging can invite rejection from workers, but that boundaries need to sit alongside an understanding that behaviour serves a function emotionally for the person or in the relationship between worker and service user. This is highly relevant to Ruth's case. If Ruth was trying to keep carers with her for longer, asking them to do additional tasks, or contacting the domiciliary care provider repeatedly, this may have been experienced by carers as demanding or unreasonable. However, a trauma-informed formulation would also consider whether this reflected anxiety, fear of being left, fear of losing care, or difficulty trusting that support would remain available.
- 5.4.31 Locally, all partner agencies have access to OSAB's Trauma Informed Practice Guidance⁵⁴. This provides an important shared foundation across the partnership and demonstrates that trauma-informed practice is recognised as relevant beyond specialist mental health services. However, Ruth's case suggests that access to written guidance alone may not be sufficient where practitioners or care staff are working with high levels of trauma, relational distress, suicide risk and care package instability. In such cases, staff may also need opportunities for reflective discussion, shared formulation and access to specialist advice.
- 5.4.32 At the PLE, health services appeared more confident in describing trauma-informed responses to Ruth. PCFT advised that trauma-informed practice is interwoven into their level three⁵⁵ safeguarding training, suicide prevention training and person-centred care planning training. PCFT also provides clinical supervision to all staff by trained clinical supervisors every 4-6 weeks to enable practitioners to develop knowledge and competence, discuss problems and identify solutions. This investment in trauma-informed and relational awareness appeared to be reflected in some good practice with Ruth. When she had a care coordinator in the community, there was evidence that they understood the relationship between trauma, EUPD and Ruth's responses to carers. The chronology indicated that they had conversations with Ruth about how she responded to carers at times, how this may not help her get the support she needed, and how she might try to understand or interpret situations differently. This was an example of relational practice because it did not simply label Ruth's behaviour as problematic. The care coordinator tried to work with her to understand what was happening and support her to respond differently.
- 5.4.33 This level of confidence was not evident across all parts of the system. Care staff appeared to find aspects of working with Ruth difficult, and this contributed to domiciliary care providers considering serving notice. At the PLE, one carer became upset when reflecting on what had happened. They described the fear they felt when they were being interviewed by police as part of the investigation and thinking they might go to prison. They also reflected that they had entered care work expecting to provide more routine practical support to people in the community, rather than support people with complex mental health needs, relational distress and suicide risk. This was a powerful reflection that illustrates the gap between what some carers expected their role to involve and the level of complexity they were actually being asked to manage.
- 5.4.34 Domiciliary care staff at the PLE said they felt supported by managers with day-to-day questions, such as what to do when medication had been missed or when practical issues arose. However, this is different from having the training, supervision and reflective space needed to contain the emotional impact of working with someone with complex trauma, fluctuating mental health, overdose risk and relational distress. The Author considers that,

⁵³ Bolton et al (2014) *Meeting the challenge, making a difference*. Available from [Meeting-the-Challenge-Making-a-Difference.pdf](#)

⁵⁴ [OSAB-Trauma-Informed-Practice-Guidance-for-Practitioners.pdf](#)

⁵⁵ The Intercollegiate Document (2024) is a UK-wide framework outlining the mandatory safeguarding competencies and training required for healthcare staff. Level 3 specifically applies to registered clinical staff who regularly assess, plan, intervene, or evaluate care for patients. Available from [rcn-adult-safeguarding-roles-and-competencies-for-health-care-staff](#)

whilst carers were part of Ruth's safety network, they may not have been equipped or supported in a way that reflected that level of responsibility.

- 5.4.35 This is important because relational practice is not only about individual warmth or kindness. It requires a shared understanding of why a person may behave in certain ways, how boundaries can be maintained without rejection, and how workers can stay compassionate without becoming overwhelmed. In Ruth's case, the domiciliary care provider response to relational difficulty appeared to focus on whether the package could be sustained, rather than whether carers could be supported to better understand and respond to Ruth's distress. This links to the earlier commissioning analysis from paragraphs 5.4.15 – 5.4.25. Where domiciliary care providers are commissioned to support adults with complex trauma, mental health needs and suicide risk, there needs to be consideration of the support, training and supervision required to make that care sustainable. Sharing relevant information about trauma, relational distress, suicide risk and patterns of difficulty within care relationships when referrals or tenders are shared with potential domiciliary care providers may help clarify whether the domiciliary care provider has the capability to meet the adult's needs, and whether any pre-commencement or ongoing training, supervision or specialist advice is required to deliver the package safely and sustainably.
- 5.4.36 The PLE identified a potential system strength that could be built upon. Some agencies, particularly specialist mental health services, had greater knowledge and confidence in trauma-informed and relational practice. There may be an opportunity to use this expertise more effectively across the partnership, including with domiciliary care providers and voluntary sector organisations who may have frequent contact with people with complex needs but less access to specialist training and supervision. This could include shared formulation discussions, advice to domiciliary care providers, reflective spaces, or clearer routes for domiciliary care providers to seek guidance when relational dynamics are affecting the sustainability of a package.
- 5.4.37 Trauma-informed and relational practice cannot depend only on individual practitioners being skilled or compassionate. It needs to be supported organisationally through training, supervision, shared formulation, clear boundaries and access to specialist advice. In Ruth's case, the agencies with the most mental health expertise appeared better equipped to understand her presentation, but the carers providing daily support did not have the same level of confidence or support. This created a risk that Ruth's distress was experienced as behaviour to be managed, rather than as communication requiring understanding, boundaries and coordinated support.

Finding 7

Trauma-informed and relational practice was better developed in agencies with specialist mental health training, but less consistently available to the carers and support workers providing daily support. Although all partner agencies had access to OSAB's Trauma Informed Practice Guidance, this is unlikely to be sufficient by itself for staff working with Ruth's level of complexity. Practitioners, carers and support workers needed opportunities for shared formulation, reflective supervision and access to specialist advice to help them understand behaviour and distress, maintain boundaries and sustain care safely.

5.4.38 *Mental health pathways and support for clinical escalation*

- 5.4.39 Mental health pathways in the community and how agencies could access support when Ruth's mental health appeared to be deteriorating is an important area of learning, as Ruth was not consistently open to CMHT, despite having complex mental health needs, previous MHA detention, overdose risk, trauma, EUPD, C-PTSD, substance use concerns and repeated episodes of instability in the community.

