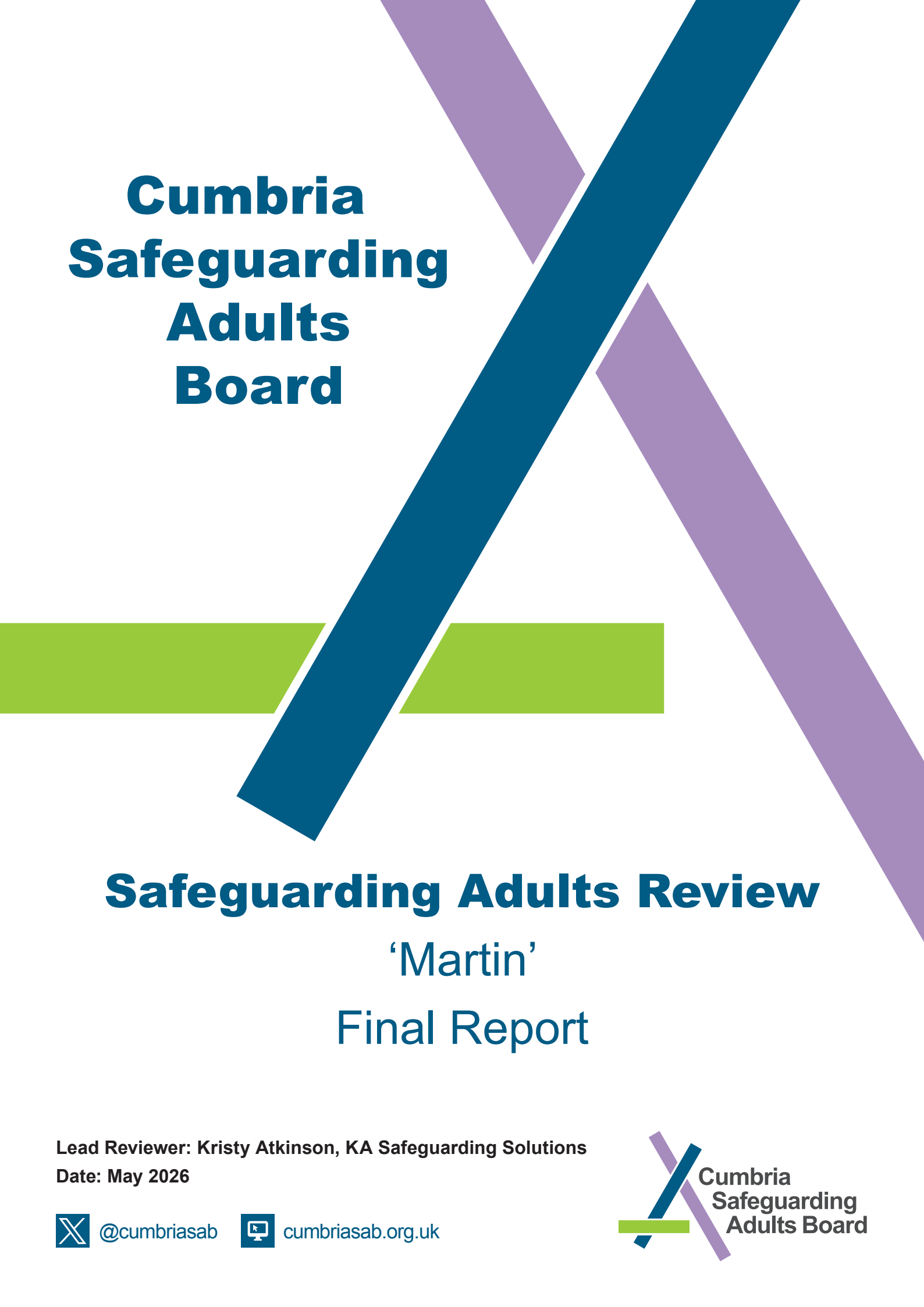




Cumbria Safeguarding Adults Board

Safeguarding Adults Review **‘Martin’** **Final Report**

Lead Reviewer: Kristy Atkinson, KA Safeguarding Solutions

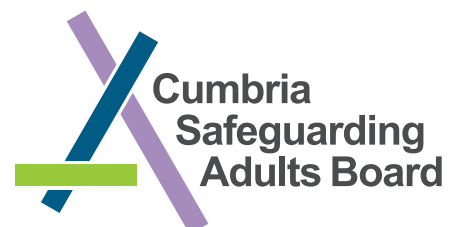
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Safeguarding Adults Review

'Martin'

Contents

1. Introduction	1
2. About the Reviewer	1
3. Organisational involvement	2
4. Parallel processes	2
5. Methodology and limitations	3
6. Scope of the review	3
7. Protected Characteristics and Equality Considerations	4
8. Terms of Reference	4
9. Family involvement	5
10. Practice context	5
11. Individual context	6
12. Organisational context	7
13. Lessons learned and Findings	7
14. Theme 1: The Person in Context	7
15. Lessons Learned	14
16. Findings	15
17. Recommendations – Theme 1	17
18. Theme 2: The System in Context	18
19. Lessons Learned	20
20. Findings	23
21. Recommendations - Theme 2	24
22. Theme 3: Professional Practice and MultiAgency Working	25
23. Lessons Learned	30
24. Findings	32
25. Recommendations – Theme 3	35
26. Conclusion	37
27. Appendix 1 - Key Practice Episodes	38
28. Appendix 2 - Complete Terms of Reference	39
29. References	41

1. Introduction

- 1.1. This Safeguarding Adults Review (SAR) was commissioned by the Cumbria Safeguarding Adults Board (CSAB). It is to understand and learn from the circumstances surrounding Martin between February 2022 and his death in May 2024. The referral for this review was made by North Cumbria Integrated Care NHS Foundation Trust in August 2024.
- 1.2. Under Section 44 of the Care Act 2014, a Safeguarding Adults Board must arrange a SAR when an adult with care and support needs has died or experienced serious harm as a result of abuse or neglect (whether known or suspected), and there is concern that partner agencies could have worked together more effectively to protect the individual.
- 1.3. The primary purpose of a SAR is to identify what actions agencies and professionals could have taken differently to prevent the death or serious harm of the adult. It also enables lessons to be learned and applied to improve future safeguarding practice.
- 1.4. The CSAB determined that Martin's circumstances met the mandatory criteria for a review. He was an adult with care and support needs who experienced issues including self-neglect and mental health difficulties. These highlighted potential areas for learning across agencies.
- 1.5. An Independent Reviewer was commissioned in October 2025 and commenced work in December 2025. The commissioning timeline was influenced by a concurrent thematic review on self-neglect, to ensure alignment and avoid duplication of learning.
- 1.6. While recognising and respecting Martin's autonomy and rights, this review explores how agencies responded to persistent risks, the challenges associated with engagement, and the opportunities to intervene earlier or more effectively. It aims to provide learning for multi-agency partners, emphasising the importance of coordinated action. It also places a focus on professional curiosity, and a shared understanding of how multiple exclusion factors influence risk and decision making when safeguarding adults experiencing self-neglect.

2. About the Reviewer

- 2.1. This SAR has been led by Kristy Atkinson. An Independent Safeguarding Consultant who has no previous involvement with this case and no existing connections to the Safeguarding Adults Board, or partner agencies. Kristy brings extensive experience in social work, learning disability and safeguarding across Local Authority and NHS commissioning contexts. They have completed Stage 1 of the SCIE SAR Reviewer Programme and progressing towards Stage 2 accreditation.

3. Organisational involvement

- 3.1. A multi-agency panel established by CSAB conducted this review and produced this report for submission to the Board. The following agencies contributed to this review.

