CONFIDENTIAL

Rochdale Adult Safeguarding Board

Tameside Adult Safeguarding Board

SERIOUS CASE REVIEW / SAFEGUARDING ADULT REVIEW

Overview Report of Mr M.

Date of birth 1.4.56

Date of death 1.3.14

Aged 57

1. Introduction

1.1. This document provides an overview of the deliberations and recommendations of the serious case review / safeguarding adults review panel, set up jointly by Rochdale Safeguarding Adults Board and Tameside Safeguarding Adults Board, following the death on 1st March 2014 of Mr M in a fire in a guest house in Tameside. The fire was thought to have been started deliberately and all the other residents escaped. Two people have been arrested and are now awaiting trial in connection with Mr M's death.

1.2. A safeguarding adults review is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help improve the safeguarding and wellbeing of vulnerable adults in the future. The particular issues in this case were whether the various agencies acted together effectively to manage both the risk that Mr M posed to others (specifically to children and young people), and the risk that others might pose to Mr M, taking into account his profile of offending and his own vulnerabilities.

1.3. This safeguarding adults review has been undertaken in line with the policy for Rochdale Borough Safeguarding Adults Board (RBSAB), and will be presented to the Safeguarding Adults Boards of both Rochdale and Tameside.

1.4. The overview report brings together, and draws overall conclusions from, the information and analysis contained in the individual management reviews and other reports provided by relevant parties.

1.5. The agencies who have contributed to the review are as follows:

Rochdale Adult Care
Tameside Adult Social Care
Greater Manchester Police
Greater Manchester Probation Service
Greater Manchester Fire and Rescue Service
Heywood, Middleton and Rochdale Clinical Commissioning Group
Pennine Acute NHS Foundation Trust
Pennine Care NHS Foundation Trust
Shelter
Stepping Stones
Rochdale Strategic Housing
Rochdale Boroughwide Housing

These agencies have all contributed Individual Management Reports and have been represented on the Panel.

1.6. Mr M's family were approached to inform them of the review and to offer them the opportunity to contribute to the report. The family have declined this offer.

2. Background to the case

2.1. Mr M was a White British man, and was 57 years old at the time of his death. He was originally from Rochdale and was temporarily housed in Tameside. Mr M was a sex offender, who had been imprisoned for his offences. He was released from prison on 31st May 2013 and at that point was subject to Multi-Agency Public Protection Arrangements. He was considered to be at high risk of reoffending, and was also vulnerable due to a number of health issues, which included longstanding alcohol abuse (although he was apparently abstinent at discharge from prison) and epilepsy resulting from a head injury in 2005. Assessments carried out on a number of occasions found that he did not meet the criteria for services from either Rochdale Adult Social Care or from secondary mental health care services. He was eligible for support from universal, prevention and primary care services.

2.2. He was estranged from his family and was homeless at the time of his release from prison. Finding appropriate housing for Mr M was difficult as due to the nature of his offences he needed to be housed away from schools and play areas; he was also prone to disclose his offending behaviour to others, which put him at risk. At the time of his death he was living in a guest house in Tameside and was waiting to take up a tenancy in a single person flat.

2.3. At his release from prison he was provided with support from Shelter to assist him in accessing housing, and this was then formalised into low level support from Shelter's Floating Offender Support Service, to support him into independent living, supplemented by support from the Stepping Stones' Substance Misuse Floating Support Service to work on his substance misuse. This package of care, commissioned by Rochdale Adult Care (Prevention services) was set to continue once he was living independently, although as this service is normally only provided for 6-12 months it was not expected to continue indefinitely.

2.4. Mr M was subject to MAPPA process and the group met monthly until 6th January, when the decision was made to close the MAPPA process and manage the case through lead professionals' meetings. Much of the focus of

the MAPPA meetings was on securing appropriate accommodation for Mr M, some effort seems also have gone into seeking further assessments in the hope that he would meet the criteria for more specialist services (and thereby allow access to additional funding.) Mr M's own vulnerability seems not to have been formally assessed.

2.5. At his release from prison Mr M started to use alcohol heavily; while homeless (from 31st May 2013 – 21st June 2014) he attended A&E or urgent care centres on five occasions, often due to fits or falls after drinking. Once he was in accommodation his attendances at A&E reduced, with one attendance in each of July, August, September and November but he went missing from the accommodation on 4 occasions in July, August and September. Two of these were quite lengthy episodes as he was missing for 6 days at the end of August, and 10 days in mid-September. The number of occasions that he went missing or attended hospital reduced between October-February; instead the support workers were noting increasing concerns about possible physical and financial abuse of Mr M.

2.6. During the time he spent at Guest House 2 (GH2), from August 2013 to February 2014, the support workers noted their concerns about Mr M's vulnerability on a number of occasions, in particular their concern that he was suffering both financial and physical abuse. No formal safeguarding referral was made until 7th February 2014, when Shelter faxed a safeguarding alert to Adult Social Care at Rochdale Borough Council. This referral did not result in any assessment of Mr M and his safeguarding needs.

2.7. At the MAPPA meeting on 6th January 2014 it was agreed that Mr M's case would be managed through lead professionals' meetings, with the police as the lead agency. The first such meeting was held on 27th February 2014; it focussed on the plans for Mr M's planned move to independent accommodation, as an appropriate flat had been identified and was undergoing repair prior to Mr M moving in. The safeguarding alert was not discussed.

2.8. On the afternoon of 1st March 2014 there was a fire at GH2, and Mr M was found dead.

3. Circumstances that led to a Safeguarding Adult review being undertaken in this case

3.1 It was decided to ask for a safeguarding adult review into this case for the following reasons:

- concerns about the management of the safeguarding referral both within Tameside and Rochdale MBC, and with the process from the referring agency
- Mr M had been subject to MAPPA proceedings: was this process effective in the management of MR M and should it have been supplemented (or replaced) by any other process?
- Mr M had particular vulnerabilities that led to him putting himself at risk from others (including, but not limited to, his tendency to disclose that he was a sex offender). How far did agencies have a duty to protect Mr M and how much personal responsibility did he need to take for his behaviour?
- How were Mr M's mental health and cognitive functioning assessed and did agencies act in accordance with the results of these assessments?

3.2 This safeguarding adult review will focus on:

- how the need to protect others from Mr M was balanced against the need to protect Mr M from others
- the quality of the planning prior to Mr M's release from prison on 31st May 2013
- the effectiveness of the MAPPA process in this case
- the effectiveness of the lead professional process
- the effectiveness of the support package
- how Mr M's brain injury and alcohol use affected him and how agencies responded to this
- the quality of safeguarding support offered to Mr M throughout the review period
- the relationship between specialist and secondary care services, and primary care / universal / preventative services in this case. This includes particular consideration of the role of housing, health care and social care services
- The circumstances and the processes followed in relation to the referral made on 7th February 2014

3.3 The request to carry out a safeguarding adults review was made by the Interim Assistant Director within Rochdale Adult Social Care on 10th March 2014. A Safeguarding Adults Review panel held on 17 March 2014 recommended that the case proceed to safeguarding adults review, and this was agreed by the Chair of RBSAB on the same day. Although Mr M was a resident of Tameside when he died, it was recognised that Rochdale Borough Council had been responsible for his care provision, and because there had been

discussion between Tameside and Rochdale over the safeguarding referral made by Shelter with regard to Mr M, it was agreed that the serous case review would be commissioned by Rochdale Safeguarding Board on behalf of both Rochdale and Tameside Safeguarding Adult Boards, and that it would report to both Boards.

3.4 Rochdale Borough Safeguarding Adults Board sent out an advertisement to all relevant contacts, asking for expressions of interest for chairing and authoring the review. The independent Chair/author selected was Eleanor Roaf, a freelance Consultant in Public Health. She worked for the NHS for over 20 years, including 5 years as Director of Public Health for North Manchester PCT. She is a Fellow of the Faculty of Public Health and is included on the UK Public Health Register. She has considerable experience in safeguarding, having been the NHS Manchester Safeguarding Children lead for eight years and the Deputy Chair of the Manchester Safeguarding Children Board for seven years. She chaired East Cheshire's Safeguarding Children Board from 2011-12.

3.5 The time period over which events were reviewed was **from 1st March 2013 to 1st March 2014,** when Mr M passed away in Tameside. However the review panel also took into consideration synopses of involvement prior to this period which were supplied by Pennine Care NHS Foundation Trust and the Greater Manchester Probation Trust.

4 Terms of reference

The following Terms of Reference form the basis for the review:

1. Are there are lessons to be learnt from the circumstances of this case about the way in which professionals and agencies worked to safeguard Mr M?

    i. From a single agency point of view

    ii. From a multi-agency point of view

2. Identify key strengths and weakness in agencies' involvement with Mr M.

3. Could agencies have communicated and shared information about Mr M's circumstances, risks and vulnerabilities more effectively?

4. Were legal processes appropriately followed and was the legal decision-making in relation to vulnerability and risk robust?

5. Were criteria regarding access to and provision of services appropriately applied, and could these criteria have posed particular issues for people who have chaotic lifestyles?

6. Identify the policies and procedures that were used in the service provision to Mr M in relation to the risk to him and others and whether staff were compliant with these policy and procedures?

7. What actions, if any, are being taken to close any identified short comings in policies and procedures relating to this case?

8. Are there are any equality, diversity or cultural issues that have impacted on the safeguarding of Mr M?

C. As an outcome from the Safeguarding Adults Review –

   a. The Safeguarding Adults Review will make recommendations to improve inter agency working to better safeguard adults at risk.
   b. For the Safeguarding Adults Review to make recommendations that may better support adults at risk who don't meet the eligibility criteria for adult care services.

5. Process of the Serious Case Review/ Safeguarding Adults Review

5.1 The Independent Chair met the Safeguarding Leads for Rochdale and Tameside on 6th May 2014 to agree the outline of the review and to draft the terms of reference. The first Panel meeting was held on 13th May 2014, and this meeting endorsed the terms of reference for the review. Subsequent Panel meetings were held on 24th July 2014 and 10th September 2014.

5.2 The review was undertaken by a Safegaurding adults review Overview Panel, chaired by an independent person. The panel consisted of the following representatives:

Interim Assistant Director, Rochdale Adult Care,

Assistant Executive Director, Tameside MBC,

Head of Sex Offender Management Unit, Greater Manchester Police,

Assistant Chief Executive, National Probation Service North West Division

Community Safety Manager, Greater Manchester Fire and Rescue Service,

Named Nurse, Adult Safeguarding, Heywood, Middleton and Rochdale Clinical Commissioning Group,

Named Nurse, Safeguarding Adults, Pennine Acute NHS Foundation Trust,

Team Manager, Community Mental Health Team, Pennine Care NHS Foundation Trust,

Strategic Housing Manager, Rochdale Strategic Housing,

Head of Access and Tenancy Support, Rochdale Boroughwide Housing.

Business Support Manager, Shelter,

Service Development and Performance Manager, Stepping Stones,

In attendance:

Head of Safeguarding and Practice Assurance, Rochdale Borough Safeguarding Adults Board

Safeguarding Adults Co-ordinator, Tameside Safeguarding Adults Board

Secretariat support was provided by the Rochdale Borough Safeguarding Business Unit.

5.3. At the first Panel meeting on 13th May 2014, a discussion was held as to whether and how to include Mr M's family members in the process. It was agreed that as the Police had contact with the family, the relevant Police Family Liaison Officer would be asked to contact the family to let them know the purpose of the review and to ask them if they like to contribute to the process. If they wished to participate, it was agreed that the Independent Chair/Author would meet the family so that their information could be included in the review.

5.4. The family declined to be involved in the process.

5.5 The twelve agencies represented on the panel contributed to the combined chronology and provided individual management reports. These reports (with the exception of the report from the Probation service, which was received on 31st July 2014) were submitted in draft form prior to the Panel meeting on 24th July 2014. At this meeting the combined chronology and the IMRs were discussed and all agencies were sent further comments on their IMRs by the Independent Chair/Author on or before 1st August, with a request for a return of the amended IMRs by 15th August 2014. All agencies, with the exception on Probation, achieved this.

5.6 An additional meeting was held on 30th July 2014 between the Independent Chair/Author and representatives from Tameside Adult Social Care (TASC), Rochdale Adult Care and Shelter to discuss discrepancies in the accounts of the events following the safeguarding alert made by Shelter on 7th February 2014. Additional meetings were also held with Probation staff to clarify aspects of their input to the case.

5,7 A third panel meeting was held on 10th September 2014. At this meeting, the draft Overview Report was discussed, together with the draft single and multi-agency recommendations. Following this discussion, all agencies agreed to review their own

recommendations and return revised versions by 19th September. The Head of Safeguarding and Practice Assurance, Rochdale Adult Care, together with the Independent Author/Chair, then revised the recommendations to the Safeguarding Boards in the light of the comments made. Some amendments were agreed to the Overview Report, and the report, together with the recommendations, was circulated to the members of both Rochdale Borough and Tameside Safeguarding Adults Boards, prior to the presentation to the Boards on 1st October 2014.

6. Facts of the Case

6.1 Brief background to the case and to agencies' involvement prior to the period covered by this review

6.1.1 Mr M was born in 1956 into a large family in Rochdale. It was recorded that both his parents misused alcohol, that his father was violent, that he himself misused alcohol from the age of 19 and that his alcohol misuse was a major factor in the breakdown of his marriage. In 2003 he was convicted of sexual assault of a child under the age of 16, and he re-offended in 2004, and received a prison sentence.

6.1.2 In 2005 he was diagnosed with a traumatic head injury after being witnessed falling (this followed a number of other head injuries caused by falls, and including being knocked over by a car when intoxicated by alcohol). He had neurosurgery in 2005 and was an inpatient on a neuro-rehabilitation unit between September 2005 and March 2006. During this time he showed significant clinical improvement in his motor and memory function and on discharge he was felt to be independent for all personal care, domestic activities and daily living as well as mobility. He retained full capacity and a good level of cognitive functioning. However, he was still drinking heavily while on the unit and he also acquired traumatic epilepsy, requiring maintenance treatment with anticonvulsant medication. He had a degree of sexual disinhibition and hypersexuality, which is a recognised behavioural manifestation of frontal lobe damage, such as that suffered by Mr M. However, his initial child sexual assault charges pre-dated his traumatic head injury and consequent neurosurgery.