5.4.40 PCFT's IMR confirms the criteria for CMHT input. This includes:

- People with complex mental health problems that cannot be managed in Primary Care and require health, social care and psychological interventions over weeks or months
- People with severe mental illness who are difficult to engage
- People with severe and enduring mental health problems requiring longer-term support, monitoring and review
- Severe and complex psychological difficulties including personality disorder
- Significant risk of self-harm and/or self-neglect
- Substance misuse with co-morbid severe and complex mental health problems
- Identified need and intervention that the CMHT can offer

5.4.41 It is recognised that eligibility for CMHT is not only based on diagnosis, complexity or risk. There must be a clear identified role for CMHT intervention, and some decisions made during the scoping period had clinical rationale at the time. The issue for this review is not simply whether CMHT should have held Ruth continuously. A better area of focus is whether the pathway provided sufficient continuity, clinical review and escalation when Ruth was discharged from inpatient care, when transfer to CMRT was unclear, and when relapse indicators later emerged in the community.

5.4.42 There were examples of good practice in this area. Following Ruth's discharge from hospital in December 2022, CMHT attended a joint visit with HTT and completed a full assessment with Ruth and her support worker present, evidencing good assessment, collaborative working and short-term intervention practice. MHLT was also used appropriately during the scoping period, including when Ruth presented in A&E and when she was on a physical health ward following overdose. There was evidence of appropriate escalation within MHLT and regular MDT discussion.

5.4.43 There was also evidence that active care coordination was effective when it was in place. The care coordinator supported Ruth to access outpatient appointments with her psychiatrist, identified practical risks within the care package, including care calls and medication timing not aligning with mealtimes, and recognised the implications this could have for Ruth's physical and mental wellbeing. The care coordinator also provided relational intervention, supporting Ruth to think about her interactions with carers and how different responses might help her get the support she needed. Tina also spoke very positively about Ruth's care coordinator and the positive impact that she had. This demonstrated the value of a role that could hold together clinical understanding, practical care arrangements and relational work.

5.4.44 However, there were also points where Ruth's pathway was less clear. During her next inpatient admission, in August 2023, the inpatient nurse consultant's judgement was that Ruth did not require CMHT support following discharge, but did require her package of care to be reviewed by the CMRT. Ruth's medication was to be locked away as part of her risk assessment and care plan, and this was linked to reducing risk of harm and relapse following hospitalisation. This therefore formed part of her s.117 aftercare.

5.4.45 Ruth was discussed at an internal CMHT pathways meeting in October 2023 and removed in November 2023 as "not for CMHT, needs referral to CMRT". PCFT's IMR identifies that there was no documentation on their clinical system evidencing that Ruth was opened to the CMRT function of CMHT, and that there was a breakdown of communication about the action for referral to CMRT. As a result of this review, PCFT has taken an agency action to address this. The Community Service Manager is reviewing the CMHT internal pathway process, with a focus on accountability, audit trail, attendance at pathway meetings, and clear ownership of agreed actions.

5.4.46 The above is significant because Ruth appears to have moved from inpatient care to community support without a clear period of active CMHT assessment or care coordination before the intended transfer to CMRT. PCFT's IMR concludes that, given Ruth's frequent contact with services and recent admissions under the MHA, it would have been good practice

for her to receive support and short-term intervention through the assessment or active care coordination function of CMHT on discharge, before transfer to CMRT. This would have allowed further assessment and review of Ruth's needs and risks, and would have tested whether the care package in place was sufficient.

- 5.4.47 The lack of a clear outcome following the December 2023 discussions between CMHT and ASC is also important. ASC questioned whether Ruth's case should be with CMRT or CMHT and advised that they were having difficulties managing her complex mental health needs. The community support organisation also appeared to believe Ruth had transferred to CMRT, which sat within the wider CMHT structure and included both PCFT and local authority practitioners. However, PCFT records did not evidence that she had been opened to CMRT. This meant that partner agencies were not working from a shared understanding of who was holding Ruth's mental health pathway, who could provide clinical advice, or how concerns should be escalated.
- 5.4.48 It should also be considered whether there should have been a clearer fast-track route back into CMHT input. Ruth had recently been discharged from inpatient mental health care, was entitled to s.117 aftercare, had known overdose risk and later showed indicators of deterioration in the community. In this context, requiring a further referral and waiting for assessment risked treating each episode as a new presentation, rather than recognising the continuity of risk and recent service history. Where a person has recently been known to CMHT or inpatient mental health services, and partner agencies identify relapse indicators or escalating risk, there should be a clear route for rapid clinical review without agencies having to rely on A&E, 999 or a standard referral pathway.
- 5.4.49 There were indicators of deterioration or relapse in the community. In December 2023, Ruth had trashed her flat and smeared faeces on the walls. In June 2024, there were concerns about disinhibition with carers. From late 2023 and throughout 2024, there were continuing concerns about medication safety and overdose risk. During 2024, these were accompanied by repeated domiciliary care provider instability and relational distress. These were not necessarily issues that required long-term CMHT care in isolation, but taken together, they should have prompted clear consideration of whether a faster route back into CMHT assessment, or another form of clinical escalation, was needed.
- 5.4.50 In January 2024, Ruth was referred to CMHT again, although PCFT's IMR notes that it was not known who made the referral due to an administration error. In February 2024, a CMHT duty practitioner was contacted after Ruth accessed the mental health helpline and her support worker from the community support organisation was worried about leaving her alone. The advice was to call an ambulance and for Ruth to attend A&E. PCFT's IMR concluded that face-to-face support from a CMHT practitioner would have been beneficial to assess and support Ruth and the support worker. This is an important point because it shows that the issue was not only whether Ruth met the criteria for ongoing CMHT allocation, but whether community agencies had timely access to clinical assessment and advice when risk escalated.
- 5.4.51 The PLE identified significant confusion among agencies about mental health pathways for people in the community. Practitioners understood that in an emergency they could call 999, and that a person could attend A&E and be assessed by MHLT. However, this is not always a proportionate or practical route, particularly where the concern is deterioration, relapse indicators, escalating distress or uncertainty about how to manage risk in the community. There was less clarity about what agencies should do when someone was not open to CMHT, when a previous referral had been declined, or when there were concerns that needed clinical advice but did not amount to an immediate emergency.
- 5.4.52 The PLE also explored whether other routes, such as talking therapies or neighbourhood mental health approaches, could have provided a pathway. PCFT practitioners advised that

emerging neighbourhood teams would be the entry route into IAPT⁵⁶ services, but that EUPD would have been an exclusionary factor. This illustrates the difficulty for people like Ruth. Her needs were too complex for some Primary Care or talking therapy pathways, but she was not always accepted for, or open to, CMHT support. This created a risk that community agencies were left trying to manage mental health deterioration without a clear clinical escalation route.