Role	Organisation
Safeguarding & Public Protection Named Nurse	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)
Safeguarding Adults Acting Team Manager	Cumberland Council (Adult Social Care)
Service Manager	Cumberland Council (Public Health, HAWC Service)
Team Leader	Cumberland Council (Public Health, HAWC Service)
Public Protection Unit	Cumbria Constabulary
Specialist Safeguarding Practitioner, Practice Education (Adults)	North Cumbria Integrated Care NHS Foundation Trust (NCIC)
Deputy Designated Professional for Safeguarding	North East & North Cumbria Integrated Care Board
Safeguarding Practitioner	North West Ambulance Service (NWAS)
Senior Operations Manager	Home Group Housing Association
Service Manager	Recovery Steps Cumbria
CSAB Business Manager	Cumbria Safeguarding Adults Board
Business Support	Cumberland Council

4. Parallel processes

- 4.1. The primary purpose of a SAR is to promote learning and strengthen safeguarding systems in order to prevent future harm. It does not apportion blame or determine accountability. Other formal processes such as criminal investigations, employment or disciplinary procedures, and regulatory action by bodies such as the Care Quality Commission (CQC), Nursing & Midwifery Council (NMC), Health Care Professionals Council (HCPC), or General Medical Council (GMC) are responsible for those functions (SCIE, 2024¹).
- 4.2. There were no parallel processes identified during this SAR. The review was not constrained by any concurrent statutory processes. The SAB did, however, have a thematic Safeguarding Adults Review underway during the wider period in which Martin's case occurred. This thematic SAR was not a parallel process to this review, but its ongoing work on self-neglect provides important context for understanding system developments and the learning that partners have been progressing during the same timeframe.
- 4.3. Where simultaneous processes do occur, effective coordination between the SAB and the relevant agencies is essential to ensure that each can progress without impeding the others.

¹ [Safeguarding Adults Reviews \(SARs\) under the Care Act - SCIE](#)

5. Methodology and limitations

- 5.1. This SAR draws on systems learning theory, recognising that harm rarely results from a single error or individual failure. It places a focus on the interaction of people, processes, decisions, thresholds, and system pressures over time.
- 5.2. In line with systems learning principles, the review did not attempt to examine every contact in detail. Instead, it focused on key practice episodes (Appendix 1) where decisions about risk, capacity, engagement, safeguarding thresholds, or escalation had a significant influence on the trajectory of support. These episodes were selected because they represented points within the system where alternative actions may have been possible. They were also understanding professional sensemaking in context to generate meaningful learning.
- 5.3. The review evaluates evidence from multiple sources. This included agency significant event chronologies, systems analysis, local and national SAR's, research, and evidenced-based practice. It also included the views of practitioners, family members, and agencies involved in Martin's case. The methodology was jointly developed and agreed by the multi-agency panel and the Independent Reviewer.
- 5.4. The review process followed these steps:
- 5.5. **First panel meeting:** Objectives, Terms of Reference, methodology, and themes for the SAR were agreed.
- 5.6. **Initial analysis:** The Independent Reviewer met with Martin's sister, collated combined agency significant event analysis and scoping information, and completed an early analysis report.
- 5.7. **Second panel meeting:** Early analysis report reviewed, and preparations made for the Practice Learning Event.
- 5.8. Practice Learning Event: Conducted face to face by the Independent Reviewer, alongside one-to-one meetings with individual practitioners as required.
- 5.9. **Draft report circulation:** System learning draft report shared with partner agencies for comments.
- 5.10. **Structured panel meeting:** Finalisation of the report and findings.
- 5.11. **Report presentation:** Report submitted to both the Safeguarding Adult Review Subgroup and Safeguarding Adults Board
- 5.12. **Report publication:** Agreed date for the report to be published.
- 5.13. There have been no limitations within the methodology that have impacted on this review.

6. Scope of the review

- 6.1. The SAR will examine the period from February 2022 to May 2024. It covers the key events and multi-agency activity relevant to Martin's care, support, and safeguarding from the initial cluster of referrals through to the date of his death. Contextual information from outside this timeframe was considered where it helped to understand historical factors, professional decision-making, or system responses that influenced practice within the review period.

7. Protected Characteristics and Equality Considerations

- 7.1. In line with the Equality Act 2010, this SAR considered whether Martin's protected characteristics may have influenced his experiences, access to services, or the responses of agencies. Martin was a 44 year old White British man. There is no evidence within agency records to indicate that Martin identified with protected characteristics such as disability, religion or belief, sexual orientation, or gender reassignment under the Equality Act 2010². As part of this review, his family member was consulted and did not identify any additional relevant protected characteristics.
- 7.2. The review does recognise that Martin experienced significant vulnerabilities. These included illiteracy, alcohol dependence, mental distress, homelessness, and social isolation. Such vulnerabilities may have intersected with service thresholds, engagement expectations, and professional decision-making.
- 7.3. This review does not assume discrimination. It explores how system design, accessibility, and proportionality of response may have disproportionately affected an individual whose needs did not consistently meet statutory thresholds, but who experienced escalating harm over time.

8. Terms of Reference

- 8.1. The purpose of this SAR is to use the experience of Martin to identify learning about how the multi-agency safeguarding system worked to support and protect him. The review aims to promote reflection and improvement across agencies by exploring the factors that enabled or hindered effective practice. It does not attribute individual blame.
- 8.2. Several key themes have been identified to guide the analysis. These form the Terms of Reference (ToR) for the review and act as the overarching research questions. They structure the findings and ensure that the learning generated is evidence-informed, relevant, and actionable. The full Terms of Reference are included in Appendix 2.
- 8.3. The key themes emerging from the Terms of Reference for this Safeguarding Adults Review span three interconnected areas:
- 8.4. **Theme 1:** The Person in Context highlights Martin's experiences of trauma, early adversity and self-neglect. It runs alongside Mental Capacity considerations and communication barriers, underscoring the importance of Making Safeguarding Personal.
- 8.5. **Theme 2:** The System in Context focuses on how accumulating risk, multiple exclusion, threshold decisions, and resource constraints shaped the system's response.
- 8.6. **Theme 3:** Professional Practice and Multi-Agency Working examines the role of professional curiosity. It observes the distinction between single-agency and multi-agency risk management, and the effectiveness of safeguarding practice. It also addresses proportionality, escalation, accountability and information sharing as essential components of coordinated intervention.

² [Equality Act 2010](#)

9. Family involvement

- 9.1. The Independent Reviewer had the opportunity to speak with one of Martin's sisters. She described him as a quiet, gentle man who was always smiling and enjoyed conversation over a cup of tea. He was known for his independence and rarely asked for assistance, including practical and financial help.
- 9.2. Martin lived with his parents for most of his life. His mother acted as his primary carer until both parents passed away within a short period of each other. Following their deaths, he continued living alone in the families three bedroom parlour house. He experienced significant difficulties maintaining the property. Due to being unable to read or write, he struggled to manage household bills and other correspondence. These responsibilities were new to him.
- 9.3. Unbeknown to him, a bedroom tax debt accumulated into several hundred pounds. This ultimately led to his eviction and subsequent homelessness. His sister described this period as the point at which his alcohol use began to increase.
- 9.4. Following discussion with his sister, the family have chosen for his real name to be used within this review. His sister confirmed her understanding that the final report may be published and placed in the public domain. She expressed the family's wish that his name be included to honour him and ensure his experience contributes meaningfully to system learning.
- 9.5. On behalf of the CSAB and its partner agencies, we offer our sincere condolences to Martin's family.

10. Practice context

- 10.1. The CSAB considered the case of Martin, a White British man who lived in Cumbria and died in May 2024. At the time of his death, he was living alone in a social landlord tenancy. He had longstanding vulnerabilities rooted in childhood learning difficulties, attendance at a special educational school, bereavements, eviction, and periods of rough sleeping.
- 10.2. Although not formally diagnosed with a learning difficulty, he was unable to read or write and relied heavily on verbal explanation. His alcohol use escalated following the deaths of both parents, after which he struggled to maintain a tenancy and manage the demands of daily life.
- 10.3. He was known to multiple agencies over many years and frequently grappled to engage with the types of support offered. His level of need, coupled with challenges in engagement, contributed to a complex pattern of risk involving his physical health, mental health, alcohol use, and housing stability. His story provides opportunities for learning around multi-agency escalation, risk formulation in chronic selfneglect, use of legal frameworks, and embedding trauma-informed, persistent approaches to engagement.
- 10.4. Figure 1 provides a visual overview of the key elements shaping Martin's circumstances. This illustrates how personal history, trauma, environmental factors, and social stressors interacted and influenced both his lived experience and professional responses. It highlights the interconnectedness of trauma, selfneglect, homelessness, substance use, and safeguarding concerns.