6.1.3 In May 2006 Mr M was convicted of indecent assault against a 13 year old boy following incidents in November and December 2003. He was sentenced to 18 months imprisonment with an extended licence of 27 months. In addition, he was issued with a Sexual Offences Prevention Order (SOPO), preventing him from having contact with children under 16, and he was made subject to sex offender notification requirements for life.

6.1.4 He was released from custody in April 2009. At this point he was referred to the Greater Manchester West mental health services and there was a recommendation that he attend a sex offender treatment programme. No records of attendance on this programme, or outcomes, were available. On moving to Middleton, his care was transferred to Pennine Care.

6.1.5 Throughout the period between his release from prison in April 2009 and his re-admission to prison on 25th July 2012, he was a frequent attender at A&E, with each attendance being related to alcohol abuse, seizures and falls. He was homeless for much of this time and living at various hostels including the Salvation Army in Rochdale.

6.1.6 On 25th July 2012 Mr M was convicted of three breaches of his SOPO, having been seen on a number of occasions in Rochdale with a 12 year old boy. He was sentenced to a further period of imprisonment of 16 months.

6.1.7 He was released from custody on 28th September 2012 to Probation Approved Premises, but due to his behaviour (threats to staff, drug and alcohol misuse) he was recalled to custody on 31st October 2012. He remained in prison until the end of his sentence on 31st May 2013.

7 Summary of key events from 1st March 2013 – 1st March 2014 (the review period)

7.1 Mr M was referred to the Shelter Prison Housing Advice Service in February 2013. On 5th April 2013 the Shelter Prison advisor, together with Mr M, completed a referral to Shelter Rochdale. This was emailed to Shelter Rochdale on 9th April.

7.2 Shelter Rochdale allocated the case on 10th April to a support worker for assessment. On 1st May, the Shelter Prison worker again contacted Shelter Rochdale for an assessment and on 10th May she drafted a homelessness application which she sent to Mr M for his approval.

7.3 The Shelter prison worker was on leave from 14th-20thMay. She arranged an appointment to see Mr M on 21st May but he did not attend.

7.4 After several emails, on 23rd May an appointment was made for Shelter Rochdale to assess Mr M on 29th May 2013. Following the assessment, the Shelter Rochdale worker contacted the Homelessness Team at Rochdale MBC.

7.5 A number of housing options were explored on 30th May. This included an approach to Turning Point's abstinence unit and to Probation Approved

premises. Mr' M's application to Turning Point was turned down, and as his sentence expired on 31st May he could only live in Probation Approved Premises on a voluntary basis, and if willing to abide by the rules of the accommodation. Rochdale Homelessness Service informed the Prison that Mr M had made a previous application to the Council and that the Council had discharged its duty at that time. As there were no changes in circumstances, the Council was of the opinion that it would have no statutory duty to assist in finding temporary accommodation. However, the Rochdale Strategic Housing officer (from the homelessness service) agreed to contact an out of borough specialist unit as he was aware that they provide accommodation for serious offenders.

7.6 Mr M was homeless when released from prison at the end of his sentence and licence on 31st May 2013, with a requirement to complete his sex offender registration within 3 days. He was also asked to meet a support worker from Shelter on the day of his release. Mr M did not attend this appointment.

7.7 Mr M was apparently abstinent from alcohol when released from prison but on the day of his release he was taken by ambulance to A&E at Fairfield Hospital in Bury, having been found slumped against a wall in the street after consuming a large amount of alcohol.

7.8 On 1st June 2013 Mr M attended Rochdale Police Station to complete his sex offender registration, registering his address as 'no fixed abode'. The recording officer failed to get a contact location, this error was spotted by the DC from SOMO who contacted the station and requested that Mr M meet her there by appointment. He did this on 3rd June 2013.

7.9 By 7th June 2013 (one week after being released from prison) Mr M was misusing alcohol, had attended A&E on four occasions, had visited his ex-wife in an attempt to speak to his adult daughter, and had reported a theft and a hate crime. He did not manage to meet the worker from Shelter until 7th June. He was still homeless and was causing the hospitals, police and Shelter concern for his health and welfare, and there were also concerns that he was at a high risk of reoffending. Finding him suitable accommodation was proving extremely difficult, in part because of the limitations caused by his offending profile, and in part because of his alcohol misuse and his previous behaviour in local hostels.

7.10 The first MAPPA meeting was held on 11th June 2013. This was chaired and minuted by the Probation Service and was attended by representatives from the Probation Service, GMP, Rochdale Adult Services, Shelter, Rochdale Community Criminal Justice Mental Health team, and Rochdale Children's Social Care. The purpose of this meeting was to enable agencies to share

information, undertake a multi-agency risk assessment and agree an effective risk management plan. At this meeting, concerns were raised about Mr M's homelessness, mental and physical state, use of alcohol and stated urge to re-offend. Because of the very high level of risk he posed, he was registered as MAPPA level 3. This is the highest category of risk.

7.11 It was noted that Mr M had previously exhausted all options with local housing providers and that the possibility of accessing a placement at Langley House Trust (LHT), which provides specialist accommodation for serious offenders, was being considered. This would require additional funding.

7.12 Rochdale Adult Care's notes from this meeting state that it was established that Mr M had capacity in relation to drinking alcohol and understanding his offending behaviour, that his acquired brain injury was not substantial enough to affect his daily living, and that therefore he would not meet Adult Social Care's criteria for support. The main issue was Mr M's offending behaviour, which was why agencies were struggling to find appropriate accommodation for him.

7.13 An action plan regarding health, accommodation, support and monitoring Mr M was agreed and a further meeting date set for 18th June 2013.

7.14 The MAPPA meeting on 18th June 2013 was concerned with ensuring access to appropriate mental health/neurological assessment, the continued pursuit of appropriate accommodation and the identification of funding to support this. By this time a GP in Rochdale had been identified for Mr M and a cognitive and dementia assessment had been arranged for 21st June. Mr M was still homeless but was attending the police station as required and it was agreed that his risk had reduced from 'very high' to 'high'. It was further agreed that Shelter would continue to provide support to Mr M in regard of his housing application and his benefits. It was noted that alcohol use was a key trigger for Mr M's offending behaviour. The focus remained on finding accommodation as it was felt that this was essential before effective support could be provided to Mr M. The next meeting was set for 4th July 2013.

7.15 On 21st June Mr M was found accommodation at Guest House 1 (GH1) in north Manchester. This is emergency accommodation for people aged over 35. It was provided on condition that JM received ongoing support from Shelter and Stepping Stones. Shelter were agreed to be the lead support organisation, proving support around housing, money, budgeting, benefits, rent, food, clothing and well being with Stepping Stones carrying out joint visits, providing additional support regarding substance misuse. These services are part of the 'prevention' services commissioned by Rochdale Adult Care.

7.16 Mr M initially failed to attend to register with the GP but was taken there by the support worker and registered on 25th June.

7.17 Shelter and Stepping Stones carried out joint visits to Mr M. on 27th June and 2nd July. Stepping Stones completed a Client dial assessment, which is a pictorial record of how the client perceives their needs, with 1 as the lowest score (ie worst state) and 10 the highest (best). On this Mr M rated himself from 0-10 on substance misuse (2), managing money (3), use of time (2), family and environment (1), physical health (5), emotional and mental health (3), alcohol misuse (2), managing tenancy (5) and offending (1). Mr M was advised to keep a drink diary and was given support in relation to completing costs and benefits assessment for alcohol misuse. The workers noted their concerns regarding comments made by Mr M in relation to young children, which they wished to raise at the MAPPA meeting on 4th July.

7.18 At the MAPPA meeting on 4th July, the focus was on the need to find accommodation and to ensure all medical assessments were completed. It was agreed that the Langley House option would continue to be explored. Shelter and Stepping Stones workers were to continue to encourage Mr M to spend his money on food and clothing, discuss the pros and cons of drinking, and to report any concerning behaviour to SOMO. The date of the next meeting was set for 24th July 2013.

7.19 Contacts between Mr M and Shelter, Stepping Stones and the police continued between 4th- 24th July, with all noting that Mr M was drinking excessive amounts of alcohol and that he was not motivated to address this. Mr M attended the GP and the result of the cognitive test was expected. A detailed offer was sent to Rochdale Adult Care from Langley House Trust, describing the care plan that they could offer Mr M. This was discussed at the MAPPA meeting on 24th July 2013, with all agreeing that, if funding could be secured, this would be the best option for Mr M. However, as the Council had no duty or budget to support this, it would have to be funded jointly with other partners. The next MAPPA meeting was set for 13th August 2013.

7.20 On 27th July 2013 Mr M arrived at North Manchester General Hospital by ambulance, having been found in the street with facial injuries and intoxicated. This did not occasion a referral to the alcohol team, but a nurse reported concerns about Mr M's statements regarding sexual feelings toward young boys to the police. The police followed this up with a visit to Mr M, and he disclosed that he was having thoughts about young boys but did not wish to re-offend. Mr M disclosed to the support workers that he was spending almost all of his benefits on alcohol. He also made an inappropriate remark to the (female) support worker from Stepping Stones.

7.21 A Vulnerable Adults assessment was carried out on 29th July, but Mr M continued not to meet eligibility criteria for social care support, and other agencies were similarly unable to find funding for the out of borough specialist placement

7.22 On 2nd August Mr M went missing from GH1, without his epilepsy medication. On 4th August the police were informed of this and reported him as a missing person. He had been stopped by police in Ardwick on 3rd August, and a stop and account carried out. He had a black eye and stated he was looking for a hostel in Longsight. He was then located again on 5th August, and it transpired that he had drunk cleaning fluid, believing it to be alcohol based. He then felt ill so attended MRI, where he was admitted and then discharged on 5th August. When this incident was discussed with him on 8th August, he had no recollection of the event or hospitalisation.

7.23 During this time there was also correspondence between Rochdale Adult Care and the MAPPA chair, regarding the non-disclosure of the risks to professionals.

7.24 On 9th and 10th August a female resident at GH1 contacted the police to inform them that Mr M had admitted to molesting a 15 year old boy. Further inquiries were undertaken but no corroboration of this could be found. However, these disclosures, together with an allegation that Mr M had behaved inappropriately to a 17 year old boy and been sexually inappropriate to female residents led to Mr M's eviction from GH1 on 13th August.

7.25 At the MAPPA meeting on 13th August, Mr M's deteriorating state was discussed, as was the eviction from GH1. A mental health assessment was requested, and new accommodation at GH2 in Tameside was identified. Because Mr M continued not to meet the criteria for specialist services from adult social care, and had been assessed as being able to live independently, no funding was available for a placement at LHT. Furthermore, other agencies were unable to provide funding because he did not meet criteria. The date of the next MAPPA meeting was set for 3rd September 2013.

7.26 The SOMU support officer accompanied Mr M to GH2 on 13th August 2013 and assisted him in completing admission documents. Mr M had been reminded, prior to leaving GH1, of the risks of disclosing his sexual offending to others. Despite this, Mr M did make reference to his offending in the presence of the landlord at GH2.

7.27 On 14th August the support workers contacted agencies to gather more information about GH2 and the other residents. They were advised to meet Mr M off the premises due to concerns about the guest house and its clientele. On 19th August the Probation Operations Manager (Tameside) raised significant concerns about the placement of Mr M at GH2 because this was not a registered address for adult services, and because a sex offender had been seriously assaulted at the property in the past. This was copied to all MAPPA colleagues on 21st August.

7.28 One of the other residents (Mr E) in GH2 took upon himself a role of unofficial 'manager' of the house. He helped out with cooking and with assisting new residents but had no formal role. This was noted in the Stepping Stones notes on 19th August. However, at points in the notes from various agencies, Mr E is referred to as the manager (and sometimes the landlord) of GH2.

7.29 Mr M was visited at GH2 on 20th August by the SOMU support officer and the Stepping Stones worker. Mr M confirmed that he was happy at GH2 but had some questions about his benefits, which were resolved. The workers visited again on 22nd August, when Mr M appeared scruffy and unkempt, and owed rent to GH2. With Mr M's agreement, he was taken to the post office to withdraw his benefits to pay rent. He also purchased a mobile phone and top up card so that professionals could contact him.

7.30 On 27th August Mr M was found by the police in Lymm, sleeping at a bus stop. Also on 27th, the SOMU officer was informed by Stepping Stones that Mr M had had an epileptic fit that morning. On 1st September, Mr M was stopped again by the police in Widnes following a report of a male trying car doors. He informed the officers that he was trying to get arrested in order to get a lift back to Greater Manchester. He was taken to the GM border but there are no further details of this incident.

7.31 Later in the evening of 1st September/morning of 2nd September, Mr M was found in Droylesden and the SOMU officer took him back to GH2. Mr M had been travelling by taxi and could not afford the fare. He informed the SOMU officer that he had been sleeping rough, but had no recollection of being in Cheshire.

7.32 On 2nd September the Stepping Stones worker returned from leave and contacted GH2. She was informed by Mr E that Mr M had not been seen for a week and so contacted the SOMU officer, who completed an Electronic Briefing System (EBS). On 3rd September, the SOMU officer contacted Stepping Stones to inform them that Mr M had been found later on 2nd September.

7.33 At the MAPPA meeting on 3rd September, there was discussion about the reports of the unsuitability of GH2. It was confirmed that there were no providers willing to accommodate Mr M in Rochdale. The support workers were tasked with supporting Mr M to pay his outstanding taxi fare (£50), to support him to pay his monthly rent payments, and to assist him to attend the GP for a full medical check. There were also continuing concerns about Mr M's functioning and possible alcohol use, and the fact that he went missing for six days at the end of August. The next MAPPA meeting was arranged for 16th October 2013.

7.34 On 5th September the support workers visited Mr M. Unfortunately, due to difficulties in one of the support workers finding the guest house, Mr M missed his GP appointment, which was at the GP practice in Rochdale. Instead the workers went with him to the post office. He was given an envelope and advised to put £50 for the taxi driver into this. He was observed by both workers putting this into his back pocket. On returning to the guest house, Mr M paid £60 to Mr E to cover food costs, and received a receipt for this. Later that day, when the taxi driver was coming for his money, Mr M said that he did not have this as he had given it to the Stepping Stones worker. This allegation was appropriately investigated and was not upheld. Following this, both Shelter and Stepping Stones agreed that they would no longer support Mr M in making financial transactions or handling money, due to the risks to their workers.