- 5.4.53 Ruth's experience reflects the kind of pathway gap that the national Community Mental Health Framework⁵⁷ sought to address, namely people whose needs are too complex for Primary Care or talking therapy pathways, but who are not clearly held by secondary mental health services. The Framework is considered further in Domain 5.
- 5.4.54 The current service context is also relevant, as locally there is a move away from the model in place during the scoping period, with CMRTs now being decommissioned and mental health social care increasingly being managed in-house by the local authority. The new Oldham mental health social work teams are working primarily with people supported by PCFT and fulfilling local authority statutory responsibilities for people with severe mental health needs. According to Oldham Council's Adult and Older Adult Mental Health Social Work Teams Standard Operating Procedure, duty pathways should operate alongside PCFT duty services, with both organisations maintaining daily contact and sharing relevant information. There should also be weekly joint team manager meetings between PCFT and Oldham Council to support communication, case transfers, escalation in relation to risk management and review of joint protocols.
- 5.4.55 Whilst these arrangements are positive, the separation of CMRT from CMHT and its return into local authority mental health social work teams also creates a potential risk if the interface between clinical mental health care and social care review is not clear. Ruth's case demonstrates why this matters. Her care package, medication safety arrangements and s.117 aftercare were not purely social care issues; they were linked to mental health relapse prevention, overdose risk and clinical formulation. If review functions sit separately from CMHT, there needs to be a clear and reliable route for clinical input, escalation and shared decision-making when mental health risk changes.
- 5.4.56 Community agencies need a clearer pathway for clinical advice and escalation when a person with complex mental health needs is deteriorating but is not open to CMHT, or where there is uncertainty about whether CMHT criteria are met. This does not mean that CMHT should hold every complex case indefinitely. However, where there are relapse indicators, recent detention under the MHA, s.117 aftercare, overdose risk, medication safety planning and domiciliary care provider instability, there should be a clear route for timely clinical review, shared formulation and decision-making about the right level of support.

Finding 8

Ruth's case highlighted a gap in mental health pathway clarity and clinical escalation for adults with complex mental health needs who are deteriorating in the community but are not clearly open to CMHT. Active care coordination was effective when in place. However, after her 2023 inpatient admission, the planned transfer to CMRT was not clearly evidenced and partner agencies were left unclear about who held mental health oversight or how to access timely clinical advice when relapse indicators, overdose risk and care package instability emerged.

⁵⁶ Improving Access to Psychological Therapies (IAPT) is a national healthcare initiative in England launched by the NHS designed to offer evidence based psychological therapies and guided self-help for individuals experiencing common mental health issues. See www.nhs.uk/tests-and-treatments/talking-therapies/

⁵⁷ NHS (2019) The Community Mental Health Framework for Adults and Older Adults. Available from www.england.nhs.uk/community-mental-health-framework-for-adults-and-older-adults.pdf

5.4.57 *Physical health pathways and pain management*

- 5.4.58 The review has already considered the impact of chronic pain on Ruth's mental health, distress and suicide risk. In this context, access to pain management was not a peripheral physical health issue; it was relevant to Ruth's overall wellbeing, risk formulation and care planning.
- 5.4.59 During the scoping period, inpatient clinicians identified that a referral to the pain clinic would be beneficial. However, this needed to be made through Primary Care and was requested via letter to the GP. The referral does not appear to have been actioned. This created a missed opportunity to support Ruth with an issue that was contributing to distress and may have interacted with her mental health, medication use and risk of overdose.
- 5.4.60 Following discussion with the ICB and NCA review panel members, the Author has been advised that pain is usually managed in Primary Care, with referral into specialist pain services considered by the GP when Primary Care options have been exhausted. The local pain management pathway includes tiered support, with specialist pain clinic input sitting within Pennine MSK Partnership⁵⁸ and using a multidisciplinary and holistic approach to pain management. The ICB also advised that a person's mental health needs to be stable prior to a referral into the specialist pain pathway being actioned. The Author therefore cannot conclude that the pain pathway itself requires review, or that mental health clinicians should routinely be able to refer directly into specialist pain services. However, Ruth's case does highlight the importance of partners understanding the local pain pathways, including what support is available at each tier, how referral is accessed, and how pain management links with mental health and risk.
- 5.4.61 Where a recommendation for specialist physical health input is made in an inpatient discharge letter, there also needs to be a reliable process for identifying, recording and following up the action in Primary Care. In Ruth's case, the issue appears to have been that the pain clinic referral recommendation was not followed up after discharge. This indicates that there is learning around the reliability of discharge letter follow-up and use of electronic patient records, rather than as evidence of a wider gap in pain management pathways.

Finding 9

Ruth's chronic pain was relevant to her mental health, medication use and suicide risk, but the recommendation for pain clinical referral following inpatient admission was not followed up in Primary Care. The local pain management pathway is GP-led, with referral into specialist pain services considered when primary care options have been exhausted and where mental health is stable. Ruth's case highlights the need for partners to understand the local pain pathway and for recommendations in inpatient discharge letters to be reliably identified, recorded and actioned where they are relevant to wider risk.

5.5 Domain 4: Governance

- 5.5.1 This domain considers how Ruth's review fits with existing OSAB learning and assurance activity. Several of the issues identified in this review overlap with themes from other OSAB SARs and action plans. SAR Jason⁵⁹ and SAR Lisa⁶⁰ both included learning and actions relating to TRAM, TAA, multiagency risk management and escalation. SAR John⁶¹ included actions relating to ASC triage, repeat referrals, discharge planning, information sharing and

⁵⁸ [Pennine MSK Partnership](#) provides community-based musculoskeletal services for patients of Oldham GPs, including persistent pain services. It aims to provide a holistic pathway in a community setting.

⁵⁹ [OSAB-SAR-Jason-Overview-Report.pdf](#)

⁶⁰ [OSAB-7-Minute-Briefing-Learning-from-Safeguarding-Adult-Reviews---Lisa.pdf](#)

⁶¹ [OSAB-SAR-John-Rapid-Review-Report.pdf](#)

the quality of referral information. SAR Aleina⁶² included learning relating to safeguarding escalation, MCA legal literacy, reflective application of learning and the duty to raise safeguarding concerns without delay.