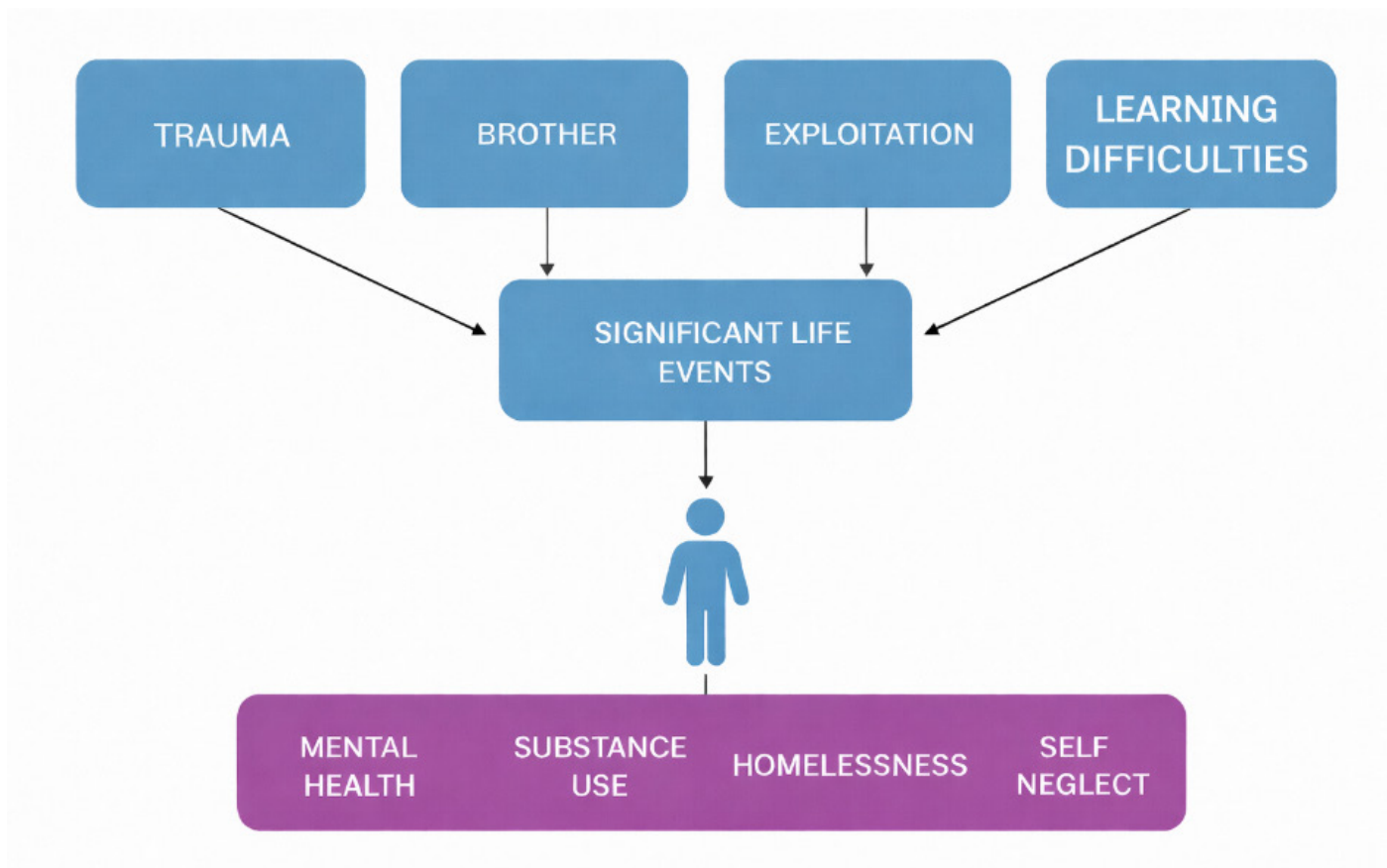


Figure 1: Key Elements in the case of Martin – a visual representation (AI generated image for illustrative purposes only)

11. Individual context

- 11.1.** Research consistently shows that people experiencing homelessness, trauma, substance dependence or self-neglect often struggle to engage with services in the ways traditional pathways assume. National studies³ demonstrate that responses to self-neglect and homelessness are frequently episodic, task focused, and fragmented. This is partly because practitioners may underestimate the impact of trauma, cognitive overload and environmental instability on a person's ability to act on advice or sustain change.
- 11.2** Evidence from lived experience research⁴ and clinical guidelines⁵ verify people facing multiple exclusion homelessness often experience services as reactive and inconsistent, and that meaningful engagement relies on persistent, relational approaches rather than self-referral or office based contact. Studies⁶ also emphasise that siloed contact and limited multi-agency planning can mean that critical risks such as exploitation, environmental harm or self-neglect remain unrecognised.

³ [Social work practice with self-neglect and homelessness: Findings from vignette-based interviews | The British Journal of Social Work | Oxford Academic](#)

⁴ [PowerPoint Presentation](#)

⁵ [Clinical guidelines for alcohol treatment - 9. Alcohol assertive outreach and a multi-agency team around the person - Guidance - GOV.UK](#)

⁶ [AHURI-Final-Report-433-Lived-experience-participation-and-influence-in-homelessness-and-housing-policy-service-design-and-practice.pdf](#)

- 11.3.** In Martin's case, these national findings resonate strongly. His vulnerabilities and experiences highlight the importance of coordinated trauma-informed responses that consider both his lived experience and his fluctuating mental capacity.

12. Organisational context

- 12.1.** Contact with Cumbria's health and social care system arose from a combination of housing needs, alcohol use, and broader physical, mental health and social care needs. Martin sought support at various times for budgeting, access to essential household items, and help managing his alcohol use. Over the review period he was supported by Adult Social Care (ASC), the police, Recovery Steps Cumbria (RSC), the Crisis Resolution and Home Treatment Team (CRHT), Health & Wellbeing Coaches (HAWC) and his housing provider, Home Group. Home Group held the clearest and most consistent visibility of Martin's daily functioning, emotional distress, environmental conditions and escalation patterns. These are evidenced through welfare concerns, and tenancy-related contacts. HAWC offered a valuable preventative service throughout. Whilst Housing Options sat outside the formal scope of this review, their historical involvement provided sustained relational contact and practical support. This illustrates the protective value of consistent, relationship based engagement for individuals with complex and fluctuating needs.
- 12.2.** Martin's trauma history, literacy difficulties and substance use shaped his ability to interact with services and take up support. Procedural system factors included limited face-to-face contact, the absence of homebased assessment, and a lack of coordinated multi-agency oversight. These reduced opportunities to identify emerging risks related to self-neglect, exploitation and environmental deterioration.
- 12.3.** In January 2023, Martin told HAWC staff that he did not feel safe in his accommodation and had been sleeping in the cemetery. Practical support was offered. However, this disclosure did not lead to multi-agency escalation relating to housing safety or safeguarding concerns. This reflects a wider system pattern in which significant information was responded to in isolation, rather than prompting coordinated review or shared risk planning.
- 12.4.** Since 2024, CSAB has strengthened its strategic oversight of homelessness and rough sleeping. In response to national ministerial recommendations⁷, the Board has identified senior housing representatives as executive members and commenced work to improve accountability, system-wide governance links (such as with Homelessness Reduction Boards) and reporting on rough sleeping.

13. Lessons learned and Findings

- 13.1.** The lessons learned and findings sections consider what we can learn from Martin's case and apply to the context of the wider system.