7.35 A referral for a mental health assessment for Mr M was made on 6th September 2013 and an appointment was offered for 23rd September. . Mr M attended his GP on 13th September and received his medication and a certificate stating he was unfit to work.

7.36 On 16th September the police were informed by GH2 that Mr M had been missing since 14th September, and that they were concerned about his vulnerability. The police created an EBS on 17th September and informed divisional police.

7.37 On 18th September Mr M was seen in Salford Precinct, the police were called as he refused to leave the toilets. Mr M was compliant for the police. He was seen by the police again on 20th September at the home of another sex offender in Salford.

7.38 On 23rd September Stepping Stones were contacted by the owner of GH2 to inform them that MR M had not returned since 14th September and that his room was a mess with lots of mouldy food. The police were informed and the SOMU officer arranged to visit Mr M in Salford on 24th September. Stepping Stones asked that Mr M be reminded that if he did not return to GH2 he risked making himself homeless. Mr M had now missed his mental health assessment that had been set for 23rd September.

7.39 On 24th September the police visited Mr M in Salford and returned him to GH2. He was given advice on inappropriate friendships and the dangers of self-disclosing his status. On arriving back at GH2 JM informed the officers that he did not have his post office card or PIN as he had given it to the offender in Salford; this had been a condition of staying with him.

7.40 Mr M's support plan was reviewed by Stepping Stones on 25th September. It was noted that the only outstanding items were the budgeting and AA meetings, the cognitive functioning was identified as 'not met'. Mr M's self assessment on the Client Dial was substance misuse (1), managing money (1), use of time (1), family and environment (1), physical health (1), emotional and mental health (1), alcohol misuse (1), managing tenancy (1) and offending (1). This represented either a marked deterioration since the assessment in June, or a change in Mr M's attitude towards his circumstances and perhaps greater honesty in the assessment.

7.41 On 27th September the support workers from Shelter and Stepping Stones visited Mr M at GH2 but were informed that he had been missing for 2 days. The worker from Stepping Stones contacted the police to report this and to share her concern that other residents were forming an opinion of Mr M and that his safety could be compromised. The SOMU duty team were made aware to monitor updates.

7.42 Mr M's GP record states that on 27th September they were notified by Manchester Royal Infirmary that Mr M had attended feeling unwell. All vital signs were recorded and it was suggested this should be followed up by the GP. This was not done.

7.43 Mr M was found by the police in Salford on 28th September. He was unkempt and confused, and was taken back to GH2.

7.44 On 2nd October Stepping Stones spoke to Mr E who raised concerns that Mr M was stealing cutlery at meal times, and that he was four weeks in arrears with his rent. Over the next few days the support workers assisted Mr M is accessing his post office account (which required proof of ID). By 14th October Mr M had still not managed to access his account and was 6 weeks in arrears with his rent.

7.45 On 11th October the Probation service contacted Stepping Stones for an update. The worker informed the probation officer that things had deteriorated and that Mr M had been absconding more often. The probation officer expressed concern at the progress with housing and said he would contact RSH.

7.46 At the MAPPA meeting on 16th October 2013 the pattern of continuing difficulties with Mr M were discussed, including the incidents of going missing. The police did not feel that there was sufficient evidence for a request for enforcement action to be successful, as it would be difficult to prove that Mr M had not returned to GH2 during these periods.

7.47 The appointment for the mental health assessment had been missed on 23rd September, a new appointment would be requested. No one from the Housing team attended the meeting, but a report was sent, although this did not arrive in time to be considered by the meeting. In this report RSH confirmed that they were continuing to look for an appropriate property. The meeting expressed concern at the delay and the Chair of the meeting then contacted the Head of Strategic Housing to discuss this. The Head of Strategic Housing confirmed that she would attend the next MAPPA meeting, which had been set for 26th November 2013.

7.48 Over the next week workers continued to look for housing for Mr M. Additionally, Mr M's seizures had increased, and Mr E was trying to arrange a local pick up for the prescriptions.

7.49 An email from RSH to Rochdale Adult Care on 24th October describes the difficulties that Strategic housing were having with the case. They were identifying properties but these were then rejected because Mr M presented too high a risk either to other residents or to others in the locality. The RSH officer expressed concern that partners on MAPPA were not consistent in their assessment of whether or not Mr M could live independently. The officer further noted that in his opinion, much hinged on Mr M's alcohol use and that Mr M had stated that he had no intention of stopping drinking, and that before Mr M's benefits were in place, he seemed able to attend appointments and fend for himself 'in a way'. The officer went on to describe the efforts being made by RSH despite the fact that they had no statutory duty towards Mr M, although they accepted they had a corporate responsibility to assist in finding a solution.

7.50 On 29th October Mr E contacted Stepping Stones asking for a repeat prescription for Mr M. This was ordered and posted to GH2 on 31st October.

7.51 On 29th October Shelter was notified that Mr M's mental health assessment had been rearranged for 18th November. Additionally, Stepping Stones completed an application for their Complex Needs Service on behalf of Mr M. This was declined on 31st October, due to the level of risk posed by Mr M and the location of their properties.

7.52 On 3rd November Mr M was seen in the back yard of Pendleton police station, looking for a police officer. He stated he had walked from Droylsden to collect medication from Salford Royal Hospital. As he appeared vulnerable he was returned to his home address. On the same day Mr M's GP was notified by Hope Hospital in Salford that Mr M had attended feeling unwell and suggesting a follow up by the GP. This was not done.

7.53 On 5th November Mr E spoke to Stepping Stones, stating that Mr M had made an allegation that a resident at GH2 had taken his post office card. Mr E stated that they had contacted the Post Office and cancelled Mr M's card and that he now had a new card. Mr E said that Mr M had agreed to let Mr S (the owner of GH2) keep his card and help him budget by giving him daily sums of money that he signed for. However, Mr E stated that this wasn't working and that Mr M asked for all of his money at once. The Stepping Stones worker recorded that Mr E did not appear to think that Mr M was vulnerable within GH2 or that there were any safeguarding concerns. The worker did not comment on the credibility of Mr E on these matters.

7.54 Following this, on 5th November the Stepping Stones worker sent an email to the SOMU officer to give an update, including a query as to whether Mr M was at risk from other residents or from Mr E. She also contacted Mr M's GP for a prescription for Mr M's medication, which she collected and posted to GH2. She then spoke to Mr E, who informed her that he had arranged with the pharmacy next door to GH2 to issue repeat prescriptions each week.

7.55 Also on 5th November there was email correspondence between RSH, Shelter and Rochdale Adult Care clarifying Mr M's support needs and his ability to manage independently. It was agreed that intensive support would be needed 'at the front end' and that an assessment of Mr M's mental and psychological health needs was due to take place on 18th November 2013. It was also noted that the Shelter worker felt that Mr M was deteriorating in the B&B but was managing to keep the placement.

7.56 On 11th November Mr M disclosed to the support workers that he had lent another resident £70 and that the resident had since left without paying the money back. He was advised to discuss this with the SOMU officer when he saw her the following week. This incident does not appear to have been reported to the SOMU officer by the support workers. Mr M's memory was known to be poor at this time.

7.57 On 14th November, Greater Manchester Fire and Rescue Services visited GH2 to undertake a Fire Safety Audit, as the property had failed to comply with requirements in the past. There was then a consultation meeting on 18th

November between GMFRS, Tameside MBC officers and GMP regarding the impact GH2 service users were having on the local community. GMFRS returned to GH2 on 18th November to describe the improvements to the property that were required following the Fire Safety Audit. This meeting was followed up by an enforcement notice being prepared and sent to GH2 on 2nd December 2013. This included a detailed schedule of the actions to be taken (dated 10th December). The property was inspected again on 9th January 2014 and it was found that suitable and sufficient measures had been taken to satisfy the requirements of the legislation.

7.58 On 18th November 2013 Mr M attended his appointment for a mental health assessment. This was carried out by a Speciality Doctor in Psychiatry and the Manager of the Community Mental Health Team was in attendance. A comprehensive assessment was carried out, and concluded that Mr M's condition had been stable over the 8 years since his discharge from the Floyd Unit. His paraphiliac (definition: need for unusual sexual stimulation) activity predated his brain injury. Mr M smelled strongly of alcohol and admitted to drinking 250mls of vodka before the assessment, however, there was no evidence of intoxication and he was appropriate and coherent throughout the interview. In the opinion of the psychiatrist, Mr M's insight was limited and although he stated he was aware of the impact of alcohol on his mental and physical health and that it increased his risk of offending, he did not acknowledge this as a problem and felt that he could control it and stop drinking when he needed to do so. He stated that he did not wish to address his alcohol misuse at this stage. Mr M was assessed as having unrealistic expectations regarding his future income, independent living and regaining a relationship with his family. However, she believed that he was not suffering from any major cognitive impairment that would affect his capacity to make decisions or his ability to recognise legal boundaries, and that therefore he was responsible for his own actions and decisions. She also found that he was not suffering from any major mental illness and that therefore he did not need secondary care mental health services. She suggested that he would benefit from placement and support that could facilitate input from the Primary Care team, allowing access for physical and mental health monitoring by his GP, and ensuring that he was compliant with his antiepileptic medication, which would reduce the risk of seizures and consequent confusion. She felt he would also benefit from engaging with local resources and alcohol services, but that this entirely depended on his motivation to address his alcohol misuse. Her assessment summary was sent to Mr M's GP.

7.59 The MAPPA meeting on 26th November 2013 was attended by the psychiatrist, in order that her assessment could be discussed. It was also attended by the Director of Rochdale Strategic Housing, a representative of Rochdale Boroughwide Housing, and, at the request of the Chair, Mr M's previous

probation officer, who was asked to become involved in the case on a non-statutory basis to assist with Mr M's resettlement. The housing representatives asserted their lack of a statutory duty to assist Mr M, but acknowledged their duty to cooperate, and as such agreed to progress his housing needs if a robust support package could be put in place. The meeting agreed a package with four elements:

- Ongoing SOMU oversight, including unannounced visits
- Probation – non-statutory support from previous probation officer to help coordinate the process and support resettlement for a three month period
- Stepping Stones/Shelter to provide ongoing support (a request to extend this beyond March 2014 was to be made)
- Ongoing GP support to be negotiated with Mr M's GP. It was not clear, from the notes available, who would do this.

The next MAPPA meeting was set for 6th January 2014; it was agreed that this would be the last MAPPA meeting and would reassess the situation, and that the multi-agency work would thereafter be progressed via lead professionals' meetings.

7.60 The support workers visited Mr M on 29th November. Mr M stated that his Post Office card had not worked the day before; upon enquiry at the Post Office it transpired that the card did not belong to Mr M. The Post Office confirmed that Mr M's card had been used to withdraw money in Droylsden, which was not Mr M's usual post office, on 28th November. Mr M was adamant that he had not given his card to anyone. His card was cancelled and a new one collected that afternoon. The Stepping Stones worker passed a safeguarding concern to SOMU. Mr E stated that Mr M had withdrawn all his money the previous day and had come back with 'goodies' but the Stepping Stones worker felt this did not fit with the card not belonging to Mr M, or the fact that Mr M was sober.

7.61 On 3rd December, RASC contacted Stepping Stones as the MAPPA minutes included an action for Stepping Stones to refer Mr M to Rochdale Adult Care. The Stepping Stones worker explained that it was more about vulnerability than safeguarding. The distinction was not clarified in the notes.

7.62 A letter from GMP SOMU officer, alerting Rochdale Adult Care to the increasing concerns about Mr M and his ability to live independently, was apparently sent on 4th December 2013 to the Probation Service, to be forwarded to Rochdale Adult Care. This letter does not appear in the chronologies of Adult Care, GMP, or Probation and thus it is not clear if it was sent or received. The SOMU seems not to have followed up the letter when no response was received, and it does not seem to have been mentioned at the MAPPA meeting on 6th January 2014.

7.63 On 9th December the support workers accompanied Mr M to the Bond Board, during the journey Mr M said that another resident claimed that Mr M owed him £10, but Mr M said he had not borrowed this. On returning to GH2 Mr M went into the building but then came out saying he had been struck by a resident. The Stepping Stones worker accompanied Mr M back into the building to speak to Mr E. During this meeting another resident threatened Mr M, who admitted he might have borrowed the money. Mr E stated that Mr M owed £120 rent, and the support workers, together with Mr E, took Mr M to the post office to collect his rent money. RSH were updated about this incident and Mr M was offered a place at a bail hostel, which he declined.

7.64 The Stepping Stones worker emailed SOMU to update, stating that although Mr M might have borrowed the money, it was possible that Mr M was being financially abused.

7.65 Over 12th/13th December a number of potential properties were identified but GMP felt that none of these were in suitable locations. A link work meeting took place on 13th December; Mr M was supported to collect and wash clothes, and to visit private lettings agencies to look at potential accommodation..

7.66 On 14th and 18th December, handwritten letters (with no stamps) were received by Mr M's GP practice. Mr M stated in these that he had run out of his medication a week previously, he had no money, his seizures had been getting worse over the past four months, and that his depression was bad. He had severe pain in his head and neck, and had no sense of taste or smell. He wished the GP and his family a happy Christmas. A note on the GP records states that the plan was to wait until Mr M contacted the surgery.

7.67 There did not seem to be any significant contact between any agencies and Mr M (other than the letters sent by Mr M to his GP) between 13th December 2013 and 13th January 2014, although Mr M was seen briefly by the workers from Stepping Stones and Shelter on 3rd January 2014.

7.68 At the MAPPA meeting on 6th January 2014, it was noted that it had been over-optimistic to hope that Mr M would be in his own accommodation by this point, but that as he was now stable on his medication and there was commitment from partners and providers to progressing his case, it was felt that the case could in future be managed through lead professionals meetings. The date for the first such meeting was set for 27th February 2014. It is not clear how the assessment regarding Mr M's medication was made.

7.69 At the meeting, concerns were raised about the instability of the placement at GH2 and the fact that residents were aware of Mr M's offending. When the

support workers had visited 'on Friday' (no date given), following a benefit payment they were surprised to find Mr M sober: this was seen as evidence of bullying at GH2. It was also noted that Mr M was due a £2000 personal dependence allowance from the Benefits Agency and there were worries that he would either spend it on a binge or have it taken from him at GH2.