- 5.5.2 It is important to recognise the timing of this review. Ruth's case took place during a period when some of those reviews and action plans were still being completed, developed or embedded. It would therefore not be fair to conclude that previous SAR learning had failed to change practice in Ruth's case. The more relevant governance point is that Ruth's review should be used alongside existing SAR action plans to inform OSAB's ongoing assurance work, particularly where similar themes recur across more than one review.
- 5.5.3 TRAM is the clearest example in Ruth's review. Previous OSAB work has already focused on embedding TAA processes and the TRAM protocol, including training, case studies, guidance updates and awareness-raising. OSAB's Second Annual Workforce Confidence Survey found that 37% of respondents in 2026 reported feeling very or quite confident in using the process outlined in the TRAM Protocol, a 3% increase from 2025. OSAB has recognised that embedding the cultural shift required by the TRAM Protocol remains an ongoing priority for partner agencies, particularly given staff turnover and the varying frequency with which different teams need to apply the protocol.
- 5.5.4 Since the TRAM protocol was introduced in 2022, the OSAB Policy, Procedure and Workforce Development Subgroup has undertaken work to support implementation. This has included seeking single-agency assurances, producing and updating guidance materials, including podcast episodes and simplified flowcharts, and delivering regular multiagency training. Embedding the TRAM protocol is a standing agenda item for the subgroup. More recent developments include a train-the-trainer model, publication of version 8 of the TRAM protocol in April 2026, and planned training for agency managers and senior leaders during 2026-27.
- 5.5.5 Ruth's review found that TAA was effective when used, but that TRAM was not consistently known by practitioners attending the learning event. This does not necessarily mean previous actions were ineffective, particularly given the timing of Ruth's case, other SAR action plans and ongoing OSAB implementation activity. However, it does support the need for OSAB to continue to seek assurance about current practitioner awareness, confidence and use of TRAM across the partnership.
- 5.5.6 The same principle applies to other overlapping themes, including information sharing, mental capacity, suicide prevention and escalation of complex risk. Ruth's review should not duplicate previous actions where those actions remain relevant, but it can help OSAB test whether those actions are now making a difference in practice.

Finding 10

Ruth's review identifies themes that also appear in other OSAB SARs, including TAA, TRAM, multiagency risk management, information sharing, mental capacity, suicide prevention and escalation. Some related SAR actions were completed, developed or embedded during or after Ruth's timeline, so Ruth's case should not be read as evidence that previous learning had failed to change practice. OSAB has also undertaken significant work to embed the TRAM protocol as outlined in paragraphs 5.5.3 – 5.5.4. However, the recurrence of similar themes means Ruth's review should inform OSAB's assurance about whether relevant learning is now embedded and making a difference for adults with complex and overlapping needs and risks.

⁶² [OSAB-7-Minute-Briefing---Learning-from-Safeguarding-Adult-Reviews---Aleina.pdf](#)

5.6 Domain 5: National Context

5.6.1 It is important to consider the wider national context relevant to Ruth's review and recognise that some of the issues identified sit within wider pressures affecting mental health services, ASC, medication safety, legal literacy and suicide prevention. These national issues do not remove the need for local learning, but they help explain why some parts of the system were difficult to navigate and why local responses need to be realistic, proportionate and sustainable.

5.6.2 *Community mental health*

5.6.3 Ruth's experience of mental health services in Oldham also needs to be understood in the context of national community mental health transformation. The Community Mental Health Framework⁶³ replaced the CPA for community mental health services, whilst retaining the principles of good care coordination and high-quality care planning. The Framework was intended to move away from disjointed and threshold-led models of care, and towards more integrated, place-based support that can respond to the whole person. The Framework describes a model aligned with Primary Care Networks and a focus on whole-person and whole-population approaches. This is relevant to Ruth because her needs did not sit neatly within one pathway. She needed mental health, physical health, social care, medication safety and voluntary sector support to work together.

5.6.4 The national Community Mental Health Transformation Programme⁶⁴ also explicitly recognises the gap between Primary Care and secondary mental health services. It identifies the risk that people with care needs can be excluded because they do not fit rigid service specifications or meet thresholds, and it specifically highlights the need to improve support for people whose needs are too severe for IAPT but not severe enough to meet secondary care thresholds, including people with complex mental health difficulties associated with personality disorders. This reflects a key issue in Ruth's review; her EUPD diagnosis would have excluded her from community IAPT services, but she was not always clearly held by CMHT. This created a risk that community agencies were left managing deterioration without a clear clinical escalation route.

5.6.5 The national direction of travel therefore supports the local learning from Ruth's review. The issue is not simply if Ruth met CMHT criteria at a particular point, but whether there was a clear way to step support up or down, avoid repeated referrals, and provide timely clinical review when risk changed. This is particularly important where someone has recently been discharged from inpatient mental health care, is entitled to s.117 aftercare, and has known overdose or suicide risk.

5.6.6 A further national report on supported housing and mental health⁶⁵ identifies the value of support providers having access to specialist mental health clinical input. Although the report focuses on supported housing rather than domiciliary care, one of its case examples (p.14) describes a support provider drawing on the clinical expertise of a CMHT, enabling a more consistent approach across services, helping the provider to understand and respond to individual needs, distress and relational complexity. This is relevant to the learning in Ruth's case because Finding 7 identifies the need for carers, support workers and voluntary sector practitioners to have access to shared formulation, reflective discussion, supervision, advice or case consultation when supporting adults with complex trauma, relational distress and suicide or self-harm risk.

⁶³ NHS England (2019) *The community mental health framework for adults and older adults*. Available from [the-community-mental-health-framework-for-adults-and-older-adults/](#)

⁶⁴ NHS England (2023) *Community Mental Health Transformation programme – NHS partnership working with the third sector*. Available from [nhs-england-community-mental-health-transformation-programme-nhs-partnership-working-with-the-third-sector/](#)

⁶⁵ Royal College of Psychiatrists et al (2026) *Breaking the Cycle: Supported Housing as an Enabler of Mental Health Hospital Discharge and Community Mental Health Service Delivery*. Available from [breaking-the-cycle-2026.pdf](#)

5.6.7 ***Domiciliary care market and workforce constraints***

5.6.8 This review has considered at length the commissioning and sustainability of Ruth's domiciliary care. The local learning was that repeated domiciliary care provider instability should have been treated as a marker of complexity and risk, not only as a brokerage issue.

5.6.9 There is also a wider national context. Domiciliary care is under significant pressure. National analysis identifies increasing demand, workforce shortages, funding pressures, and provider instability. CQC's State of Care report⁶⁶ describes a health and social care system under severe strain, with community services needing significant investment in capacity and capability if the national shift from hospital to community care is to be delivered. The report also identifies that homecare vacancy rates are more than double those in care homes, that some providers are handing back local authority contracts due to rising costs, and that insufficient homecare capacity can delay hospital discharge and affect people's health and wellbeing.