14. Theme 1: The Person in Context

- 14.1.** Martin's first recorded engagement with services followed a significant personal loss. The death of his mother and subsequent eviction from their shared tenancy in 2013 led to

⁷ [Ministerial Recommendations for Safeguarding Adult Boards.pdf](#)

the onset of street homelessness. This formed an early cluster of traumatic events that shaped the pattern of his later interactions with services. During this period, he started to use alcohol regularly. He was described as dependent by himself, his family, and practitioners. Alcohol is believed to have served as a coping strategy following multiple losses.

- 14.2.** Martin was unable to read or write. He attended a special educational school and identified as having dyslexia. Several agency records indicated possible learning difficulties. He could often recall information and occasionally attend appointments. Martin required support to understand written communication and to follow through on plans.
- 14.3.** Between November 2013 and December 2014, Martin received support from HAWC and Housing Options. He was located sleeping rough in a park and cemetery, and interventions focused on immediate safety and stabilisation. A duty to refer was made, resulting in a prompt move into temporary B&B accommodation.
- 14.4.** His contact with Housing Options was variable. Practitioners indicated he engaged best through practical, relational support, particularly from a consistent male worker. At times, he required daily 1:1 contact despite policy specifying weekly visits. From his initial eviction to securing his flat in Whitehaven in 2019, they deployed their statutory duties in securing temporary accommodation, supported housing and practical support to access permanent accommodation.
- 14.5.** Services did take account of his wishes, notably when he later declined accommodation in Carlisle. This was due to anxiety about unfamiliar environments. He was instead housed in a flat locally, reflecting an element of personalised care and partnership.
- 14.6.** Practical assistance was also offered. This included food bank vouchers, benefits advice, and housing guidance via the HAWC. Housing related support was commissioned via the Supporting People Grant⁸ for 3 hours per week intended to support him with his tenancy needs. Housing Options helped to carpet and furnish his accommodation.
- 14.7.** Family members described him as vulnerable and already struggling over this timeframe of being accommodated. His sister recalled that although services were expected to visit twice weekly, she was uncertain whether this level of contact was consistently maintained. HAWC and Housing Options records note that Martin frequently left his accommodation before staff arrived. This limited opportunities for engagement.
- 14.8.** National research⁹ on homelessness and self-neglect illustrate such patterns are common among people experiencing Martin's degree of trauma and cognitive overload. Rather than reflecting "non-engagement," these behaviours often indicate distress, avoidance linked to past adversity, or difficulties with executive functioning. The research emphasises episodic contact, avoidance and missed appointments should be interpreted as risk indicators.

⁸ The Supporting People programme was launched on 1 April 2003. The main aim of the programme was to help end social exclusion and to enable vulnerable people to maintain or to achieve independence through the provision of housing-related support. It was delivered largely by the Third Sector and helped around 1 million people.

⁹ [Social work practice with self-neglect and homelessness: Findings from vignette-based interviews | The British Journal of Social Work | Oxford Academic](#)

- 14.9.** National learning from the Making Every Adult Matter (MEAM¹⁰) and the Changing Futures programme¹¹ also show adults experiencing multiple disadvantage frequently struggle to access traditional ASC pathways. ASC functions, already under considerable resource pressure, can find it difficult to offer the flexible, outreach based and incremental assessment approaches. These are needed to understand the lived experiences of people whose circumstances fluctuate or who find office based contact inaccessible. As a result, individuals who would likely meet Care Act eligibility may not receive timely assessment or support. Safeguarding responses can become inconsistent or overly procedural rather than enabling.
- 14.10.** Nationally, areas vary in the extent to which MEAM or Changing Futures approaches are embedded. This review highlighted Cumberland council does not currently have a strategic lead for MEAM or a coordinated MEAM oversight structure. This was also reflective of the period in scope. As a result, this limits the visibility of multiple disadvantage pathways into the systems safeguarding, homelessness and adult social care practice. This contextual factor contributes to understanding why Martin's needs were not brought together into a shared multi-agency picture.
- 14.11.** These inconsistencies and uncertainties around contact also suggest early instability in the service relationships intended to support him. They mirror national findings¹² around engagement challenges helping explain the pattern of avoidance and crisis led contact observed throughout the review period. They also indicate that his needs were not yet fully understood or coordinated across the system. A contributing factor being his mother had previously provided substantial day-to-day support. Much of his practical and emotional care had taken place outside formal services. This limited Martin's historical footprint with agencies. As a result, the system lacked a clear baseline understanding of his vulnerabilities, daily living needs, and the level of support he required once this informal care was no longer present.
- 14.12.** During the Practice Learning Event, practitioners reflected on the wider impact of post COVID service changes. While the immediate pressures of the pandemic shifted much contact to telephone based models, the longer-term changes in service delivery led to the closure of local offices. There are fewer opportunities for people to seek support in person. Practitioners also noted a decline in the quality of interpersonal relationships between professionals. This move away from shared workplaces has reduced opportunities for informal spontaneous discussions, now often replaced by the need to schedule formal virtual meetings.
- 14.13.** For many adults experiencing multiple disadvantage, particularly those who cannot read or write, who lack digital access, or who struggle with the cognitive demands of online systems, they now face significant barriers to initiating contact or asking for help. For Martin, this loss of accessible, face-to-face route into support further reduced opportunities for

¹⁰ The MEAM Approach helps local areas design and deliver better coordinated services. It encourages collaboration between statutory and voluntary agencies, ensuring that support is flexible, inclusive, and tailored to individual needs. Currently, the approach is implemented in 42 local areas across England, with partnerships meeting regularly to discuss care plans and coordinate interventions. [Cumberland - MEAM](#)

¹¹ Changing Futures is a 5-year, £91.8 million programme aiming to improve outcomes for adults experiencing multiple disadvantage – including combinations of homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system.

¹² [ACUK_SafeguardingAdultReviews_A4Report_July2019_36pp_WEB-July-2019.pdf](#)

timely intervention and relational connection. This structural shift has been recognised by practitioners as a continuing barrier within the system and one that may disproportionately affect adults with complex needs.

- 14.14.** Practitioners also reflected on the geographical context of the area in which Martin lived. While he resided relatively close to local services, the wider locality is predominantly rural, and access to support is shaped by factors beyond distance alone. Travel across the area often requires multiple bus journeys, which can be time consuming and costly. For individuals who are financially vulnerable experiencing difficulties with planning and completing such journeys, present significant barriers attending appointments or sustaining engagement. This highlights the importance of recognising not only geographical proximity to services, but the wider structural and personal factors that influence accessibility in rural settings.
- 14.15.** Martin's story resonates with national evidence¹³ highlighting the "fatal consequences of chronic disinvestment from rural infrastructure." Rural areas see the largest increases in deaths among people experiencing homelessness. Martin was exposed to the same barriers described in this report, including long travel distances, limited-service availability and reduced visibility to services.
- 14.16.** Within this context, no coordinated contingency plan was anticipated to manage fluctuations in engagement for an individual whose vulnerabilities were emerging, episodic, and not yet fully understood across the system. Although agencies met legal and procedural requirements, the absence of a relational or persistence based model of practice meant that opportunities for earlier or more sustained intervention were limited. At the same time, the lack of available permanent and secure accommodation meant that Martin was unable to transition from temporary housing into a stable tenancy. This contributed to a return to street homelessness.
- 14.17.** Across the wider chronology, Martin's engagement with services continued a pattern of episodic, crisis driven contact. Police recorded several assaults and missing from home episodes during 2019 - 2020. Further concerns were raised in October 2021 by Home Group and the Local Energy Advice Partnership after visiting his property. He had also sent messages to Home Group expressing increasing distress. At this part of the chronology, Martin had been in a tenancy for around three years following his last period of homelessness.
- 14.18.** Throughout these visits, practitioners identified significant concerns about his living conditions and self-neglect. His gas was capped, and the property had no running water, heating, internal doors or floor coverings. He was using a single electric heater that did not adequately warm the home. One room contained numerous bin bags, and he had no reliable means of storing or preparing food. Martin was described as unkempt, eating inadequately, and sleeping on the floor.
- 14.19.** Due to the operating constraints of COVID-19, much of the professional contact with Martin took place either by telephone or through requests for him to attend weekly drop-in appointments at the local library. ASC further reported limited staffing capacity. National guidelines dictated telephone based engagement unless an urgent face-to-face visit was required. These structural conditions shaped the ways in which support could be offered.