7.70 The notes of the MAPPA meeting made by Stepping Stones worker includes a reference to a referral being made to Rochdale Adult Care. There are no other references to this.

7.71 On 13th January a potentially suitable property was identified by RBH.

7.72 Also on 13th January, the SOMU support officer, together with the support workers from Shelter and Stepping Stones carried out a joint visit to Mr M at GH2. Mr M appeared unkempt but stated that he had not drunk alcohol in recent weeks. Mr M stated that he wishes to leave GH2 but refused to divulge any information on whether he was being threatened or under pressure from other residents.

7.73 The notes from Shelter and Stepping Stones include a further discussion with Mr E, who reported that Mr M was often visited by sex workers, was purchasing drugs, and expressed a desire to sleep with a female resident's boyfriend. Mr S was no longer willing to look after Mr M's post office card but Mr M had lost his card on three occasions. The Stepping Stones worker rang the SOMU officer to share this information.

7.74 On 13th January an email was sent by Stepping Stones to MAPPA attendees in relation to concerns about Mr M's accommodation, the risk to MR M from self-disclosure, and the risk of financial and physical abuse whilst at GH2. Mr M had had £20 stolen by a sex worker whose boyfriend was a resident. The Stepping Stones worker had advised Mr E that he should not allow residents to exploit Mr M. Mr E stated that Mr M had disclosed his offending to four residents, and that many residents now knew that he had been in prison for assaulting a 14 year old boy. The Stepping Stones worker expressed the view that the only thing keeping Mr M safe was him being used for his money.

7.75 The Stepping Stones chronology includes visits to Mr M on 20th and 23rd January but no further details are given.

7.76 On 28th January Shelter referred the case to their solicitor for advice on how it could be moved forward, given the length of time the case had been open and the current unsuitable accommodation.

7.77 On 29th January Mr M's GP sent his prescription to the chemist in Audenshaw, it included a letter informing Mr M that he needed to register with a GP in Audenshaw, as the GP did not want to continue to provide a service to an out of area patient. He was removed from the GP's list on 10th February.

7.78 There was a joint visit to Mr M by Stepping Stones and Shelter on 30th January 2014. Mr M had two black eyes and a swollen nose, and said he had fallen in his bedroom. The SOMU officer was contacted to share concerns.

7.79 On 31st January it was confirmed that the property identified on 13th January would be appropriate. The property required some repairs prior to being re-let and would not be available for several weeks. It was agreed that if another property became available more quickly, it would be offered to Mr M. Partner agencies were informed on 5th February.

7.80 Mr M was seen by police at a bus stop in Pendleton around 4am on 4th February and again at 2.30am on 5th February in Irlam o'th'Heights. He was taken home by the police patrol.

7.81 An email from Stepping Stones, expressing concerns for Mr M, was noted on the GMP system on 5th February 2014. This documents Mr M's vulnerabilities and incidents of financial exploitation. The worker also reported seeing Mr M with two black eyes on 13th January, however, he denied any assault but had no money. When the worker visited GH2 on 4th February Mr M was not there. She was informed by Mr E that Mr M's injuries were a result of an assault by another resident. He also stated that Mr M was being forced to withdraw all his money and hand it over to the residents in question. The worker stressed the need for alternative accommodation to be provided as a matter of urgency.

7.82 On Friday 7th February Shelter faxed a safeguarding referral to Rochdale Adult Care, citing concerns that Mr M may be subject to financial and physical abuse by other residents at GH2. This was felt to be having an impact on his wellbeing and vulnerability. A summary of the history and recent events was included. The risk assessment stated that Mr M was potentially at risk within the next 48 hours and that criminal acts are potentially being committed.

7.83 On Monday 10th February an email from Rochdale Adult Care, including a copy of the fax from Shelter, was received by Tameside MBC. The Tameside Safeguarding Business Support officer telephoned Shelter Rochdale to ask if Mr M had given consent for the referral.

7.84 On 11th February the support worker from Stepping Stones, together with the tem lead from Shelter, visited Mr M, and informed him of the safeguarding alert.

Mr M was thankful for the concern and was happy to be visited by Adult Social Care, but denied that anyone had taken his money or hit him. Mr M presented well and his room was tidy. He was told about the potential offer of a property. Mr E informed them that Mr M owed two weeks' rent.

7.85 On 12th February Tameside Safeguarding Business Support emailed managers in the Integrated Response and Intervention Service at Tameside to inform them that Shelter had confirmed Mr M had given consent for a safeguarding review. The original fax from Shelter was included as an attachment. The email states that Mr M was a Rochdale client but as Tameside was the host authority it was potentially Tameside's responsibility to investigate.

7.86 This contact was then passed to the Customer Care Officer within the Integrated Response and Intervention Service, who, on advice from her manager, sent the referral to the duty officer in the West Locality team, together with a scanned copy of the original referral from Shelter.

7.87 The Duty Social worker in the Tameside West Locality team then phoned Rochdale Adult Social Care and asked to be put through to the Duty Social Worker. She then had a conversation with a member of staff at Rochdale but did not confirm the person's role. She was asked to send a copy of the fax to Rochdale, and that once it was received it would be discussed with the manager in Rochdale. She did this and then rang to confirm it had been received. Neither Tameside nor Rochdale recorded who would lead any investigation into the case.

7.88 Rochdale Adult Safeguarding then contacted the IT service to get access to the 'locked down' file for Mr M. (In line with Rochdale practice, because of Mr M's offending profile, his file was locked down so only named workers could access this). This request was made at 13.14 on 12th February; access was granted at 14.17 the same day, and the Head of Service was notified. This notification was not passed on to the Safeguarding Team Manager.

7.89 On 13th February the social worker in Rochdale spoke to her team manager about the case, and was told to phone Tameside to discuss it. There is no record in either Tameside or Rochdale of this call being made, although from the IMR, the Rochdale social worker thought she rang but could not speak to anyone.

7.90 The referral was not faxed back to Tameside and when interviewed for the IMR, the social worker stated that the hard copy of the referral may have become confused with some other documents and been put into the confidential waste bin.

7.91 The social worker was used to working with recorded contacts on the computer and was not used to having hard copies. Because the file was locked down (and the team were unaware it had been unlocked) her normal pattern of work was disrupted and this could have contributed to the failure to respond.

7.92 No further action was taken by either Tameside or Rochdale in relation to this referral, and Shelter did not follow up whether Mr M had in fact been seen following their referral.

7.93 The formal offer of housing was confirmed to agencies on 13th February, although it had been communicated informally previously. The property still needed repairs and the date of completion of these was not yet known.

7.94 On 18th February there was a joint visit by Stepping Stones and Shelter to Mr M. Mr M confirmed his interest in the property and RBH were phoned to enquire about a viewing.

7.95 Mr M was visited again by Shelter and Stepping Stones on 25th February. Mr M was in good spirits and Mr E confirmed that the rent had been paid. Mr M said that he had not had any problems with the other residents and that he was attending the local church.

7.96 On 27th February the first professionals' meeting was held. The notes of this meeting confirm that there remained a risk that Mr M would reoffend. The concerns about the unsuitability of GH2 were discussed, although no mention was made of the safeguarding referral of 7th February. It was agreed that the frequency of visits would increase after his move; it was noted that he was very unkempt when visited on 25th February but that it was thought that this would improve when he was in his own property. While he has been sober when he has been visited, it was thought that he was going out drinking in the afternoons. It was noted that he had money to furnish the property and that it was expected that he would manage his money better when living on his own, although the reason for this view was not given. He had been attending church; it was noted that this had proved problematic in the past as he was likely to disclose his offences. It was agreed that the SOMU officer would make contact with the church and complete the appropriate disclosure, if required, as well as disclosures to the care home where the victim of the sexual assault was residing.

7.97 The meeting concluded that Mr M still remained a risk and in unsuitable housing. Shelter and Stepping Stones would remain in contact with Mr M and

the Homelessness team would work with RBH on the timescales for the completion of the repairs.

7.98 On 1st March the GM Fire and Rescue Service reported that there had been a fire at GH2 and that Mr M had died. All other residents escaped.

7.99 On 5th March 2014, when the information held on Mr M by Rochdale Adult Care was checked, the Emergency Duty Team referral and the referral from Tameside were forwarded to the Interim Assistant Director of Rochdale Adult Social Care. Interviews with the safeguarding team manager and the social worker regarding the non-action of the safeguarding referral were undertaken on 11th March 2014.

7.100 The decision to undertake a safeguarding adults review was made on 17th March 2014.

8 Analysis of the case

8.1 Key features of the case: about Mr M

8.1.1 Mr M proved to be a very difficult case to manage. He was estranged from friends and family. The nature of his offending behaviours meant that he was a high risk to others (specifically to young people). Furthermore, he was prone to disclosing his status as a registered sex offender, and this put him at risk of abuse from others.

8.1.2 Over the years since his traumatic brain injury in 2005 and his discharge from the Floyd Unit in 2006, Mr M was subject to a number of assessments, both through health and social care services. The results of these assessments were invariably that he did not have a level of need that required specialist services, whether from health or social care.

8.1.3 In all these assessments he also appears to have been deemed to have capacity to make decisions and to understand legal boundaries. Frontal lobe damage, such as that experienced by Mr M, is often associated with a degree of sexual and social disinhibition, however, Mr M's offending predated his brain injury. The notes provided for this review are also clear that Mr M had a stated desire not to re-offend.

8.1.4 Despite the fact that his level of need was assessed as low and he was considered not to be suffering from any major cognitive impairment, he did not seem to be operating at this level. From the material presented, this seems to have been in large part due to his use of alcohol, which appears to have been highly problematic, leading as it did to an increased risk of offending; to an

increased risk of epileptic seizures, which often left him injured, confused, and with memory problems; and to an increased propensity to disclose his offending behaviour to others.

8.1.5 Mr M appeared to have limited insight regarding his alcohol use. In the psychiatric assessment carried out on 18th November 2013, although Mr M stated he was aware of the impact of alcohol on his mental and physical health and that it increased the risk of offending, he did not acknowledge this as a problem. He felt that he could control his drinking and could stop drinking when he needed to do so.

8.1.6 Because of the nature of his offending, he could not be left unsupervised or unsupported. Finding appropriate accommodation was seen by agencies as the vital element in managing Mr M and the risks he posed. However, securing appropriate accommodation for Mr M was extremely difficult.

8.1.7 Furthermore, because of the nature of his offences, he could not be accommodated near schools or play areas, and ideally needed to be in accommodation without a communal entrance. However, the availability of such accommodation for a single person is very limited.

8.1.8 Additionally, because of his long history in the Rochdale area of disruptive and anti-social behaviour (generally linked to alcohol use), the usual hostels and homeless shelters were in the main not prepared to accommodate him. Furthermore, some of the services that could have tolerated his drinking were in locations that were unsuitable because of the risks he posed to children and young people.

8.1.9 In summary, therefore:

- He posed a risk to himself and a risk to others.
- He was very difficult to house, because of his offending profile.
- He lacked insight into the impact of his alcohol use and did not want to address this.
- His needs were assessed as ‘low level’ and therefore many specialist services were not available to him. But he appears to have been functioning less well than the assessment of his needs would indicate, which seems to have led to difficulties for universal services.
- It was felt that he could not be left to fend for himself because of his pattern of offending.
- He had no family or friends prepared to support him.

8.2 Professional Involvement with Mr M

8.2.1 Mr M was well known to services in Rochdale, in particular to the police, Probation and homelessness services. He was subject to Level 3 MAPPA procedures from the time of his release from prison until 6th January 2014; it was then agreed that the risk could be managed through lead professionals' meetings,

8.2.2 It is clear from the chronology that the mismatch between the risk he posed, his level of functioning, and his assessed level of need was of great concern to the professionals involved in this case.

8.2.3 There appears to have been a hope from some that, if further (or the 'right') assessments were undertaken, his needs might be assessed as 'high' and he would then meet the criteria for specialist provision or funding.

8.2.4 A specialist housing provider (with some therapeutic input) was identified in June 2013, and while all agreed that this was the ideal placement for Mr M, no agency could fund this either in full or in part. The reasons for believing this to be the right placement, and the problems with funding, will be discussed later in this report.

8.2.5 The MAPPA process is designed to manage the risk an offender poses to the public. This case demonstrates that it may work less well in managing the risks to the offender from the public, and that there may need to be supplementary processes involved.

8.2.6 In this case, it appears that there were unrealistic expectations of the MAPPA process, and that it was expected to cover case planning and strategy as well as risk management. This does not appear to have been discussed overtly and possibly led to misunderstandings and misapprehensions among professionals about their (and others') roles.

8.2.7 Much of the difficulty in providing suitable housing for Mr M was due to his offending behaviour and thus any housing near schools or play areas was ruled out by the police, as was housing where there would be vulnerable young people living or visiting regularly. It is not clear whether these conditions related to the specific risks that Mr M posed or whether these are policy decisions applied to all child sex offenders. A risk assessment of the specific danger that Mr M posed might have enabled a wider choice of housing locations to be considered: from the material presented, Mr M did not appear to pose a high risk to, for example, primary school children, but was

clearly a very high risk to especially vulnerable young people, in particular boys, in their early secondary school years.

8.2.8 GMP are clear that the advice that they give regarding housing is advisory only; from other agencies' recordings, it is clear that this was not understood by all and there does not appear to have been sufficient attention given to the risk to both Mr M and to the public from him remaining at GH2, especially given that he was frequently missing. The risks this posed should have been discussed and assessed against the risks he might present if housed for example, near a primary school or playground.

8.2.9 Mr M was provided with support from two voluntary sector organisations, commissioned through the prevention element of Rochdale Adult Care. These workers engaged well with Mr M but it is arguable that they were not as effective as they could have been, because of the lack of an effective support plan or effective engagement with other universal or preventative services such as primary care or alcohol and substance misuse services. Attempts were made by the Stepping Stones worker to engage Mr M in addressing his alcohol use but these were unsuccessful.

8.2.10 Professionals and agencies worked hard in this case. On a number of occasions, people offered input to which Mr M was technically not 'entitled'. Thus he was assessed by services that knew from their initial screenings that he would not be eligible for support, in order to provide information to others; he was supported and found accommodation by the Homelessness Team, despite the fact they believed they had discharged their statutory duty; and the prevention services lengthened the time period for voluntary sector involvement in order to provide support to Mr M's care plan.