5.6.10 The Homecare Association's report⁶⁷ is more direct about the funding and commissioning pressures affecting the sector. It describes a national homecare funding gap of £3.25B, workforce shortages and commissioning practices that can focus on price rather than outcomes. It also highlights the dominance of framework and spot-purchase arrangements, which can make it difficult for providers to offer stable employment or build consistent teams. This matters for Ruth because the review has identified the importance of continuity, relational practice, trauma-informed support and staff confidence. These are difficult to achieve where care is commissioned and delivered within a pressured, fragmented and unstable market.

5.6.11 This national context does not mean local systems cannot improve. It does mean that recommendations about commissioning complex care need to be realistic. The learning from Ruth's review is not that an ideal provider could necessarily have been sourced, but when a care package repeatedly breaks down, this should trigger senior oversight, commissioning review and consideration of whether additional support, specialist advice, training or alternative models are needed.

5.6.12 ***Autonomy, capacity and suicide risk***

5.6.13 The review has also identified learning about how practitioners understood the balance between mental capacity, autonomy, human rights and foreseeable suicide or overdose risk, as discussed at paragraphs 5.2.28 – 5.2.34. Within the chronology, there was reference to the difficulty of intervening where Ruth had capacity and may be making unsafe choices, with concern about infringing her human rights. This was not an unreasonable concern. Practitioners were trying to balance lawful respect for autonomy with concern about risk. However, Ruth's case illustrates how easily 'having capacity' can be understood as limiting the scope for intervention.

5.6.14 The national legal and practice context is more complex than this. The presumption of capacity is a core principle of the MCA, but it is not a substitute for assessing capacity where there is a proper reason to do so, particularly in the context of suicide⁶⁸. Capacity is decision-specific and time-specific. In the context of suicide or overdose risk, practitioners need to consider not only autonomy under Article 8 European Convention on Human Rights (ECHR), but also the positive obligation to protect life under Article 2 ECHR where there is a real and immediate risk. The MCA framework outlines that capacity should not be judged in a broad sense, but what specific decision is being considered, whether the person can use and weigh the relevant information at the relevant time, and what lawful, proportionate and least restrictive steps remain available to reduce risk.

⁶⁶ CQC (2025) The state of health care and adult social care in England 2024/25. Available from www.cqc.org.uk/publications/state-care/2024-2025

⁶⁷ Homecare Association (2025) *The Homecare Deficit 2025*. Available from [The Homecare Deficit Report](http://TheHomecareDeficitReport)

⁶⁸ Ruck Keene (2021) *Capacity and suicide*. Available from www.mentalcapacitylawandpolicy.org.uk/capacity-and-suicide

5.6.15 This is consistent with findings from the second national analysis of SARs⁶⁹, which identified repeated difficulties in applying the MCA in complex cases. The national analysis found that practitioners sometimes misinterpreted the principle of unwise decision-making as meaning that intervention was not possible, even where the adult was exposed to extreme risk. It also identified the importance of considering executive capacity, fluctuating capacity, trauma, coercion, alcohol or substance use, and the person's ability to use and weigh information in practice.

5.6.16 Ruth's case fits within this wider learning. The issue was not that practitioners ignored autonomy but that they needed clearer support to navigate the space between autonomy and active duty of care, particularly where medication access formed part of a foreseeable overdose risk. This supports the findings in Domain 1 and the recommendation that multiagency medication risk guidance should include capacity, consent, human rights and foreseeable suicide or overdose risk.

5.6.17 ***Fragmented medication systems and medication safety***

5.6.18 Medication management in Ruth's case involved multiple agencies. It was identified in Domain 3 that medication changes were not always reflected promptly in GP prescribing, pharmacy arrangements were disrupted at points, and that domiciliary care provider administration concerns were not consistently brought together as one medication safety picture.

5.6.19 This also reflects a wider national issue about fragmented medical systems. Research⁷⁰ identifies that medicines and allergy information is often held in separate systems, including GP and hospital electronic medication records, and that it may be fragmented, stored in different formats, use different vocabulary, and sit in systems that do not connect. The research also identifies that mistakes can occur when medicines information transfers between settings, and that fragmented medication information can lead to clinically important medicines being omitted or given inappropriately.

5.6.20 This national context is directly relevant to Ruth. Her medication safety depended on accurate prescribing, dispensing, administration, storage, stock control, review and escalation. When medication changed in one setting but was not updated or communicated effectively across the wider system, risk increased. The national move towards a Single Patient Record⁷¹ is relevant because it aims to bring patient information together in one place to support safer, faster and more coordinated care. However, Ruth's case also shows that digital improvement alone will not be enough. Medication safety in complex community cases also requires clear ownership, timely communication, agency coordination extending beyond the NHS and escalation when concerns repeat.

5.6.21 ***Suicide Prevention***

5.6.22 Suicide prevention has been a central theme in this review. The national suicide prevention strategy for England⁷² is relevant because it frames suicide prevention as everyone's business and says that people outside mental health and suicide prevention roles should have the confidence and skills to play their part. This supports the learning in Ruth's case that domiciliary care providers, voluntary sector agencies, housing, primary care, mental health services and adult social care all had a role in recognising and responding to risk.

⁶⁹ Partners in Care and Health (2024) *Second national analysis of safeguarding adult reviews: Stage 2 analysis*. Available from [Second national analysis of SARs: Stage 2 analysis](#)

⁷⁰ Elliott et al (2023) Estimating the impact of enabling NHS information systems to share patients' medicines information digitally. Available from [Meds Interoperability full report Elliott et al 2023.pdf](#)

⁷¹ www.england.nhs.uk/digitaltechnology/the-single-patient-record/

⁷² DHSC (2023) *Suicide Prevention in England: 5-year cross-sector strategy*. Available from [suicide-prevention-strategy-for-england-2023-to-2028](#)