¹³ [About the Dying Homeless Project | Raise Awareness and Take Action — Museum of Homelessness](#)

- 14.20.** Within this context, triage by the safeguarding social worker identified HAWC were actively involved and liaising with the Home Group regarding Martin's housing needs. At the same time, Martin was awaiting intervention from the Screening and Assessment Team (SAT). Based on this configuration of services, a decision was made not to progress a Section 42 enquiry¹⁴.
- 14.21.** Parallel processes were in place, but they did not converge in a way that would enable a holistic view of Martin's situation. No mechanism was in place to support a joint review of risk or emerging concerns from the different agencies. Practitioners felt that a cross agency "need to know" system would have enabled earlier recognition of escalating risks. Such a system would ensure that when a person's risk increases, whether identified by Police, GPs, ambulance services or community teams, other partners are alerted promptly. This would allow a shared and timely safeguarding response. This represents a gap in interagency coordination across the system throughout this phase.
- 14.22.** Across the timeline, there is limited evidence that practitioners consistently distinguished between decisional capacity (the ability to understand, retain, use/weigh and communicate a decision) and executive capacity (the ability to carry out that decision in day-to-day life). This distinction is repeatedly highlighted in SAR learning. ADASS¹⁵ guidance specifies that where executive dysfunction is suspected, findings from a conversation based assessment should be corroborated with real world observation in the person's home environment. This is of particular importance in the context of trauma, substance use, cognitive impairment or overwhelming distress.
- 14.23.** This gap is illustrated at several episodes. In the March 2022 CRHT practitioners undertook a telephone based triage in line with standard crisis service operating procedures. During this contact, Martin was described as alert, oriented to person and place, and able to articulate his needs. He retained information and weighed the options discussed. There was no evidence of acute distress, agitation or mental health deterioration requiring face-to-face assessment or Mental Health Act consideration.
- 14.24.** Panel discussion highlighted that telephone triage is an appropriate and clinically justified response within crisis mental health services. However, it was also recognised that such assessments are inherently limited in their ability to explore a person's capacity to carry decisions through in realworld conditions. In Martin's case, the assessment necessarily relied on verbal presentation and self-report. This did not allow practitioners to observe how factors such as alcohol dependence, literacy needs, trauma or self-neglect were impacting his daily functioning.
- 14.25.** Home Group records show a consistent pattern of stated intentions such as moving property, providing documentation, and improving his living conditions. These were not followed through in Martin's day-to-day practice. This pattern aligns with executive functioning difficulties. It reinforces the need for functional assessment rather than a reliance on conversational capacity.

¹⁴ A Section 42 enquiry is the statutory duty placed on local authorities under the Care Act 2014 to make, or cause to be made, safeguarding enquiries where there is reasonable cause to suspect that an adult has needs for care and support, is experiencing or at risk of abuse or neglect, and because of those needs, is unable to protect themselves from that abuse or neglect. The purpose of the enquiry is to establish what action, if any, is required to prevent or stop the abuse or neglect, and who should take that action.

¹⁵ [executive-function-practice-guidance-final.pdf](#)

- 14.26.** Housing Options reported that as part of their statutory homelessness processes, a standard mental capacity check was completed to ensure Martin understood the terms of a tenancy, including the need to pay rent and bills. This assessment concluded that he had decisional capacity. Practitioners acknowledged that it did not explore whether he was able to execute these decisions in everyday life. Martin's literacy needs and alcohol significantly affected his ability to manage correspondence, budgeting and tenancy responsibilities in practice.
- 14.27.** In April 2024, during his endoscopic procedure, Martin received standard written and verbal information in line with organisational guidance. Records noted his alcohol dependency and thiamine use. They do not indicate if staff explored any communication needs, checked comprehension, or considered whether his substance use affected his ability to retain or weigh advice.
- 14.28.** Whilst the provision of information was aligned to organisational guidelines, NCIC have acknowledged that good MCA aligned practice would have included checks of how he understood the information. This would have involved whether he required support with written materials, or if his circumstances affected his decision making ability. The absence of such enquiry is significant given family reports of him routinely bringing his letters to them to read. This suggests his apparent compliance may have masked underlying difficulties.
- 14.29.** Following a referral for a washing machine to be delivered via a "leave a light on"¹⁶ arrangement, his sister later expressed concern. This was due to him routinely using her home for his laundry needs and enabled opportunity to monitor his wellbeing. As a result, the washing machine delivery was subsequently cancelled without involving Martin in the decision. In this example, there was an initial assumption that he could independently use and maintain the appliance. The later cancellation was made without his participation. This illustrates gaps in assessing his functional capacity and supporting his involvement in decisions affecting daily life.
- 14.30.** Taken together, these examples indicate a system that focused primarily on decisional capacity through interview based assessments. There was limited attention given to reflect the lived reality of his abilities and the duty to support a person to make decisions for themselves wherever possible. The panel concurred, assessing capacity without sight of Martin's environment, patterns of self-neglect, or barriers to follow through meant significant vulnerabilities were not visible.
- 14.31.** Considerable variation was identified in practitioners' MCA role, responsibility and knowledge of the tools hosted on CSAB website. While some staff were aware resources existed, they did not always view the assessment of capacity as part of their professional role. This contributed to inconsistent practice and, in some cases, an overreliance on others to lead assessments.
- 14.32.** Confidence was further affected when practitioners were required to assess individuals with highly complex needs. This was particularly where greater expertise in executive functioning and decision making processes was necessary. Several practitioners reported anxiety about the potential local implications of getting an assessment wrong. This at times led to overly cautious or fragmented approaches.

¹⁶ Leave a Light on is Cumbria's main community support and coronavirus help group for the people of Carlisle and surrounding areas.

- 14.33.** Practitioners further reflected on how Martin's alcohol dependence created significant complexity when assessing capacity. Withdrawal symptoms and periods of instability made it difficult to distinguish decisional capacity from fluctuating capacity, further contributing to practitioners' lack of confidence. Without specialist advice or structured opportunities to explore such challenges, staff described feeling uncertain about leading MCA assessments and concerned about the risk of making incorrect determinations.
- 14.34.** Alongside MCA requirements, Making Safeguarding Personal (MSP) principles were highly relevant. MSP emphasises proportionate, person led safeguarding. Reasonable adjustments and communication methods should be tailored to the individual. This is crucial where literacy difficulties, trauma, or executive functioning affect a person's ability to understand or engage.
- 14.35.** Research¹⁷ consistently highlights that for people experiencing homelessness or self-neglect, practitioners must use accessible communication, advocacy, and flexible, outcome focused approaches to enable the person to meaningfully shape their own plans.
- 14.36.** For Martin, this would have meant:
- Avoiding written correspondence as a primary communication method.
 - Providing repeated, face-to-face explanations of key information.
 - Offering advocacy or supported conversations earlier for benefits, housing, and treatment.
 - Using practical, hands-on support such as accompanying him to appointments or assisting with essential tasks.
- 14.37.** These themes align with evidence from Alcohol Change UK¹⁸. It highlights how early, flexible interventions can prevent evictions and abandonment. This requires psychologically informed environments and the need for integrated approaches across housing, health and social care. The report further stresses the importance of recognising cognitive impairment, trauma and executive functioning challenges when designing responses for people with alcohol dependency.
- 14.38.** Had adjustments been available, Martin may have had greater opportunities to understand, weigh, and act upon decisions affecting his safety and wellbeing. Seen through this lens, Martin's presentation could be understood as expressions of distress, cognitive overload, and impaired executive functioning. This was exacerbated by trauma, isolation, and alcohol dependence. Both MSP and MCA frameworks recognise that support must adapt to these realities. Apparent verbal understanding in a single conversation does not equate to meaningful, functional capacity in everyday life.
- 14.39.** The learning from this review aligns closely with the Cumberland Joint Local Health and Wellbeing Strategy 2023 - 2028¹⁹, particularly the strategic priority of promoting healthy behaviours across the life course. This recognises the importance of early intervention, prevention and coordinated responses to mental health, addiction and social exclusion. It includes adults whose needs fall between traditional service thresholds. This strategy reflects a positive shift in challenging the barriers that were evident in Martin's experience.