8.2.11 Other services worked less well, possibly because their potential role was not understood or there was a lack of information sharing and engagement. Thus some universal services, such as primary care, that had the potential to be of great value in assisting Mr M, appear not to have been engaged or involved in the process and so their contribution was limited.

8.2.12 How effectively people worked together, whether the individual roles were clearly defined, whether there were misunderstandings about leadership and accountability, whether Mr M's own vulnerability was addressed effectively and whether the strong focus in the case of 'accommodation first, sort the rest later', was justified, will be discussed later in the next section.

9 Are there are lessons to be learnt from the circumstances of this case about the way in which professionals and agencies worked to safeguard Mr M?

9.1 How was the need to protect others from Mr M balanced against the need to protect Mr M from others?

9.1.1 Balancing Mr M's need to be protected against the risk he posed to others became an increasingly important part of this case, but his own vulnerability was not well recognised at the start of the process.

9.1.2 Representatives at the MAPPA meetings seemed not to be in agreement about Mr M's needs or what services were required to address his needs, his vulnerability, and the risk he posed to others. There did not appear to have been conclusive discussions on these aspects, which led to some topics being returned to on frequent occasions. This is particularly evident regarding the level of Mr M's needs, with some agencies continually chasing further assessments, perhaps in the hope of being able to access funding for a specialist service.

9.1.3 There does not seem to have been agreement about how much responsibility Mr M should have taken for managing his behaviour and for reducing the risks that others posed to him.

9.1.4 Mr M was deemed by all assessments to have the capacity to make informed choices. Because of this, even though his use of alcohol clearly blurred his judgement, it was difficult for agencies to protect him as he had the right to make choices that others might have seen as unwise. His lack of willingness to address his alcohol use made it very difficult to help him, as his alcohol use enormously increased the risks to himself and others. For example, while living at GH2, he was offered alternative accommodation on one occasion, which he refused as it was a dry house.

9.1.5 The nature of Mr M's offending was such that services felt they could not withdraw and leave him to 'sink or swim', because there was a need to protect children and young people from his potential behaviour. The assessments carried out by health services or by adult social care were to an extent inappropriate or unhelpful in the context of Mr M, where the need for him to access services was more because of the need to reduce the risk he posed to others than the because of his own level of need or desire to access a service.

9.1.6 It is worth noting that when Mr M was released from prison in 2009 until his re-imprisonment in 2012, he was not subject to MAPPA proceedings. During that time he was mainly homeless or living in hostels, with frequent evictions because of his anti-social or abusive behaviour (usually triggered by his alcohol use). It is

not clear that the risk he posed had increased when he was released in 2013, but it is understandable that authorities in Rochdale felt the need to manage this risk more robustly in 2013 than in 2009 because of increased local concern about the prevention of sexual abuse of children.

9.1.7 Although it was in the interest of agencies to manage and reduce the risk Mr M posed, this was not necessarily mirrored by Mr M's own interest in reducing his risk to himself or others. It is not clear from the notes provided whether this discrepancy was understood by, for example, all the MAPPA partners and this may be one of the reasons that so much time was spent repeating assessments or referring into a range of services.

9.1.8 There was a failure to assess the specific risks, both to him and to others, that were caused by Mr M's placement at GH2. Given that Mr M was frequently missing, it was not a successful placement in terms of enabling professionals to keep track of him. Furthermore, there was evidence from the start that there was a potential for him to be abused in this setting, and as time went by there was increasing evidence that Mr M was being abused, both physically and financially. The urgency of the need to remove him from GH2 was not recognised or acted on. In particular the very specific risk he might face from residents once it was known he was moving into independent accommodation appears not to have been discussed and no plan to mitigate this was made.

9.2 The quality of the planning prior to Mr M's release from prison on 31st May 2013

9.2.1 There was insufficient planning prior to Mr M's release from prison on 31st May 2013. In particular, there should have been far more focus on finding Mr M accommodation before he was released from prison, and in describing precisely the risk he posed to himself, to members of the public, and to professionals.

9.2.2 Mr M was referred to the Shelter Prison team in February 2013, but his homelessness application was only received by the Rochdale Homelessness Team on 29th May, two days before he was released from prison. Given his long (and well documented) history of difficulties with accommodation, this delay in referral meant that it was highly likely he would be homeless once released, with all the associated risks, both to himself and others.

9.2.3 Had his referral in February 2013 been acted on more swiftly, there is a possibility that Mr M would not have been homeless on release and it might have been easier to address his other issues from the start. As Mr M was

abstinent on his release from prison, there was an opportunity to capitalise on this and the option of finding him 'dry' accommodation should have been considered (although Mr M might well have refused such accommodation).

9.2.4 This failure to ensure that his homelessness application was progressed was exacerbated by a lack of discharge planning and information sharing within the Probation service, with a meeting scheduled for 12th March 2013 being cancelled and not rearranged prior to Mr M's discharge.

9.3 The effectiveness of the MAPPA process in this case

9.3.1 Using the MAPPA process alone was not effective in this case, and the role and focus of the MAPPA meetings in such cases needs to be supplemented by case planning/case management, with an identified lead professional to co-ordinate the care plan.

9.3.2 The MAPPA process focused on managing the risk Mr M posed to others but this left other aspects of the case unmanaged. Agencies did not appear to discuss this overtly, which led to misunderstandings and a mismatch of expectations from the process.

9.3.3 Some specific issues from the meetings are:

- Why was the first MAPPA meeting not held until 11th June 2013? Was a pre-release meeting considered? By the time the first MAPPA meeting was held, Mr M was homeless, drinking heavily, and had attended A&E on a number of occasions. He posed an extremely high risk to himself and others in this period.
- The strong focus on housing, while understandable, left the underlying problem of Mr M's alcohol use unaddressed.
- There was confusion about the risk that Mr M posed to professionals, with contradictory messages being given in regard to this.
- Did the MAPPA organisers realise that other agencies attending appeared to be seeing these meetings (inaccurately) as a substitute for case planning? Was this ever discussed?
- The meetings appear to have been distracted by Mr M's brain injury, and the opportunities for him to be funded for specialist provision that this might give. Why did the meeting not accept the repeated view from health and social care professionals that Mr M did not have specialist level needs? The hope that Mr M might be eligible for specialist services seems to have reduced the groups' focus on the support that might be available from universal services, or the importance of engaging with services such as the GP and other primary care support.

- The conclusions from some of the MAPPA meetings do not appear to have been based on any evidence. For example, why did the MAPPA meeting on 6th January come to the conclusions it did regarding Mr M being stable at that time?

9.3.4 This case has demonstrated the need for a care planning approach to supplement the MAPPA process An individual should have been identified as Mr M's case co-ordinator. This person could have ensured that there was an effective strategy in place to manage Mr M's needs and to identify and co-ordinate the support available from the different agencies.

9.3.5 This would have included ensuring that Mr M was receiving the services he needed, was being referred on into more specialist support as required, and enabled issues to be escalated if required. This approach would have made it more likely that there was a continued focus on the range of Mr M's needs and that the expected delivery outcomes of the Stepping Stones and Shelter support were clear and were monitored for impact.

9.3.6 To summarise: it would be beneficial to

- Identify a lead professional, to take a strategic overview and co-ordinate the case
- Be clear about the role and remit of people on the group
- Be clear about what is agreed and why
- Make sure the group agrees a strategy and focus as well as actions
- Ensure that there are effective risk assessments in place, updated as required
- Recognise when risks might increase and act accordingly

9.4 The effectiveness of the support package

9.4.1 There needs to be more open discussion on controversial aspects of cases. Any such discussions need to be properly minuted and the conclusions (and reasons for them) clearly documented.

9.4.2 There did not appear to be agreement on Mr M's ability to live independently, but this does not seem to have been discussed openly. It seems to have left some agencies (particularly housing) feeling that they were expected to put together a solution (independent living for Mr M) that they were not confident would work, but while they raised this with Adult Social Care, it is not clear that this was discussed constructively within the MAPPA meetings.

9.4.3 It is not completely clear from the notes of the various agencies how capable Mr M was. On some occasions he was described as unkempt, and the state of his room was often described as untidy. On other occasions, he appeared to be

managing better. During the period of the review, he was getting considerable support but this was at most weekly visits and he seemed to manage, to a degree, in between. The various assessments were all clear that he had no need for daily support, and the plan was for him to have increased support at the start of his tenancy. The concerns continued, however, regarding whether he would, if living independently, pay his bills or prioritise buying food over alcohol.

9.4.4 There was therefore, despite the positive assessments, understandable scepticism, especially within Housing, about his ability to manage on his own. Clearly, his alcohol use had a large part to play in this, but motivating Mr M to address this seemed to be low on the list of priorities. Spending some more time discussing Housing's (and others') reservations might have lead to a more effective care plan being developed. The letter (possibly not received) from SOMU on 4th December to Rochdale Adult Social Care also expresses reservations about Mr M's capabilities but was not followed up by any agency.

9.4.5 Overall, there was a lack of evaluation and monitoring of the support package. There do not seem to have been any clear goals set, other than to assist in finding Mr M appropriate housing, and to ensure that Mr M was supported to maintain his tenancy. The impact of Mr M failing to engage with aspects of the care package do not seem to have been addressed.

9.4 6 There were misapprehensions about the leadership in the case, with a lack of clarity about the police/SOMU role in co-ordinating the care package.

9.5 How Mr M's brain injury and alcohol use affected him and how agencies responded to this.

9.5.1 Mr M's alcohol abuse was longstanding and highly problematic. He had been misusing alcohol since the age of nineteen, and he attributed, for example, the failure of his marriage to his alcohol use. Mr M when drunk could be abusive to staff and others, was more likely to offend, and was more likely to disclose his offending. It increased his likelihood of suffering an epileptic fit, with the associated risk of injury and confusion.

9.5.2 A number of agencies could have worked more effectively together, to encourage Mr M to consider his drinking and to challenge his complacency on the subject.

9.5.3 The serious problems that were caused by Mr M's drinking were well recognised at the start of the case. It was for this reason that the Stepping Stones Substance Abuse Floating Support was included in the care package for Mr M. However, Mr M's refusal to engage with discussions regarding his alcohol use meant that this element of his care package seemed to get dropped and the Stepping Stones worker instead worked alongside the Shelter support, offering a very similar service and ensuring that the requirement for two workers to attend was met. There

does not seem to have been any active decision to drop the alcohol/substance misuse work and the implications of this work not being undertaken do not seem to have been discussed.

9.5.4 There were a number of missed opportunities for a more focussed or motivational approach to Mr M's alcohol use. These include Mr M's hospital attendances, where despite attending drunk on more than one occasion, Mr M was not offered any brief interventions or referred to alcohol services.

9.5.5 The psychiatric report in November notes that Mr M's alcohol use at that time was highly problematic but states simply that while he would benefit from engaging with alcohol services, this entirely depends on his level of motivation to address his ongoing alcohol misuse. No comment was made on what might be done to increase his motivation to address this.

9.5.6 Both the GP and the Stepping Stones worker had expertise in working with alcohol abusers, and the GP was able to refer to specialist alcohol services, but this was not done in this case. Mr M declined the offer of support, provided by Stepping Stone Projects, to engage with the various specialist alcohol services within the Rochdale area.

9.5.7 The possibility of finding Mr M accommodation where his drinking might have been addressed should have been considered. There is mention in the notes of the possibility of Mr M being accommodated by Turning Point (referred on 30th May) to Mary and Joseph's (mentioned on 13th August). These placements would have given Mr M more of an opportunity to consider addressing his alcohol use. Mary and Joseph's is not a dry house and therefore might have been more acceptable to Mr M; unfortunately, however, they do not accept sex offenders. The role of alcohol in this case seems to have been viewed as a secondary issue, meaning that it lacked sufficient focussed attention. In the author's opinion, Mr M's alcohol use was key to the difficulties both that he experienced, and that agencies had in helping him.

9.5.8 At various points, Mr E alleged that Mr M was using heroin and other drugs. No action appears to have been taken following these allegations and it is not known whether they were substantiated, and if true, what the implications were for Mr M, his care, and the risks he posed to himself and others.

9.5.9 Mr M's brain injury caused frontal lobe damage, which is associated with a degree of social and sexual disinhibition. He was an inpatient at the Floyd Unit for neuro-rehabilitation in Rochdale between September 2005 and March 2006, and during that time he showed significant clinical improvement in his memory and motor functions, and on discharge was assessed as being independent for all personal care, domestic activities, daily living and mobility. He was noted, both while on the unit and thereafter, to have a degree of sexual disinhibtion and hypersexuality, but his offending behaviour predated his brain injury. On discharge from the unit and at

later assessments, he was deemed to have full capacity and a good level of cognitive functioning.

9.5.9 Overall, the main impact of Mr M's having had a brain injury appears not to have been on himself or his behaviour, but on the agencies that were working with him. The label 'brain injury' seems to have led people to assume that Mr M had a need for, or would be eligible for, specialist services. This was repeatedly demonstrated not to be the case by both health and social care assessments, but despite this, a huge amount of time in this case was spent chasing further assessments, in the hope that these would open doors to services or funding. This appeared to lead to some drift in managing Mr M's situation.

9.6 The quality of the safeguarding support offered to Mr M throughout the review period

9.6.1 There appeared to be some misunderstandings and misapprehensions about how actions should be progressed in this case. It appears from the Stepping Stones notes that the worker felt that her route for raising safeguarding concerns was either via the MAPPA meetings or the GMP SOMU. She emailed or contacted the SOMU with safeguarding concerns on at least 5 occasions between 5th November 2013 and 5th February 2014, (5th November, 29th November, 9th December, 13th January, 5th February) but while the concerns were (usually) noted, it is clear from the notes of the case that neither MAPPA nor the SOMU saw it as their role to translate these concerns into formal referrals to adult safeguarding.

9.6.2 At the MAPPA meeting on 26th November 2013 there was a reference to making a referral to vulnerable adults' services. When this was followed up by Rochdale Adult Social Care contacting Stepping Stones, the worker apparently described the concerns as being more about vulnerability rather than safeguarding. What these terms meant at this point is not clear, particularly given the worker's documented concern about physical and financial abuse of Mr M.