- 5.6.23 The strategy identifies a number of priority groups and risk factors, including people in contact with mental health services, people who have self-harmed, people affected by domestic abuse, physical illness, financial difficulty, alcohol and drug misuse, social isolation and loneliness, and domestic abuse. These are relevant to Ruth because her suicide risk was shaped by several interacting factors rather than by mental health diagnosis alone.
- 5.6.24 The strategy is also relevant to the review's analysis of domestic abuse, physical pain and medication. It recognises the link between domestic abuse and suicide, including evidence that suicide attempts are more common among victims of intimate partner violence. It identifies physical illness as a suicide risk factor and states that people seeking help for physical illness need support for both their physical and mental health needs. It also identifies reducing access to means and methods of suicide as a priority, including safe prescribing and reducing risks associated with certain medicines. These points align with the review's findings about Ruth's domestic abuse history, chronic pain, overdose risk and the need for a clearer multiagency approach to medication safety.
- 5.6.25 The strategy is particularly relevant to the review's consideration of mental capacity, autonomy and duty of care. Professor Sir Louis Appleby states in the foreword that mental health patients at risk of suicide should not be denied support because of assumptions about mental capacity or impulsiveness. This supports the learning in Domain 1 that 'having capacity' should not be understood as meaning there are no lawful or proportionate steps available to reduce foreseeable suicide or overdose risk.
- 5.6.26 Lastly, although this was not a central theme in Ruth's review, it is notable that the national strategy does not make specific reference to faith or religion. This is a gap because faith may be protective for some people, a source of identity and support, or a factor influencing how distress, suicide, shame, help-seeking and bereavement are understood. Ruth's identity and faith were considered within the review, and this reinforces the importance of local suicide prevention work being culturally competent and attentive to faith, even where national strategy does not explicitly develop this issue.

6. CONCLUSION

- 6.1 Ruth was known to a number of agencies during the scoping period and there was evidence of committed, persistent and person-centred practice. The community support organisation provided consistent relational support, responded to Ruth's wishes for female support workers, supported her to receive a DVDS disclosure, and shared concerns with statutory partners. FCHO listened to Ruth's wish to move from accommodation associated with abuse and facilitated a managed move. ASC coordinated care and safeguarding activity at key points, including through earlier TAA arrangements, care package planning and responses to safeguarding concerns. Domiciliary care providers gave daily support in difficult circumstances, and there were examples where carers and managers sought advice, raised concerns and tried to respond to practical risks such as missed medication or difficulties during care calls.
- 6.2 There were also examples of effective interagency working and reflective practice. There was a coordinated multiagency response to domestic abuse risk at points, including use of MARAC, TAA, safeguarding processes, housing liaison and consideration of disruption and enforcement options in relation to P. Police supported Ruth to receive the DVDS disclosure in a planned way and responded to incidents where immediate safety concerns were raised. There were examples of good communication within Health services, including between PCFT, NCA, Primary Care and MHLT. The GP attended the PLE and was candid and reflective about their involvement, including recognising that they could have been clearer with Ruth about the implications of repeatedly changing pharmacy and how this may affect medication continuity. When Ruth had an active care coordinator, this was effective in supporting her to attend outpatient appointments, identifying practical risks in the care package, and providing relational intervention to help Ruth think differently about some of her interactions with carers. The community support organisation and Ruth's care coordinator also responded jointly when she

disclosed possible exploitation by neighbours in August 2024, planning and completing a joint cold call visit the following day to check on her safety.

- 6.3 However, the review found that these strengths were not always held together by a sufficiently coordinated system. Ruth's risks were cumulative and interconnected. Her mental health, trauma, domestic abuse history, physical pain, possible exploitation, medication access, domiciliary care provider instability, housing, capacity and suicide risk all interacted with each other. Agencies often recognised individual concerns, but the system did not always have a clear mechanism for bringing those concerns together, reviewing them cumulatively and agreeing who was responsible for coordinating the response.
- 6.4 Medication was a significant example of this. Ruth's medication arrangements were intended to reduce a known overdose risk, but over time they became a complex multiagency risk management issue. Concerns about prescribing, administration, storage, access to the medication safe, stockpiling, missed or unsupervised doses, changes in mental state and pharmacy arrangements, were not consistently drawn together into one shared medication safety plan. Practitioners were also trying to balance Ruth's capacity, autonomy and human rights with a foreseeable risk of suicide or overdose but did not have a clear shared framework to support this decision-making. Alongside this, delays in updating GP prescribing, pharmacy disruption and domiciliary care provider administration concerns showed that the wider organisational arrangements around medication were not robust enough. These issues led to **Findings 1, 2 and 5**, and support the need for a multiagency medication policy or guidance for complex community cases.
- 6.5 The review also found that Ruth's trauma-related needs and expressed wishes were not always consistently reflected in how commissioned care was planned, communicated and delivered. There were examples of good trauma-informed and person-centred practice, particularly from the community support organisation, FCHO and PCFT, but Ruth's preference for female carers, especially for personal care, was not consistently recorded, communicated or assured across care arrangements. Ruth also experienced repeated changes of domiciliary care provider. This should have been recognised as a marker of complexity and risk, not just a brokerage issue. These issues led to **Findings 3 and 6**, supporting the need to strengthen how complex domiciliary care is commissioned, reviewed and escalated when domiciliary care provider instability emerges.
- 6.6 TRAM provided a useful structure for coordinating complex multiagency risk, and TAA was effective when used earlier in Ruth's case. However, awareness and use of TRAM did not appear to be consistent among practitioners who attended the learning event. There was also a practical barrier for agencies who may have wanted to initiate TAA but did not know which other professionals or services were involved. Similar themes about TAA, TRAM, escalation and multiagency risk management have appeared in previous OSAB SARs, although some related actions were completed, developed or embedded during or after Ruth's timeline. Ruth's case should not therefore be read as evidence that previous learning had failed to change practice, but it does support the need for continued assurance that TRAM is now understood and used across the partnership. This led to **Findings 4 and 10**, which support a recommendation to review the TRAM protocol so that it includes a clear mechanism for agencies to confirm current professional involvement and seek assurance that the revised process is understood by partner agencies.
- 6.7 The review also identified that trauma-informed and relational practice was not equally available across the system. Specialist mental health services appeared more confident in understanding Ruth's trauma, EUPD, distress and relational behaviour, but carers and support workers providing daily support did not appear to have the same level of training, reflective supervision or access to specialist advice. This is not a criticism of individual carers. It reflects the reality that non-specialist staff were being asked to support someone with complex trauma, mental health needs and suicide risk without always having the tools or support to do so. This led to **Finding 7**, and an opportunity to build on existing strength by considering how specialist mental

health advice, formulation and reflective support can be made available across the partnership, including to support domiciliary care and third sector partners working with shared cases.