¹⁷ [Adult safeguarding and homelessness: experience informed practice | Local Government Association](#)

¹⁸ [Improving housing options for people with complex needs | Alcohol Change UK](#)

¹⁹ [Theme 2: Healthy behaviours through the life course | Cumberland Council](#)

15. Lessons Learned

- 15.1.** Across the system, individual practitioners demonstrated care, persistence, and a commitment to supporting Martin. Staff made repeated attempts to contact him. They provided practical assistance such as food and accommodation during crises. All agencies contributed helpful actions within their respective roles.
- 15.2.** However, these efforts operated as isolated, short-term interventions rather than components of a coordinated, sustained, trauma informed plan. No single agency maintained consistent oversight. Multi-agency involvement was episodic. It was driven largely by presenting incidents rather than a shared understanding of underlying need.
- 15.3.** Accurate application of the MCA was particularly important in Martin's circumstances. There were indicators of executive and functional impairment. While the MCA presumes capacity, practitioners are required to explore capacity where "reasonable doubt" exists. This is particularly important in contexts of Martin's circumstances. The modalities of contact provided minimal visibility of his home environment and daily functioning. They restricted opportunities to observe whether he could translate decisions into action. As a result, apparent verbal understanding was sometimes interpreted as capacity.
- 15.4.** The review identified inconsistent awareness of MCA resources and an uncertainty about professional responsibility for leading capacity assessments. This contributed to variable practice across the system. Practitioners reported reduced confidence when working with individuals with complex, fluctuating needs. An anxiety about "getting it wrong" combined with limited access to specialist advice or reflective supervision, sometimes resulted in overly cautious or fragmented approaches. This highlights the importance of strengthening workforce confidence, shared understanding of executive capacity, and access to support that enables practitioners to undertake robust, proportionate MCA assessments in complex contexts.
- 15.5.** A more proactive application of the MCA is supported by practicable steps. This would have strengthened alignment with MSP principles which emphasise accessible communication, person led planning and proportionate support. Given the fluctuating capacity associated with Martin's alcohol dependence and the confidence issues described by practitioners, such steps were crucial but were not routinely embedded.
- 15.6.** Systems often expect individuals experiencing homelessness or self-neglect to access services on the system's terms. This involves attending appointments, navigating written communication, and responding to calls without sufficient adjustment for trauma, executive functioning difficulties, or daily survival pressures. When people cannot meet these expectations, services may withdraw, unintentionally reinforcing disconnection.
- 15.7.** Responses in Martin's case remained episodic and reactive. Opportunities for sustained oversight, early intervention and coordinated planning were not available. A trauma informed system would include:
- Clear multi-agency leadership and case oversight.
 - Predictable, relationship based engagement.
 - Flexible outreach and home visiting options.
 - Contingency planning for nonengagement.

- Shared understanding of how trauma, adversity and neurodiversity affect engagement and safety.
- 15.8.** These findings align with CSAB's thematic SAR (Braye 2025²⁰) and the Second National Analysis of SARs (2024²¹). Both highlight structural pressures such as resource constraints, high workloads, inconsistent and limited relationship based or preventative services.
- 15.9.** A whole system approach grounded in real world observation, consistent oversight, trauma informed engagement and shared risk formulation was required to recognise and respond effectively to the interaction of executive dysfunction, self-neglect and complex trauma in Martin's life.
- 15.10.** Home Group have advised since this scope, they have introduced courtesy calls providing regular proactive contacts to support relationship building and to identify concerns at an earlier stage.

16. Findings

- 16.1. Finding 1 - The engagement model relied on help seeking behaviours and appointment based pathways that did not align with trauma impacted needs.**
- 16.2.** Service pathways depended heavily on telephone contact, letters, and structured appointments. The system assumed Martin could attend drop-ins, request support, and articulate his needs. In practice, the closure of local offices, loss of face-to-face access points, increasing reliance on digital contact, and the rural requirement to travel long distances on public transport created additional and significant barriers for Martin. These were expectations that exceeded his capacity for self initiation and executive functioning.
- 16.3.** These methods did not consider Martin's trauma history, learning needs, or avoidance patterns. As such, this created structural barriers to his participation. When he did not respond, his case was closed or stepped down. Adapted outreach or alternative engagement approaches were not available which made help seeking even less achievable. This limited the system's ability to apply both MCA duties and MSP principles when interpreting Martin's behaviour.
- 16.4. Finding 2 - A coordinated trauma informed response was not established**
- 16.5.** Agencies responded to individual issues as they arose. There was no mechanism for bringing together the full picture of Martin's vulnerability. Without coordinated review, Martin's cumulative risks were not recognised as requiring a more structured safeguarding response. Although trauma indicators appeared across agencies, no system existed to synthesise them into a shared formulation.
- 16.6.** During the Practice Learning Event, practitioners described challenges in securing attendance from relevant agencies in the current MDT routine model. They highlighted that the system requires a mechanism that signals urgency. This would bring partners together when risk is escalating, particularly where Section 42 thresholds are not met. They explored what a trusted professional model could provide in respect of relational

²⁰ [CSAB Self-Neglect Thematic SAR EXECUTIVE SUMMARY REPORT.pdf](#)

²¹ [Second national analysis of safeguarding adult reviews. Final report: Stage 1 analysis](#)

continuity, coordinating engagement and holding oversight, without risk being disproportionately transferred onto them.

16.7. Finding 3 - Cognitive, communication and trauma related barriers were not consistently recognised or explored

16.7.1. Executive functioning was not adequately considered within capacity assessments

16.7.2. Information about Martin's literacy needs was known within the system. However, the way communication and engagement were structured did not always enable these needs to be fully explored or incorporated into assessment approaches. Patterns of non-attendance were often understood through the lens of disengagement. Remote modalities limited opportunities for reasonable doubt to be recognised. This limited opportunities to consider whether literacy barriers, trauma, anxiety, or the effects of addiction were influencing his ability to respond or follow through with actions. This may also have contributed to an optimistic view of his ability to manage risks independently and reduced the visibility of underlying support needs.

16.8. The system primarily assessed aspects of decisional capacity during conversations. There was less emphasis or opportunity to assess whether he was able to implement and sustain decisions in his daytoday environment. This reflects a wider systems pattern, commonly identified in national research²², in which opportunities for functional observation are limited when contact occurs largely through remote or episodic interactions. Strengthening the routine consideration of executive functioning within capacity assessments would support more comprehensive and person-centred decision making.

16.9. Practitioners reflected that executive functioning considerations were not routinely embedded into everyday practice. They described uncertainty about how to incorporate executive capacity thinking into routine assessment, planning and reviews. They identified the need for clearer prompts, shared language and specialist supervision to help staff recognise when executive functioning may be impacting a person's ability to act on decisions.

16.10. Practicable Steps were not consistently made to support meaningful participation

16.11. There is limited evidence that practicable steps were consistently applied to support Martin's understanding or ability to act on decisions. Information was often conveyed verbally or through standard processes without adaptation to his individual needs. Apparent agreement or engagement may not have reflected meaningful, informed, or sustainable choice. Reasonable adjustments requires increased attention to communication methods including pacing, repetition, accessible formats and practical support which may have enabled Martin to participate more fully in decisions affecting his safety and wellbeing.