9.6.3 Consideration should have been given to moving Mr M from GH2 even if this was not directly into independent living. At the time of his placement in GH2 in August 2013 a number of concerns were raised about its suitability, particularly because of previous attacks on residents in the house, including an attack on a sex offender. No formal safeguarding referral was made at this time (and such a referral would probably have been premature) but there should have been an investigation into the allegations regarding GH2.

9.6.4 Mr M went missing from GH2 on a number of occasions and over time there were increasing concerns that he was being financially and physically abused. There should have been a risk assessment undertaken in relation to his placement at GH2, both at the start and later as the specific risks emerged.

9.6.5 While Mr M was living at GH2, there appeared to be misunderstandings about Mr E's role, and this may have added to the risk for Mr M. When Mr M moved to GH2, it was clearly noted that Mr E was a resident. However, as time went on, Mr E becomes referred to as 'the manager' at the guest house and he became actively involved in the case. For example, there were discussions with Mr E about Mr M's rent arrears; Mr E was involved in managing Mr M's money; and with fetching his prescriptions.

9.6.6 The support workers also discussed their safeguarding concerns with Mr E and solicited his opinion in relation to this. Mr E should not have been involved in the management of the case, nor should his opinion have been sought. There were occasions when it was reasonable to ask him questions as a witness and co-resident of Mr M but he should not have been involved in any professional capacity, and undue weight should not have been given to his opinions.

9.6.7 Once it appeared that suitable accommodation had been (or was about to be) identified for Mr M, agencies appear to have become overoptimistic about Mr M's prospects and this seems to have led to agencies ignoring indicators that all might not be well.

9.6.8 The MAPPA meeting on 6th January 2014 was not very well attended, but a number of optimistic statements were made about Mr M, his ability to live independently, and for example, his compliance with medication. It is not clear what basis there was for this optimism, as no one had seen Mr M between 13th December 2013 and the date of the meeting, other than very briefly on 3rd January 2014, and on 9th December 2014 there were allegations that Mr M was being physically and financially abused. On 14th and 18th December the GP surgery had received letters (not shared with other agencies) from Mr M stating that he had run out of his medication, that he had no money, and that he was in pain. Given the escalating concerns about Mr M in November and early December, it is not clear why Mr M was not seen for a month, especially as the Christmas period might have been expected to contain particular risks.

9.6.9 Agencies need to be alert to the increased risk at times of change, and the MAPPA meeting on 6th January 2014, and the lead professionals' meeting on 27th February, instead of focusing largely on the plans for managing Mr M's move and support arrangements, should have also spent some time considering how to keep him safe until the move was completed.

9.6.10 The risk that Mr M ran in remaining at GH2 was underestimated by all agencies, although the support worker from Stepping Stones did note at one point that 'the only thing keeping Mr M safe is his money'.

9.6.11 In particular, there did not seem to be any consideration given to the additional risk that Mr M might face from other residents at GH2, once it was known that he was moving and that they would no longer be able to exploit him. There is a

huge body of evidence from domestic homicide reviews into the increased risk that victims face when they make the decision to leave. It is not unreasonable to draw parallels with Mr M's situation.

9.6.12 Where there is an urgency to find safe accommodation, consideration should be given to whether it is possible for an individual or family to move into an identified property before the repairs are finished.

9.6.13. With hindsight, it seems that a formal safeguarding referral should have been made before 7th February 2014. By 13th January there certainly seem to have been sufficient concerns for a referral to have been made, and any of the agencies involved could have identified this. Again, whether this would have changed the outcome in this case is debatable, as it is not clear that Mr M would have accepted alternative accommodation, especially if it limited his drinking.

9.7 The relationship between specialist and secondary care services, and primary care/universal/ preventative services in this case

9.7.1 It was noted at the MAPPA meeting on 24th July 2013 that a placement at a specialist out of borough unit would be 'in Mr M's best interests'. However, it is not clear what this option would have offered in reality. For example, what outcomes were expected? What were the chances of these being achieved? How long would a placement be and how much improvement could be expected? How would its cost effectiveness be assessed?

9.7.2 With hindsight, it would have been beneficial if agencies had been able to demonstrate a clearer understanding of what the specialist placement could offer. This would have enabled them to explore whether a similar package could have been put together locally, using preventative or universal services as well as more specialist support from, for example, alcohol services.

9.7.3 Taking such an approach would also have given agencies an opportunity to assess the relative costs and benefits of different approaches to managing the risks posed by Mr M. This might have enabled agencies to take a wider view of the funding criteria, and to have made a decision on the relative merits of the out of borough placement.

9.7.4 Whether Mr M would have accepted any intervention that required him to address his alcohol use remains a moot point.

9.7.5 Secondary care or specialist services from Mr M were ruled out, either because of cost (in the case of the specialist placement) or because Mr M failed to meet the criteria for the service. There remains therefore a question about whether primary health care services could have been better engaged in Mr M's care.

9.7.6 While partner agencies were keen to ensure that Mr M was registered with a GP and had access to prescriptions for his anti-convulsant medication, there seemed to be very limited engagement with the GP. Given that Mr M consistently failed to meet the criteria for specialist services, and given the gatekeeping role of the GP in relation to referrals for both primary and secondary care services, it is disappointing that so little effort was made to engage the GP practice.

9.7.8 Consequently, it appears that the GP, apart from issuing prescriptions, did not develop a detailed understanding of the case or of their (potentially crucial) role in supporting Mr M. The notes of the MAPPA meeting of 26th November include a recommendation that ongoing GP support should be negotiated, but it is not clear that anyone actioned this. This may have meant that the GP was not aware of the complexity of the case or the anticipated role of primary care within this, and so did not give Mr M's case the attention that it needed.

9.7.9 While specialist health services were very clear that Mr M did not meet their criteria for access, the support and guidance that they gave to primary care was weak. The assessment by the psychiatrist on 18th November 2013 states that 'Mr M would benefit significantly from appropriate placement and support to facilitate input from the Primary Care Team, allowing access for physical health and mental health monitoring by the GP, ensuring he receives regular prescriptions and is compliant with his anti-epileptic medication'. What appropriate placement and support would look like, or how to access it, is not described.

9.7.10 There were some significant missed opportunities by the GP practice. These included the failure of the practice to follow up the advice from hospitals following Mr M's attendances at A&E; their failure to action the recommendations following Mr M's psychiatric assessment on 18th November 2013; their failure to respond to Mr M's letters of 14th and 18th December 2013; and their decision (not shared with other agencies) to remove Mr M from the practice list with effect from 10th February 2014.

9.7.11 This failure to engage the GP with the case meant that when the practice took the decision to remove Mr M from their list (because he was living in Tameside and so was out of their catchment area), they did not inform any of the agencies working with Mr M of this decision. While the GP practice was legally entitled to remove Mr M from their list, the potential implications of removing a vulnerable patient without notifying the new area do not appear to have been considered in this case.

9.8 The circumstances and processes followed in relation to the safeguarding referral made by Shelter on 7th February 2014

9.8.1 Shelter submitted a safeguarding referral on Friday 7th February 2014, citing concerns that Mr M might be subject to financial and physical abuse by other residents at GH2. The risk assessment stated that Mr M was potentially at risk within the next 48 hours and that criminal acts were potentially being committed. It included a summary of the history and recent events. This was received in Rochdale at

4.33pm. No action was taken on this until 10.12 am on Monday 10th February, when the referral was faxed to Tameside, as Mr M was a Tameside resident.

9.8.2 While this was the correct action (and Shelter should originally have sent the referral to Tameside) this should have been done when the referral was received on the Friday afternoon. It is not clear why this did not happen.

9.8.3 On receipt of the referral, the Tameside business support officer telephoned Shelter Rochdale to ask if Mr M had given consent for the referral. The support worker from Stepping Stones, together with the team lead from Shelter, visited Mr M on 11th February and obtained his consent for the referral.

9.8.4 On 12th February Tameside Business Support emailed the Tameside Integrated Response and Intervention Service, who sent the referral to the duty officer in the West Locality team, together with a scanned copy of the original referral from Shelter.

9.8.5 The Duty Social worker in the Tameside West Locality team then phoned Rochdale Adult Social Care and had a conversation with a member of staff at Rochdale but failed to confirm the person's role. She was asked to send a copy of the fax to Rochdale, so that it could be discussed with the manager in Rochdale. She did this and then rang to confirm it had been received. Neither Tameside nor Rochdale recorded who would lead any investigation into the case. This was a failing on both sides.

9.8.6 Rochdale Adult Safeguarding then contacted the IT service to get access to the 'locked down' file for Mr M. (In line with Rochdale practice, because of Mr M's offending profile, his file was locked down so only named workers could access this). This request was made at 13.14 on 12th February; access was granted at 14.17 the same day, and the Head of Service was notified. This notification was not passed on to the Safeguarding Team Manager, so the team were not aware that the records were available. This may have had an impact on the management of the case, as the social worker was working from a hard copy rather than using the computer systems. This was an unfamiliar way of working and there is a possibility that the reason that the case was not followed up is that the hard copy was mistakenly put into the confidential waste.

9.8.7 On 13th February the social worker in Rochdale spoke to her team manager about the case, and was told to phone Tameside to discuss it. There is no record in either Tameside or Rochdale of this call being made, although the Rochdale social worker thinks she rang but could not speak to anyone. A record should have been made of this, and a further call made.

9.8.9 No further action was taken by either Tameside or Rochdale in relation to this referral, and Shelter did not follow up whether Mr M had in fact been seen following

their referral. All three agencies have policies and procedures for referrals and this failure by all three agencies was caused by human error.

9.8.10 There was an opportunity for the safeguarding referral to be discussed at the professionals' meeting on 27th February, but this was missed, due to this meeting focussing on the proposed move. The referral should have been discussed at this meeting.

9.9 Comments relating to the terms of reference, not already covered above

9.9.1 There were many aspects of good practice from all agencies. Many agencies provided services that were over and above their statutory duty or their contracted requirements. Examples of these included (but are not limited to):

- the GP ensuring that Mr M could access his medication at a local pharmacy
- Rochdale Adult Social Care enabling Mr M to access the prevention support from Shelter and Stepping Stones
- the high level of engagement by the support workers from Stepping Stones and Shelter
- the early focus from the SOMU on the case and the initial elevation of the risk level
- the work of the homelessness team within Rochdale Strategic Housing, despite the fact that they felt they had already discharged their statutory duty to Mr M
- the continued efforts of Rochdale Boroughwide Housing to identify suitable accommodation, despite their reservations about the case
- the mental health assessment offered by Pennine Care

9.9.2 Despite this, there were also a number of lessons for individual agencies and for multi agency working.

9.9.3 Firstly, and as is commonly found, there were issues with information recording within and information sharing between agencies. There is a need to ensure that recording of information is accurate and contemporaneous, and that, where information is shared, that there is clarity about what actions (if any) are expected to follow and by whom. This was an issue identified by Tameside ASC, Rochdale Adult Care, GMP and the Probation service, in all of which it is clear that there were significant gaps in recording or sharing of information.

9.9.3 The gaps in recording of information by GMP, and the delay in the allocation of a SOMU offender manager to Mr M after his original offender manager went off sick, means that at some key points, GMP officers were not in full possession of the all the facts in the case, and that the schedule of visits to Mr M was not adhered to.

These failings were particularly significant, given the leadership role that the police were seen as having in the management of this case.

9.9.4 In other cases, information was shared but there was a lack of clarity about what action(s) were expected to follow. This was evident not only in the mis-communications between Rochdale and Tameside Adult Social Care following the safeguarding referral on 7th February 2014, but also in the communications between Stepping Stones and the SOMU officer regarding the possible abuse being suffered by Mr M. It is possible that the Stepping Stones worker saw the SOMU officer as the appropriate person to be take these concerns forward. It is clear that this was not the SOMU officer's understanding.

9.9.5 This case did not present many issues in relation to legal processes. Because Mr M had capacity to make decisions and was able to recognise legal boundaries, he was able to consent to or to refuse interventions. While agencies may have felt that some of his decisions (for example in relation to disclosure of offences, or excessive alcohol use) were not in his best interests, Mr M had free will and could not be forced into accepting or acting on the advice or recommendations of others.

9.9.6 One aspect of the legal process that could have been used differently was in relation to Mr M's compliance with the requirements arising from his sex offender registration. Mr M was required to inform the SOMU of any change of address. Although he was missing from GH" for 10 days at one point (from 14th – 24th September), because of the difficulties in providing robust evidence on this, no action was taken. However, as he was not required to live in supervised accommodation, it is unclear how this could have been managed differently.

9.9.7 In relation to the question within the terms of reference: Were criteria regarding access to and provision of services appropriately applied, and could these criteria have posed particular issues for people who have chaotic lifestyles?
This matter has been extensively considered above. In summary, the evidence shows that the criteria were appropriately applied by health and social care but the confusion caused by Mr M's brain injury and his mental health issues meant that there was constant questioning and reassessment. Far from being excluded from services. Mr M was sometimes assessed for services even when he did not meet the screening criteria.

9.9.8 However, the specific service where Mr M (or anyone else with a chaotic lifestyle) may experience disadvantage in access is primary health care. The GP's decision to remove Mr M from their list while legal, put him at a substantial disadvantage. It is evidently very difficult for a vulnerable person, especially one with a chaotic lifestyle, to find a GP and complete the registration process. For this reason, CCGs do support vulnerable patients in registering with a GP, but in this

case, as the local CCG was not informed, Mr M would have potentially had disruption to his access to health services and to his required medication.

9.9.9 Were there any equality, diversity or cultural issues that impacted on the safeguarding of Mr M? Mr M was a White British man. He had poor memory but otherwise his cognitive functioning did not cause him problems. There were no obvious cultural, diversity or equality issues that affected Mr M or his safeguarding. His alcohol use meant that some services were closed to him (and others refused to consider him because of past behaviour). Equally, his status as a registered sex offender meant that some services would not accept him, and others placed limitations on their offer (for example, regarding where he could be housed). Some of these limitations will have had implications for his safeguarding but it is arguable that they were proportionate to the equal duty on services to protect others from Mr M.