- 6.8 Mental health pathway clarity was another important area of learning. Active care coordination was effective when in place, but after Ruth's 2023 inpatient admission, the planned transfer to CMRT was not clearly evidenced and partner agencies were left unclear about who held mental health oversight or how to access timely clinical advice when relapse indicators, overdose risk and care package instability emerged. This led to **Finding 8**, and supports a recommendation for PCFT, ASC and relevant health partners to provide clearer routes for clinical advice, escalation and rapid review where adults with complex mental health needs are deteriorating in the community but are not clearly open to CMHT.
- 6.9 Ruth's chronic pain was also relevant to her mental health, medication use and suicide risk. A pain clinic referral was recommended following mental health inpatient admission, but this does not appear to have been actioned in Primary Care. Following clarification from the ICB and NCA, the learning is not that the pain pathway itself requires review, but that partners need to understand the local pain management pathway and that recommendations in inpatient discharge letters need to be reliably identified, recorded and followed up in Primary Care where they are relevant to wider risk. This led to **Finding 9** and supports a recommendation for the ICB to share the local pain management pathway with relevant partners, and seek assurance that the learning about follow-up of discharge letter recommendations has been considered by the GP practice.
- 6.10 Overall, this review is not about one missed opportunity or one agency response. It is about how systems recognise and hold cumulative risk when an adult's needs do not sit neatly within one pathway. The recommendations are intended to strengthen the existing local system by improving medication safety, TAA processes and the TRAM protocol, commissioning oversight, access to specialist mental health advice and formulation, clinical escalation, trauma-informed support, and understanding of pain management pathways. They also build on existing OSAB work, particularly in relation to TRAM, escalation and multiagency risk management, where Ruth's review can support assurance that learning is understood and applied in practice.

7. RECOMMENDATIONS

- 7.1 The findings from this review have been converted into recommendations that are designed to be practical, proportionate and capable of improving safeguarding practice across the partnership. Themes from previous relevant reviews have been taken into account to ensure recommendations build on existing learning rather than repeat it.

Recommendation 1 (in response to Findings 1, 2 and 5):

- 7.2 Relevant partner agencies should develop multiagency guidance for medication management in complex community cases where medication forms part of a risk management plan. This should include cases involving known overdose risk, fluctuating mental state, multiple prescribers, domiciliary care involvement, medication storage controls, stockpiling concerns, missed or unsupervised administration, changes in medication across care settings, and changes or limitations in pharmacy dispensing arrangements.
- 7.3 The guidance should clarify roles and responsibilities, communication of medication changes, review triggers, escalation routes, and how practitioners should consider capacity, consent, autonomy, human rights and foreseeable risk where medication access forms part of a safety plan. It should also clarify how known suicide or overdose risk should be flagged to prescribers and other practitioners involved in medicines support, regardless of healthcare setting, and should take account of relevant local, Greater Manchester or national guidance and good practice on safer prescribing and dispensing.
- 7.4 The guidance should build on and refresh OSAB's existing procedure on when to consider raising a safeguarding concern following a medication error.

- 7.5 As part of this work, the ICB medicines optimisation and pharmacy functions should consider whether Ruth's case identifies any wider learning about community pharmacy involvement, communication, escalation or signposting where overdose risk is known, and whether any learning should be reviewed and shared with relevant partners. This should include how community pharmacy interfaces with local safeguarding, suicide prevention and neighbourhood mental health arrangements.

Recommendation 2 (in response to Findings 3 and 6):

- 7.6 OSAB should seek assurance from ASC commissioning, quality, care provisioning and operational services that care packages for adults with complex mental health, trauma, suicide risk and safeguarding needs are commissioned, matched, quality assured and reviewed in a way that reflects the level of complexity and risk. This should include how domiciliary care provider capability, workforce training, relational continuity, trauma-informed preferences, risk information-sharing and escalation triggers are considered at tender, care matching and quality monitoring, and Care Act review or reassessment stages.
- 7.7 This assurance should include how repeated domiciliary care provider concerns, domiciliary care provider notice, placement breakdown or difficulty sustaining a package are treated as indicators of complexity and risk, and are used to review whether the commissioned care model remains suitable, sustainable and sufficiently supported for the adult's needs.
- 7.8 This should also include how commissioning expectations align with Oldham's Suicide Prevention Strategy where domiciliary care providers are commissioned to support adults with known self-harm, suicide or overdose risk. OSAB should share this learning with the Suicide Prevention Board so that consideration can be given to whether expectations for commissioned domiciliary care providers should be reflected in the next suicide prevention strategy, delivery plan or associated assurance arrangements.

Recommendation 3 (in response to Finding 4 and 10):

- 7.9 OSAB should review the TRAM protocol to ensure it includes a clear mechanism for agencies to confirm which professionals and services are already involved with an adult where this information is not known and is needed to support multiagency risk management. This should include consideration of how such requests are made, who can receive and respond to them, what information can lawfully be shared, and how this process can support timely convening of a TAA.
- 7.10 As part of this process, OSAB should take account of previous SAR learning and existing TRAM implementation activity, and seek assurance that the revised process is understood by statutory, voluntary and commissioned domiciliary care provider agencies.

Recommendation 4 (in response to Finding 7):

- 7.11 OSAB should work with PCFT, ASC and relevant partner agencies to consider how specialist mental health advice, formulation and reflective support can be made available to domiciliary care, voluntary sector and other partners working with adults with complex trauma, relational distress and suicide or self-harm risk.
- 7.12 This should focus on case-specific support where agencies are working with the same adult, rather than a generic training offer alone. It should include consideration of shared formulation, reflective discussion, case consultation, supervision or advice, and how these could link with existing local pathways, multiagency risk forums or specialist mental health resources where relevant.
- 7.13 In developing this approach, OSAB may wish to draw on relevant models used in other areas where support domiciliary care providers have access to specialist mental health clinical input to help them understand and respond to individual needs, distress and relational complexity.

Recommendation 5 (in response to Finding 8):

- 7.14 OSAB should seek assurance from ASC, PCFT, NCA, Primary Care and relevant health partners that local mental health pathways provide clear routes for clinical advice, escalation and rapid review when adults with complex mental health needs are deteriorating in the community but are not open to CMHT. This should include the interface between CMHT and local authority mental health review functions, clarity about service thresholds, whether there are any gaps for adults whose needs do not meet CMHT criteria but still require timely clinical advice or review, use of a fast-track route back into CMHT assessment where risk escalates, and clarity for partner agencies about who is holding mental health oversight.
- 7.15 This assurance should include how pathways respond to adults with diagnoses such as EUPD, complex trauma, co-occurring substance use, sustained suicidal ideation or repeated overdose risk, where the person may not require long-term CMHT care but may still need timely formulation, clinical advice, short-term intervention or escalation when risk changes.