16.12. Professionals described situations where Martin needed to drink to feel physically well. Attempts to reduce his alcohol intake triggered withdrawal symptoms that impaired both his mental capacity and physical safety. These factors created significant barriers to implementing "support to decide," and meant opportunities to maximise Martin's understanding, retention and weighing of information were not fully realised.

16.13. Professional capacity and confidence were not consistently understood

²² [Second national analysis of safeguarding adult reviews Final report: Stage 3](#)

16.14. Although MCA training is available, staff explained that it is not always prioritised due to competing operational pressures. Opportunities for deeper skill development are uneven across agencies. Practitioners emphasised the need for crossagency specialist supervision to build confidence, develop shared understanding, and support reflective practice. They also highlighted the importance of each organisation identifying priority staff groups for targeted MCA continual professional development. This would ensure workers most likely to encounter complex capacity issues have the capability and support needed to undertake robust assessments.

17. Recommendations – Theme 1

17.1. Recommendation 1 - Strengthen the Application of the Existing Trauma informed Pathway for Adults Experiencing Multiple Disadvantage

17.2. Relevant CSAB partners should strengthen the application of the existing trauma informed practice framework²³ specifically for adults experiencing multiple disadvantage, homelessness, or self-neglect. This should ensure that trauma responsive engagement and early intervention approaches align with the Cumberland Joint Local Health and Wellbeing Strategy 2023-2028).

17.3. This strengthened approach should:

- Ensure the existing trauma informed pathway is systematically applied across all services working with adults who experience recurrent disengagement or escalating risk.
- Embed trauma responsive engagement expectations (e.g. outreachbased contact, persistence, relationship led practice, graded offers of support).
- Include consideration of structural accessibility. This must recognise that digital only contact, loss of local office access, rural travel demands, and cognitive/literacy barriers may prevent adults from seeking help or attending appointments.
- Ensure early contingency planning, including agreed cross agency actions when the person does not attend appointments or withdraws from contact.
- Develop a cross agency “need to know” alerting system to ensure that escalating risks are visible to all relevant partners. This should include the Police, GPs, community health services, ambulance staff and adult social care. This must enable timely information-sharing, coordinated responses and consistent risk escalation.
- Support systemwide training, reflective practice and supervision so that practitioners understand how trauma, executive functioning difficulties, homelessness, substance use and mistrust of services shape engagement.

17.4. Align this strengthened pathway with the Cumberland MEAM Strategy. This should recognise national evidence that people with multiple disadvantage often do not receive the flexible assessment or coordinated support they need. Trauma informed engagement must be embedded across adult social care, housing, health and community partners.

²³ [Trauma-informed resources | Cumbria Safeguarding Adults Board](#)

17.5. CSAB should seek assurance from partners on the consistent application of trauma informed practice. This should clarify the roles of 'Trauma Informed Cumbria' in supporting, guiding and evidencing this work across the system.

17.6. CSAB should seek assurance that the objectives of MEAM are being progressed and embedded consistently across the partnership. Whilst the MEAM remains a recognised strategic priority, it is acknowledged that the function sits within Public Health, which is undergoing restructure at the time of writing. This has resulted in limited capacity and the absence of a dedicated leadership role to oversee and drive this portfolio.

17.7. Recommendation 2 – Executive Capacity and Reasonable Adjustments Framework review

17.8. Relevant CSAB partners should strengthen and integrate its existing [MCA resources](#) by embedding explicit guidance on executive capacity into multi-agency assessment, training, triage and audit processes. This should include:

- Clear differentiation between decisional and executive capacity
- Routine consideration of executive functioning where literacy needs, trauma history, substance dependence, or repeated non follow through are present
- Systematic recording of practicable steps (accessible formats, advocacy, pacing, repetition, practical assistance, accompanied actions)
- Followup where there is a mismatch between stated intentions and observed outcomes
- Incorporation of executive functioning prompts into safeguarding screening tools and Care Act assessments.

This will support Making Safeguarding Personal by ensuring that apparent agreement reflects meaningful and achievable choice.

17.9. Relevant partners should explore the development of cross agency specialist supervision for staff working with adults who may lack capacity, recognising current gaps in shared learning and reflective spaces.

17.10. CSAB should seek assurance that partner agencies identify how such supervision can be embedded within their own structures and how priority staff groups will be supported to access MCAfocused CPD.

18. Theme 2: The System in Context

18.1. In 2020, police recorded several assaults and missing from home episodes. Martin was noted at times to appear under the influence of substances and in the company of known drug users. These incidents were closed following unsuccessful telephone attempts to reach him or his decision not to pursue criminal action.

18.2. In October 2021, when Housing and the Local Energy Advice Partnership raised significant concerns about Martin's living conditions, a safeguarding social worker was unable to establish contact with the referrer. Without this direct dialogue or a home visit, ASC relied on existing information within the system. This suggested that HAWC and Citizens Advice were offering support around benefits and budgeting support. A food voucher had been arranged and records indicated that the outstanding gas debt related to a previous tenant. The social

worker concluded that a plan was in place at that time. In addition, Home Group records indicate a hoarding referral was made to the hoarding hub albeit, there was no evidence of follow-up or correlation to the hoarding guidance.

- 18.3.** This contributed to the perception that risk remained low, despite emerging concerns. The Practice Learning Event highlighted significant crosssystem issues that influenced how Martin's risk was understood during this first cluster of referrals. Although multiple agencies were in contact with him, the system was unable to bring together these separate insights into a coherent picture of escalating vulnerability. Each service held only a fragment of information, and there was no mechanism to synthesise these into a shared formulation or coordinated plan.
- 18.4.** Practitioners reflected that early assumptions contributed to this fragmentation. ASC believed Martin was still attending drop-ins. Police, HAWC, the GP and RSC each reported partial awareness of previous safeguarding concerns. RSC recorded alcohol withdrawal, risk of self-harm when intoxicated, and repeated detox attempts without sustained recovery. They were aware of bereavement and crisis involvement but not of safeguarding concerns or the home invasion. The GP attempted contact but were unaware of environmental or exploitation risks. Police held information about welfare concerns. ASC knew about literacy needs and historical self-neglect, while HAWC saw him at drop-ins but assessed risk as low. Police and Home Group were the only services with recent access to his home.
- 18.5.** This early pattern reflects how fragmented information, incomplete inter-agency communication, and threshold based decision making diluted visibility of accumulating risk in Martin's home. When concerns are interpreted in isolation, opportunities for early multi-agency review can become lost. As a result, this episode did not trigger any multi-agency risk escalation or review. The environmental concerns were incorporated into routine service activity rather than recognised as part of a broader pattern of self-neglect and deteriorating wellbeing.
- In February 2022, a continued pattern of anticipatory response continued when both Police and Housing raised referrals due to escalating concerns about Martin's welfare. The referral referenced alcohol dependence, deteriorating home conditions and emerging self-neglect. There were also indicators of possible exploitation. During the triage, HAWC shared valuable contextual information. They described literacy difficulties, history of homelessness, and withdrawal from structured support.
- 18.6.** The safeguarding referral led to a request for a Care Act assessment by the SAT. This was subsequently arranged at his sister's home following repeated difficulties in making direct contact with Martin. This created a valuable opportunity for the system to build a more holistic understanding of his needs, supported by the advocacy and relational stability available in a familiar environment.
- 18.7.** However, important limitations emerged. Due to the assessment being conducted away from his own living environment, practitioners were unable to directly observe his day-to-day functioning, and environmental risks. For someone with Martin's complexity, the absence of home based assessment significantly restricted the system's capacity to understand how these factors affected his real world safety and independence.
- 18.8.** Compounding this, no completed assessment from this episode is recorded on ASC systems. Without a documented assessment, the system lost a critical opportunity to develop a shared baseline understanding of his needs and vulnerabilities. This limited the ability of agencies

to coordinate planning, formulate risk collectively, or recognise the cumulative significance of his deteriorating circumstances.