RECOMMENDATIONS
(see document below)

Acronyms and abbreviations

CCG	Clinical Commissioning Group
CJMHT	Community Justice Mental Health Team
CPN	Community Psychiatric Nurse
EBS	Electronic Briefing System
GH1	Guest House 1
GH2	Guest House 2
GMFR	Greater Manchester Fire and Rescue Service
GMP	Greater Manchester Police
HMRCCG	Heywood, Middleton and Rochdale Clinical Commissioning Group
IMR	Individual Management Report
MAPPA	Multi-Agency Public Protection Arrangements
RAC	Rochdale Adult Care
RBSAB	Rochdale Borough Safeguarding Adults Board
RBH	Rochdale Boroughwide Housing
RSH	Rochdale Strategic Housing

SCR	Serious Case Review
SAR	Safeguarding Adults Review
TASC	Tameside Adult Social Care
TASP	Tameside Safeguarding Adults Partnership

Multi Agency Action Plan: M

Lead: Ms Jax Effiong (Community Safety Manager), Greater Manchester Fire & Rescue

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**The need for a closer working relationship with internal departments and external agencies working with the most vulnerable and hard to reach individuals has been identified within Greater Manchester Fire and Rescue Service, and is being implemented at present.** **This involves Home Safety Checks targeting the most vulnerable and hard to reach.**	Deliver PAIROF training to Protection department (internal department) Deliver PAIROF training to external partners. Clear pathways identified for information sharing and joint visits implemented.	Training material will be sent to Tameside Adult Safeguarding Partnership and new partnership agreements which capture the training requirements of external agencies, can be sent to the board also. Updated information on progression can be sent to the board on a quarterly basis if required.	Increased awareness of multiagency referrals, quicker access to GMFRS services. Increase in number of home safety checks targeting the most vulnerable inclusive of joint working.	Community Safety Managers in Rochdale and Tameside.	Throughout 2014 and 2015.
2	**Internal Partners: Protection Department**	Clear pathways identified for information sharing and joint visits implemented.	Updated information on progression can be sent to the board on a quarterly basis if required.	Increase number of referrals into the Prevention Department from internal partners.	Community Safety Manager	December 2014
3	**External Partners**	Ensure agency has updated information on GMFRS referral pathway processes. Develop partnership agreements inclusive of appropriate GMFRS training to staff as appropriate	Updated information on progression can be sent to the board on a quarterly basis if required. New Partnership agreement can be sent to the board if required	Increased awareness of multiagency referrals, quicker access to GMFRS services.	Community Safety Manager	By March 2015

Lead: Detective Inspector Joanne Reid, GMP

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**When Registered Sex Offenders are notifying at prescribed police stations that they are 'no fixed abode' it is imperative that details of where that offender may be contacted is recorded in accordance with the relevant legislation.**	Provide guidance to all enquiry counter staff as to their responsibilities when completing the registration process Ensure that SOMU officers check that notifications have been made in full and that all of the requisite information has been recorded. Dip sample completed registration forms to ensure compliance	Training material Notes from staff meetings Dip sample of completed registration forms	Compliance with statutory obligations Enhanced capacity to assist offenders with particular safeguarding concerns	DI (SOMU)	December 2014
2	**All relevant information/intelligence from partner agencies should be updated on police systems within specified timescales.**	Provide bespoke CPD training session for existing SOMU officers Review training plans for training courses for new members of staff Dip sample of ViSOR records to ensure compliance	Training material Results of dip sample process	An ability to formulate accurate risk management plans based on all available information	DI (SOMU)	February 2015
3	**Each Registered Sex Offender should have a dedicated offender manager. If an offender manager is to be abstracted for more**	Review current situation with regard to abstracted and absent officers Reallocate offender managers where appropriate Issue guidance to SOMU line	Each offender is allocated a current offender manager	An ability to be able to react swiftly to new information or intelligence Provide ownership of offenders and associated issues	DI (SOMU)	December 2014

	than two weeks then that manager's nominals should be reallocated	managers				
4	**Registered Sex Offenders should, where possible be visited according to the visits regime dictated within the risk management plan.**	Application of existing governance and tasking processes Dip sampling of ViSOR records Provide bespoke CPD training session for existing SOMU officers	Minutes from governance meetings Results of dip sample process Training material	Offenders will be visited according to the visits regime indicated with their risk management plan	DI (SOMU)	December 2014
5	**SOMU offender managers should ensure that they take the appropriate action in response to changes in circumstances with each of their offenders. This should include an assessment as to whether the risk to/from the nominal has changed and therefore may generate a new risk management plan. In particular, consideration needs to be given to whether the risks posed to an offender outweigh the risks that offender**	Provide bespoke CPD training session for existing SOMU officers Review training plans for training courses for new members of staff Dip sample of ViSOR records to ensure compliance	Training material Result of dip sample process	An ability to be able to react swiftly to new information or intelligence Provide opportunities to update risk management plans to reflect current risk Provide opportunities to conduct investigations where appropriate	DI (SOMU)	February 2015

	poses to others when making decisions about ongoing management. In addition, when information is shared, SOMU officers need to clarify with the informant as to what actions they expect to be taken.					
6	**When taking part in 'professionals meetings' which sit outside of the MAPPA process actions generated should take account of all aspects of risk including but not exclusively current risk and risks associated with move-on plans.**	Provide training to persons likely to undertake such roles Ensure that a person with sufficient knowledge of the case attends such Meetings	Training material Minutes from professionals meetings	Informed decisions can be made with regard to appropriate actions and safeguarding activity	DI (SOMU) DS (MAPPA strategy manager)	December 2014
7	**Where the police and in particular SOMU are the lead agency in the management of a case, it is important that other agencies are made aware of what the role and remit of SOMU is. Agencies need to be made aware that although the police are the lead**	Provide bespoke CPD training session for existing SOMU officers Review training plans for training courses for new members of staff Dip sample of ViSOR records to ensure compliance	Training material Result of dip sample process	Agencies involved in the management of cases will be aware of the role of SOMU and what their own responsibilities regarding case management are.	DI (SOMU)	February 2015

	agency, they do not have sole responsibility for all aspects of the management of that case.					
8	**When the police and in particular SOMU give advice about the suitability of a particular address, it must be made clear to partner agencies that this is for guidance only. The reasons for advising against a particular address should be given.**	Update guidance to officers Dip sample of records	Training material Result of dip sample process	Agencies involved in cases will have better understanding of the risk management options	DI (SOMU)	January 2015

Lead: Karen McCormick (Designated Safeguarding Adults Nurse), NHS HMR CCG

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**To encourage GPs to identify adults at risk when they de register from the practice and liaise with relevant agencies to ensure adults at risk are encouraged to re register with another GPTo ensure adults at risk have support to register with a GP, both when they initially register and when moving GP**	To identify adults at risk when they are deregistering with a GP	Learning from SCR shared with GP safeguarding leads including the importance of sharing information about adults at risk. Minutes from engagement meetings	Safe transfer of adults at risk when they move out of area	Safeguarding Lead Named GP for Safeguarding with support from the engagement officers	June 2015 December 2014
2	**To encourage GPs to follow up vulnerable patients who attend accident and emergency departments are followed up**	To monitor patients safety and welfare when problems have been identified needing an accident and emergency visit.	Learning from SCR shared with GP safeguarding leads including the importance of following up patients who attend A&E. Patient electronic record	To ensure patients are safe and receive the appropriate care	Safeguarding Lead Named GP for Safeguarding with support from the engagement officers	June 2015 December 2014
3	**To encourage GPs that, where patients pose a high risk to others (such as those subject to MAPPA processes), there is understanding and engagement by general practice in delivery of any care plan and that information regarding the patient is appropriately shared**	To increase GP understanding of MAPPA	Learning from SCR shared with GP safeguarding leads including the importance of engagement in multi agency processes Evidence of improved GP engagement with MAPPA process	Better delivery of primary care services and improved care planning for high risk individuals	Safeguarding Lead Named GP for Safeguarding with support from the engagement officers	June 2015 April 2015

4	**To ensure Gps understand the agreed process to follow when receiving and sharing information about their patients who are open to the MAPPA process**	To increase GP understanding of MAPPA To develop an agreed Greater Manchester pathway and protocol for all GPs	Learning from SCR shared with GP safeguarding leads including the importance of engagement in multi agency processes Evidence of improved GP engagement with the MAPPA process. Improved communication between all agencies	Better understanding around the MAPPA process.	Safeguarding Lead Named GP for Adult safeguarding.	June 2015 April 2015

The Pennine Acute Hospitals NHS
NHS Trust

Lead: Ann Christopher (Named Nurse, Safeguarding Adults), Pennine Acute

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**Enhance training around the risk of all types of abuse, alcohol abuse and chaotic life styles have on vulnerable adults, Ensure that alcohol misuse is identified, Audit C completed and appropriate referrals made**	The key learning from this SAR will be shared with all staff during mandatory safeguarding adults training. Dissemination of the findings of this SAR via the Trust's "Lessons Learnt" bulletin Audit staff awareness by targeted walk rounds in A/E and ward areas	Adherence to: Adults at Risk Policy Alcohol Strategy Policy for the Management of Patients/Visitors who pose a risk to children, young people and Vulnerable people.	Consideration will be given to how this case could have been managed differently within current practice.	Named Nurse Safeguarding Adults Lead Nurse Alcohol Liaison	April 2015 April 2015

Pennine Care NHS
NHS Foundation Trust

Lead: Matt Walsh (Team Manager), Pennine Care & CMHT

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**Reduce the time between new Patient Appointments for assessment of needs where it is indicated that the person who has been referred has a chaotic lifestyle that increases their vulnerability. This should be highlighted at the screening of the referral stage and monitored by individual team managers in liaison with other agencies where there are any, e.g. Housing, Probation etc.**	Community Services Manager to table at Tier 4 meeting	Notes of Tier 4 meeting	Chaotic service users may be seen in a more timely and assertive manner	Chair of the Tier 4 meeting	December 2015
2	**Where the outcome of an assessment indicates that a person does not meet the criteria for secondary care mental health services then consideration of a referral to adult care services should be routinely considered. This would need to be added to the CMHT Operational Policy**	Community Services Manager to table at Tier 4 meeting	Notes of Tier 4 meeting	Service users who have vulnerable adult needs but not mental health needs could be offered screening into Adult Care services	Chair of Tier 4 Meeting	December 2015

Lead, Jon Longden (Head of Access & Tenancy Support), Rochdale Boroughwide Housing

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**RBH need to review procedures for High Risk Offenders to consider:** **a. To ensure relevant support in place before independent living found** **b. That more than one person involved in the decision making process** **c. Review communications to ensure all partners updated of progress** **d. Consider moving in a tenant in emergency situations before all repairs completed**	Procedures to be reviewed and implemented by December 2014. Training for relevant employees.	Copy of the new procedures	This will lead to a more consistent approach, improved communications and a thorough set of procedures developed. Having more than one person involved in the decision making process will strengthen the decision making process and reduce the reliance on individual employees	Home Choices Manager	December 2014
2	**The need for a clear recommendation to be brought to MAPPA meetings on the housing options for high risk offenders**	The Homeless Service to lead on providing a clear report to MAPPA where housing needed for individuals. To liaise with partners such as RBH, the private rented sector and supported housing. Also	Update reports brought to MAPPA meetings where needed	Improved process for considering housing options for high risk offenders, taking into account the needs of the individual and the wider risk	Head of Access and Support Strategic Homelessness Manager	From November 2014

		to make clear recommendations where housing not suitable due to the risks presented by individuals. . Likely to be level 3 MAPPA meetings – lower level MAPPA will not require this process		presented to the community.		
3	**Develop training programme for partners in MAPPA process**	Training on housing issues to be offered to MAPPA partners.	Completion of training where required	Increase awareness of housing issues	Home Choices Manager	April 2015.

ROCHDALE BOROUGH COUNCIL

Lead: Donna Bowler (Head), RMBC Strategic Housing

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**Reinforcement of Safeguarding of Adults procedures across the staff base in Strategic Housing.** **Further training and identification of Safeguarding across the homeless service now that it is in RBH will be undertaken.**	Head of Service will review the case with CEO of RBH to ensure that all lessons learnt and recommendations in this review are implemented. SHM 1-1's Monthly contract monitoring of RBH. Training attended by all staff. Design a bespoke training package specifically for homeless service Indicate the actions or series of actions to be taken to achieve the expected outcomes.	Minutes of meetings with CEO and at RBH monitoring meetings. Training log of attendees for training.	There must be a discussion with Accommodation Managers and Deputies for all current clients living in homeless hostels to assess if they require Adult Safeguarding support . For each new service user an Adult Safeguarding analysis will be undertaken	Head of Service SHM SHM & RBH Homeless Accommodation Manager	Following review an Action Plan to be completed and monitored by Housing SMT and at Joint monitoring meetings with RBH. Performance on action plan to be reported in monitoring meetings. all actions to be agreed at First monitoring meeting following final review.