Recommendation 6 (in response to Finding 9):

- 7.16 The ICB should share the local pain management pathway with relevant partners, including Primary Care, NCA, PCFT and ASC, so that agencies understand how pain is managed across the pathway, what support is available at each tier, and how referral into specialist pain services is accessed.
- 7.17 The ICB should also seek assurance from the GP practice involved in Ruth's care that the learning has been considered about how requests or recommendations in inpatient discharge letters, including requests relating to pain clinic referral, are identified, recorded and followed up.

Appendix A

Mapping the KLOE to the SAR Five Domains Framework

The table below shows how the ten KLOE agreed in the Terms of Reference have been addressed through the SAR Five Domains analytical framework. Some KLOE map to more than one domain because the issues in Ruth's case were interconnected. The mapping is intended to show the analytical route from the original enquiry questions to the report findings. It does not mean each KLOE is considered only within one domain; rather, the domains provide a structured way of presenting the cross-cutting learning arising from the review.

KLOE	Summary focus of KLOE	Primary Domain	Secondary Domain(s)	Rationale
1	Understanding Ruth's mental health, physical health, exploitation, vulnerability & how this influenced risk assessment and care planning	Domain 1: Direct Work	Domain 3: Organisational Support for Practice Domain 5: National Context	This is the broadest KLOE & is reflected across the report. Domain 1 considers how Ruth's lived experience, trauma, domestic abuse, pain, medication risk & suicide risk were understood. Domain 3 considers how this translated into pathways, care coordination, medication arrangements & pain management. Domain 5 provides national context around community mental health, fragmented systems & suicide prevention.
2	Domestic abuse, coercive control & associated risks. How vulnerability shaped understanding & response	Domain 1: Direct Work	Domain 5: National Context	Domestic abuse is mainly analysed in Domain 1, including its impact on Ruth's trauma, accommodation, dignity, safety & suicide risk. Domain 5 provides national suicide prevention context, including the link between domestic abuse & suicide risk
3	Mental health pathways, CMHT eligibility and service thresholds	Domain 3: Organisational Support for Practice	Domain 5: National Context	This KLOE focused on CMHT/CMRT, clinical escalation, active care coordination, fast-track access & partner confusion when Ruth was not clearly open to CMHT. Domain 5 links this to the Community Mental Health Framework & the national gap between primary care/talking therapies & secondary mental health services.
4	Statutory duties, Care Act, Human Rights Act/ECHR, MCA, MHA, s.117 aftercare & community mental health arrangements	Domain 1: Direct Work	Domain 3: Organisational Support for Practice Domain 4: Governance Domain 5: National Context	The MCA/human rights/suicide risk analysis sits primarily in Domain 1. Section 117 and CMHT/CMRT pathway issues sit in Domain 3. Domain 4 considers whether previous SAR learning about MCA & escalation is embedded. Domain 5 gives national legal & policy context, including autonomy, Article 2 and suicide risk.

5	Deterioration, medication risk, support gaps, escalation & governance	Domain 3: Organisational Support for Practice	Domain 1: Direct Work Domain 4: Governance	Medication risk is analysed in Domain 1 as suicide/overdose risk & in Domain 3 as a complex organisational system involving prescribing, dispensing, administration, storage & safeguarding escalation. Domain 4 considers governance & assurance, including whether medication-related safeguarding concerns are recognised cumulatively.
6	Care coordination, lead professional role, TAA/TRAM & multiagency forums	Domain 2: Interagency TAA	Domain 3: Organisational Support for Practice Domain 4: Governance	Domain 2 considers TAA, TRAM, & multiagency risk management. Domain 3 considers care coordination & mental health oversight. Domain 4 considers whether previous SAR learning about TRAM & multiagency risk management is embedded in practice.
7	Medication needs across agencies, including prescribing, administration, supervision, storage, & governance	Domain 3: Organisational Support for Practice	Domain 1: Direct Work Domain 4: Governance	Domain 1 addresses overdose risk, capacity, autonomy & duty of care. Domain 3 addresses the medication system across GP, PCFT, NCA, pharmacy, domiciliary care provider, ASC & the community support organisation. Domain 4 considers whether existing OSAB medication-error safeguarding guidance is understood and applied.
8	Commissioning, care brokerage, domiciliary care provider capability, suitability and instability	Domain 3: Organisational Support for Practice	Domain 1: Direct Work Domain 5: National Context	Domain 3 considers repeated domiciliary care provider changes, commissioning oversight & domiciliary care provider capability. Domain 1 includes Ruth's trauma-related preference for female carers & whether this was embedded in care planning. Domain 5 considers wider domiciliary care market & workforce pressures.
9	Trauma, EUPD/C-PTSD, relational practice, organisational culture, workforce capability & supervision	Domain 3: Organisational Support for Practice	Domain 1: Direct Work	Domain 1 considers trauma-informed practice from Ruth's perspective, including female carers, DVDS support & the managed move. Domain 3 considers whether carers & support workers had the training, supervision, formulation & specialist advice needed to sustain relational practice.
10	Identity, faith, poverty, housing, social circumstances & intersecting vulnerabilities	Domain 1: Direct Work	Domain 5: National Context	Domain 1 considers Ruth's identity, faith, domestic abuse, accommodation, dignity, pain & intersecting risks. Domain 5 adds national suicide prevention context, including the limited explicit reference to faith or religion in the national strategy and the need for culturally competent local practice.

Appendix B

Medication found in Ruth's property during police investigation

The below should be read in conjunction with paragraph 5.4.9.

Tegretol tablets 100mg

X5 empty blister packets. Each packet contained x 14 tablets.

Co-Dydramol tablets 10mg/500/mg

X1 blister packet of x 4 tablets – empty

X9 blister packet of x 10 tablets – empty

X1 blister packet of x 10 tablets – 9 missing

**There were also 2 empty boxes which state dates of issue – 17.7.24 and 02.08.24

Weekly Issue medication Box 1 –

Issued on 06.08.24. Box was completely empty. When issued would have contained –

Mirabegron 50mg x 7

Montelukast 10mg x 7

Naproxen 500mg x 14

Omeprazole 40mg x 7

Peppermint oil 0.2mg x 42

Weekly Issue medication Box 2 –

Issued on 06.08.24. Box was completely empty. When issued would have contained –

Zopiclone 7.5mg x 7

Melatonin 2mg x 7

Phenergan 25mg x 14