		Training attended by all staff				

Lead: Julie Moore (Service Unit Manager), Tameside Council

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**Review SGA guidance and current working practices.**	Develop best practice guidance that ensures implementation of the Policy correctly.	Provide step by step guidance that all levels of staff adhere to for all referrals received and for responding to.	Every SGA referral will always go to lead SAM to determine response.	Head of Assessment and Care Management Service	March 2015
2	**Review the current Business process for new and existing SGA.**	To reduce the number of handoffs within the Business process and or electronic system.	Practice guidelines to be implemented across all teams around improved Business process and best use of electronic system	Consistent practice across all teams around decision making, communication, recording of information	Head of Assessment and Care Management Service	December 2014
3	**Review communication process and recording and sharing of information.**	Review as part of improving the Business process and best use of electronic system.	Case Audits, Staff Training, Team Meeting agenda items, supervision agenda item	Improved communication and information sharing, quicker response to SGA.	Head of Assessment and Care Management Service	March 2015
4	**Re circulate the protocol around the Host Authority responsibility.**	Provide copies and awareness sessions for all staff	Minutes from Team Meetings, Supervision, awareness sessions across all teams.	Lead SAM to be identified across multi agencies/lead co-ordinator.	Head of Assessment and Care Management Service	December 2014

Lead: Steven Blezard (Assistant Director), RMBC Adult Care

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	Need for clear procedure on restricting and unlocking access to electronic case records	Develop a clear protocol and process for restricting and unlocking access to electronic case records and updating case records that are restricted.	Protocol in place	Staff, Managers and information colleagues are aware of the process to be followed to restrict access to a care record and to enable the updating of a restricted record.	Head of Service Access and Enablement	Completed June 2014
2	Need for refresher risk assessment training for social workers receiving referrals	Refresher Risk assessment training to be provided to all social workers receiving referrals	Record of training undertaken	The timely actioning of referrals evidence a sound understanding of risk.	Head of Safeguarding and Practice Assurance	April 2015
3	Additional training in safeguarding awareness and referral procedures for housing related services supporting vulnerable adults.	Refresher safeguarding awareness and referral process training for related support service providers.	Record of training	Enhanced safeguarding awareness and risk identification.	Head of Safeguarding and Practice Assurance	April 2015
4	Need for revised duty social worker access arrangements.	Review Duty Social Worker access arrangements and expectations of administrative staff.	New process in place	Consistent timely access to Duty Social Worker	Assistant Director Operations	October 2014

5	To examine the findings of this SAR in light of the Care Act expectations regarding support offered to Vulnerable Adults who would not meet current thresholds for service	To establish a working party to review services (e.g. Alcohol /substance misuse) where people have little mental/physical functional impairment but are not willing to engage with prevention/treatment services available, and compare access criteria now and under the expectations of the Care Act. This group should identify any required changes and options for delivering these changes.	Working group established, ToR agreed, report produced and agreed by Director of Adult Social Care, RMBC	Report from the working party, describing the required changes, the rationale for these, and the options for delivery. This report should be presented to Rochdale Adult Care Senior Management Group and Rochdale Borough Safeguarding Adult Board.	Head of Safeguarding & Practice Assurance, RMBC	February 2015

Shelter

Lead: Tricia Euston (Business Support Manager), Shelter

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**Periodic reviews must be undertaken to reflect on the support work and progress so far and to ensure that the clients wishes, opinions and needs remain central to any support provided.**	Our operating procedures on case progression will be amended to include a formal review stage. The revised procedures will then be communicated to staff in both a team setting and on a one to one setting.	A copy of the revised procedures.	Clearer direction and guidance for staff on best practice. Enables progress against the support plan to be assessed and puts the client at the centre of the support provided.	Deputy Head of Business Support	November 14
2	**Ensure that staff are aware of the requirements in respect of safeguarding alerts.**	. The Business Support Team will include the lessons learned and recommended actions in an update to all services in the Operations division. Our safeguarding panel will consider if and how our new case management system can help to review safeguarding alerts more effectively. The outcome of the	A copy of the update	More effective Safeguarding practices, more adherence to the required policy and improved assurance activity.	Deputy Head of Business Support for the dissemination and update. Head of Business Support on the safeguarding panel	November 14.

		panel's monthly review of alerts will feed into the Business Support Teams assurance activity.				
3	**Ensure that all action plans are clear, succinct and with appropriate timescales in order to progress cases effectively and achieve the desired outcome.**	We will develop a Working With Our Clients policy and review our support service procedures ensuring that we meet the requirements of the Quality Assurance Framework. New policy and procedures will be presented to senior managers by Business Support and then cascaded down to services by Service Managers and/or Team Leaders.	A copy of the new policy and a copy of any revised support procedures.	Clearer direction and guidance for staff on best practice. More efficient working and improved case progression.	Deputy Head of Business Support	November 14
4	**Shelter safeguarding panel to review our safeguarding policies.**	Review the policies and determine if guidance needs to be provided in situations when there is both a host and placing authority.	Report on the outcome of the review and a copy of any updated policies.	Ensuring our policies covers such situations.	Safeguarding Panel	November 14
5	**Improve communication and information handling between internal teams at Shelter.**	Within our Operating Framework we will develop guidance on Integrated Service Provision and a section within the support service procedures on integrated working/referrals.	A copy of the guidance and procedures.	Clearer direction and guidance for staff on best practice. Seamless access for our clients to all our services.	Deputy Head of Business Support	November 14

		The Business Support Team are tasked with assurance of all services and compliance with our Operating Framework.				

Lead: Julie Evans (Service Development & Performance Manager), Stepping Stone Projects

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	**Ensure staff are clear on how and when to raise Safeguarding Alerts, that is, the need to raise a Safeguarding Alert in addition to raising concerns at MAPPA and other multi agency meetings.**	Review Safeguarding Policy to emphasise the need to raise a Safeguarding alert directly to the Safeguarding Board. All Safeguarding concerns to continue to be an agenda item during Supervision Meetings and Team Meetings. Add a Safeguarding Alert Event on Case Management System.	Copy of the revised Safeguarding Policy and Procedure and Form will be forwarded to the Board. Update Training records. Minutes of Meetings. Correspondence.	Safeguarding Alerts being raised directly by the organisation. Increased awareness of local processes.	Service Development and Performance Manager and Service Managers	January, 2015
2	**Regular reviews of Support Plans and Risk Assessments to be carried out in timely manner to reflect changes in circumstances.**	Ensure each Support Worker is aware of the importance of reviewing Support Plans, Client Dials, Risk Assessment and Risk Management Plans and Home Risk Assessments in line with Policy and Procedures and as	Minutes of Team Meetings Correspondence File Audits	Ensure records are current and reflect the actual work being carried with the client. Increased awareness	Service Managers	December, 2014

		circumstances substantially change. To be addressed during Team Meetings by the Service Manager to ensure consistency. To ensure that Joint Support Plans are in place when Stepping Stone Projects are jointly providing support with another agency, and that joint working arrangements are reviewed regularly. To ensure that the service provided match the client's needs.		of when to withdraw services where clients are not engaging with different elements of the service.		
3	**Ensure that all Safeguarding Alerts are covered within Staff Supervision Meetings.**	Support Workers to ensure that all clients, where there are concerns in relation to vulnerability or safeguarding issues, are highlighted within the Client Update Sheet which is completed prior to a Supervision meeting. Service Managers to run a report on Safeguarding Alerts/Concerns prior to Supervision Meeting to ensure that all safeguarding issues are discussed.	Minutes of Meetings Client File Audits	Ensure good practice and consistency of service and provision. Ensure formal safeguarding alerts are raised Ensure Service Managers are aware of and updated in relation to safeguarding concerns	Service Managers	December 2014

Lead: National Probation Service, North West Division, Rochdale

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	Single agency risk training to include refresher training on the requirement to provide evidence of ongoing risk assessment and management by recording fully information, decisions and actions on the appropriate systems.	To be included in risk training to be delivered locally to probation practitioners during October 2014 and led by Risk SPOs.	Copy of relevant training material and completed attendance sheets.	Improved evidence of risk assessment and management work undertaken to safeguard the offender and protect the public.	Local ACE & Risk SPOs.	31/10/14
2	MAPPA Vice / Chairs and minute takers to be reminded of the requirement to complete MAPPA minutes in full to record accurately and reflect the information, decisions and actions taken and outcomes achieved by the agencies involved.	To re-issue guidance to MAPPA Vice / Chairs / minute takers and bring to attention of all members of the Probation Public Protection – Risk Practice Development Group (RPDG)	Copy of email / guidance sent to MAPPA Vice / Chairs / minute takers and copy of relevant agenda item recorded in minutes of the RPDG.	Improvement in MAPPA minutes to accurately record agency feedback shared and taken into account in decision making and actions set to manage risk, Improvement to be	MSU Lead Manager	31/10/14

				assessed by case file audit		
3	MAPPA Vice / Chairs / minute takers / M'SU representatives to be reminded of the requirement to set SMART actions so that the panel is clear about what exactly is required, by whom, from whom and when.	To re-issue guidance to MAPPA Vice / Chairs / minute takers and bring to attention of all members of the Probation Public Protection – Risk Practice Development Group (RPDG)	Copy of email / guidance sent to MAPPA Vice / Chairs / minute takers and copy of relevant agenda item recorded in minutes of the RPDG.	Improvement in MAPPA minutes to set SMART actions so that the panel is clear, in terms of risk management / safeguarding, about what exactly is required, by whom, from whom and when.	MSU Lead Manager	31/10/14
4	Agency representatives to be reminded to provide information, in relation to attendance or feedback / updates as requested.	i. To re-issue guidance to all local agency representatives about the duty to co –operate with MAPPA and action to take if unable to attend. ii. To review standard invitation email to ensure action to take in the event on non attendance is clearly stated. iii. To be reinforced by MAPPA Chairs at the	i. Copy of email / guidance sent to all local agency representatives. ii. Copy of standard MAPPA invitation. iii. Copy of relevant section of MAPPA	Improved attendance at meetings or a written update of sufficient quality to enable the panel to make informed decisions and actions to manage risk of harm / safeguarding.	Local Head of Service and Risk SPOs	i. 31/10/14 ii. 31/10/ 2014

		start of next two MAPPA L2 & 3 meetings. iv. To bring to the attention of members of the RPDG	minutes. iv. Copy of relevant agenda item recorded in RPDG minutes.			iii. End Oct 2014 iv. December 2014
5	Over reliance on MAPPA process: lack of resources / contingencies to safeguard vulnerable adults subject to MAPPA registration.	i. Probation to contribute fully to the SCR on Mr M. ii. to bring to the attention of the RPDG for information and discussion. iii. to bring to the attention MAPPA SMB Greater Manchester for discussion and advice. iv) Probation Service to offer training and information on the	i. Active participation in SCR. Attendance at meetings / completion of IMR. ii. copy of relevant agenda item recorded in RPDG minutes. iii. copy of relevant agenda item recorded in SMB minutes. iv) Training and information in place	Increased awareness of the difficulties faced by local agencies and the MAPPA process in adult safeguarding; to work together to improve inter-agency co-operation; identify local resources and / or agreed contingencies to improve support in safeguarding / risk management.	Local Head of Service and Risk SPOs.	i. December 2014 ii. December 2014 iii. January 2014

		MAPPA process to all external partners				January 2014
6	When an individual is subject to MAPPA processes, consideration should be given to whether there is a need to identify a care co-ordinator, to ensure that required actions are progressed and that where a person is potentially vulnerable, that due consideration is given to mitigating this.	For the initial MAPPA meeting to consider whether a care co-ordinator is required and if so, to identify a lead professional to take on this role. Subsequent meetings should review this decision.	Case file audit to identify Improved action planning and progress against the action plan	Better understanding of goals of the plan and progress against these		December 2014
7	Single agency risk training to include refresher training on the MAPPA/resettlement requirement to identify vulnerable high risk cases at least 6 months prior to release, secure appropriate support/services and develop a robust multi-agency risk management plan	To be included in risk training to be delivered locally to probation practitioners during October 2014 and led by Risk SPOs	Copy of relevant training material and completed attendance sheets	Improved risk assessment and management of work undertaken pre-release to safeguard the public	Local ACE and Risk SPOs	November 2014

Actions for Tameside Adults Safeguarding Partnership and Rochdale Borough Safeguarding Adults Board

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	Promote adherence to information sharing protocols	TASP and RBSAB to review guidelines on information sharing – in particular, to ensure when information is shared, the person sharing the information is clear about why they are sharing it and what they expect the receiver to do with the information	In response to organisations information sharing protocol individuals are encouraged to challenge or question why information is being shared	Better understanding within and between agencies of why information is shared More clarity between workers on expectations	Head of Safeguarding , Rochdale Adult Care and Safeguarding Adults Coordinator, Tameside Adult Social Care.	April 2015
2	TASP and RBSAB to request that Prison Service take note of this SCR with aim of ensuring that prison discharge planning starts early enough to enable partner organisations to provide appropriate support in timely manner	TASP and RBSAB to write a joint request to HMP Service and NPS to highlight how the lack of discharge notice given to partner organisations in this particular case caused avoidable homelessness and associated risks	Evidence of Formal correspondence.	To improve prison discharge arrangements for prisoners with care and support needs, in line with Care Act guidance.	Head of Safeguarding, Rochdale Adult Care and Safeguarding Adults Coordinator, Tameside Adult Social Care.	Jan 2015
3	TASP and RBSAB partner organisations to ensure that all staff are aware of the need to make	TASP and RBSAB Business Units to send reminder to all partners	To include in organisational safeguarding audit	Avoidance of delay in assessment;	Head of Safeguarding, Rochdale Adult Care and Safeguarding	January 2015

	timely alert/referrals in accordance with multi agency Out of Borough Safeguarding Adult s policy and procedures.				Adults Coordinator, Tameside Adult Social Care	
4	Ensure that multi agency safeguarding adults policy and procedures for TASP and RBSAB reflect that professionals making a referral/alert need to take responsibility for following up any alert within the agreed time frame if they have not received a response from the receiving team.	To update Safeguarding Adults at Risk Multi Agency policy and procedures	Updated policy and procedures in place	Early identification of referrals that have not been acted upon.	Head of Safeguarding, Rochdale Adult Care and Safeguarding Adults Coordinator, Tameside Adult Social Care	March 2015
5	Respective Tameside and Rochdale SAB's to consider introducing a Multi-Agency Risk Management escalation policy for high risk cases	Discussion at Board level of the need for a multi-Agency risk management escalation policy	Discussion reflected in respective Board minutes	Consideration of multi – agency risk management escalation policy for High Risk cases	Head of Safeguarding, Rochdale Adult Care and Safeguarding Adults Coordinator, Tameside Adult Social Care	March 2015
6	Safeguarding referrals should be a standing agenda item at MAPPAs to consider any changes in circumstances of the individual that might necessitate a Safeguarding referral.	TSAB and RBSAB should contact the National Probation Service to draw attention to this case and request that safeguarding referrals become a standing item on agenda	Response from National Probation service	All partners can discuss individual circumstances and thresholds that may necessitate a referral for quicker access to services.	Head of Safeguarding, Rochdale Adult Care and Safeguarding Adults Coordinator, Tameside Adult Social Care	December 2014
7	Ensure learning from this SAR is cascaded to staff in partner agencies. This will include issues regarding pathways, care co-ordination in MAPPA processes and the role of alcohol in this case.	Boards to co-ordinate a multi-agency learning event to cascade the learning from the Serous case review to partner organisations orgs Make the SAR available nationally	Event run SAR available via internet (publicised via independent chair network)	Improved understanding among staff regarding people who are risk to themselves as well as to others	Head of Safeguarding, Rochdale Adult Care and Safeguarding Adults Coordinator, Tameside Adult Social Care	April 2015

8	Share the learning from this SAR with GM MAPPA Strategic Parternship	The SAR to be put on the agenda of the GM MAPPA Strategic Management Board	SAR on the agenda and the outcome of the discussion recorded	Improved systems for linking MAPPA and safeguarding across Greater Manchester	Independent Chair, TSAP and RBSAB	December 2014