- 18.9.** Case notes from the time suggest that his needs were viewed as manageable through the HAWC drop-in service. In the absence of a synthesised or recorded assessment to anchor professional understanding, there was no mechanism for determining whether drop-in or remote models of support were proportionate to the concerns raised by family members or observed in other parts of the system.
- 18.10.** Over time, this contributed to the system gradually losing sight of the complexity of his needs and reduced the likelihood that risks would be understood cumulatively rather than as isolated, lowlevel contacts. Consequently, the full breadth of his vulnerabilities became invisible across the system.
- 18.11.** Collectively, system observations would have indicated medium level self-neglect under the local self-neglect threshold tool used during the scoping period. The accompanying guidance identified several factors that contribute to individuals being overlooked. These included persistent needs being viewed as lifestyle choice, fluctuating engagement creating uncertainty about thresholds, desensitisation to chronic risk, and inconsistent application of safeguarding criteria. Many of these dynamics were evident in Martin's case. The CSAB thematic review (2025²⁴) reflects similar findings, highlighting the need for clearer escalation routes such as MARM/VARM²⁵ processes.
- 18.12.** Severe environmental deterioration was observed by NWS in May 2024. This included clutter, restricted mobility, and fire risk (assessed retrospectively by the independent reviewer as Clutter Rating Level 6²⁶). This demonstrated how risk had escalated without professional visibility. Consistent with findings from the CSAB thematic review, this case highlights key structural challenges. Early concerns were not consistently followed up, cumulative risk was not recognised, safeguarding pathways were underutilised, and preventative services continued involvement without multi-agency coordination. Fragmented information holding meant no single agency or forum held the full picture of his deteriorating circumstances.
- 18.13.** Taken together, the trajectory underscores the importance of sustained, coordinated, relationship based responses to self-neglect. Particularly where engagement fluctuates and harm accumulates slowly over time.

19. Lessons Learned

- 19.1.** A key theme emerging from this case is how risk accumulated gradually and became normalised across the system. Martin's deteriorating living conditions, alcohol dependence, and fluctuating engagement came to be seen as longstanding patterns rather than indicators of escalating harm. As concerns became familiar, their significance diminished, reducing opportunities for timely intervention.

²⁴ [CSAB Self-Neglect Thematic SAR EXECUTIVE SUMMARY REPORT.pdf](#)

²⁵ MARM/VARM (MultiAgency Risk Management / Vulnerable Adult Risk Management) refers to local multiagency processes used when an adult is at significant risk of harm but does not meet the threshold for a Section 42 safeguarding enquiry. These frameworks provide a structured way for agencies to share information, coordinate oversight, create a joint risk plan, and review escalating or complex risks such as selfneglect, exploitation, or fluctuating capacity. The process ensures that concerns are not managed in isolation and that responsibility for risk is shared across agencies rather than resting with a single service.

²⁶ [Clutter Image Ratings - Hoarding Disorders UK](#)

- 19.2.** A further learning relates to the inconsistent application of safeguarding thresholds in cases involving self-neglect. Despite clear indicators of significant risk, a Section 42 enquiry was not initiated. This is subject to the adult's consent or valid grounds to override it. These frameworks were not consistently applied or revisited as circumstances changed. Dynamic risk environments require dynamic safeguarding responses. Refusal alone should not end safeguarding consideration where risk to wellbeing or life is increasing.
- 19.3.** During the Practice Learning Event, practitioners described the challenges inherent in triaging safeguarding concerns when only partial or limited information is available at the point of referral. They reflected that this often resulted in decisions being made without the benefit of wider system context or cumulative risk insight.
- 19.4.** Practitioners also noted that when a Section 42 enquiry was not opened, this was sometimes interpreted across the wider system as a sign that the situation was less serious than it appeared. This has created a false sense of security and, in some cases, reduced professional curiosity and escalation. Practitioners recognised the need to challenge this narrative and emphasised that a 'no Section 42' decision should never be viewed as reassurance but as a prompt for further exploration, information sharing, escalation and multi-agency review where concerns persist.
- 19.5.** Martin's circumstances should have prompted consideration of whether he was unable to protect himself due to his care and support needs (a central criterion for a Section 42 enquiry). This reflects a wider national pattern²⁷ in which self-neglect and alcohol dependency sit uneasily within safeguarding pathways, particularly when engagement fluctuates or appears inconsistent. This challenge is especially marked for individuals with complex health or cognitive needs.
- 19.6.** The case also demonstrates limited multi-agency coordination. Several services held important information about Martin's mental health, alcohol use, home environment, and day-to-day functioning. This insight was not brought together into a shared risk formulation. As a result, agencies responded to discrete issues rather than recognising the cumulative nature of his vulnerability. Opportunities to identify exploitation, hidden environmental risk and deteriorating health were missed as risks remained compartmentalised within separate services.
- 19.7.** As his service offer reduced, no triggers reconsidered risk, escalation, or redistribution of responsibility across statutory services. The dependence on these services resulted in concerns remaining siloed. No mechanism was in place to bring together emerging indicators of harm or to ensure coordinated oversight as his vulnerability increased.
- 19.8.** Practitioners reflected that wider system initiatives designed for people with multiple disadvantage (such as Changing Futures and MEAM), have not translated into sustained pathways for individuals like Martin and lacked clear criteria locally. The upcoming Hope Haven initiative²⁸, offering daily access to GP, mental health and thirdsector support was viewed positively. Housing Options reported challenges in being recognised as a core partner within emerging multi-disciplinary models despite their sustained contact with people in similar circumstances.

²⁷ [Adult safeguarding and homelessness: experience informed practice | Local Government Association](#)

²⁸ [About Us - West Cumbria Mental Health Partnership](#)

- 19.9.** Whilst system learning highlights the impact of COVID19 restrictions and capacity pressures within earlier involvement, later opportunities for home visits were still missed. Without direct observation, emerging indicators of selfneglect and environmental deterioration went unseen. The severe conditions later documented by NWS illustrate how harm can escalate out of sight without routine home visits and coordinated oversight.
- 19.10.** Gaps in Care Act assessment practice and recording further contributed to system blind spots. An assessment was completed, but no completed documentation or eligibility decision was located. This absence created assumptions that needs had been formally assessed and found ineligible, when in fact not uptodate assessment was available for scrutiny. This limited transparency, hindered continuity, and reduced the system's ability to reconsider thresholds as circumstances deteriorated.
- 19.11.** Under the Care Act 2014, a needs assessment should be completed whenever it appears an adult may have care and support needs. This is even when engagement is inconsistent, and risk is present. Martin displayed multiple indicators of need across several presentations to various agencies. Earlier assumptions that he did not have eligible needs continued to shape practice, limiting opportunities to reevaluate his needs and risk and initiate preventative safeguarding action.
- 19.12.** Panel members noted that, historically, joint working between safeguarding and SAT had been limited during COVID 19 pressures. This has improved considerably since the scoping period. This in part is a response to the introduction of CSAB's escalation policy²⁹ that was published in June 2025. This defines the process of resolving professional differences and disagreements. They confirmed that, under current guidance, practitioners would now be expected to conduct a home visit where self-neglect is suspected. The panel agreed that faceto face assessment would likely have provided a more accurate understanding of his needs, safety and ability to manage daily living.
- 19.13.** System capacity pressures, including staffing shortages, high caseloads, and reliance on telephone based contact shaped the nature of intervention. These pressures contributed to task focused responses, fewer proactive visits and limited relational engagement. While such pressures are real, they interacted with threshold uncertainty and fragmented coordination in a way that increased the likelihood of underresponse.
- 19.14.** Taken together, this trajectory shows that sustained, coordinated, multi-agency responses are essential in cases of chronic selfneglect and alcohol dependency. The Cooccurring Mental Health and Substance Use Delivery Framework (2024³⁰) reinforces this. It emphasises the need for consistent oversight, proactive information sharing, and clear escalation routes such as a MARM/VARM model. A shared understanding of how trauma, executive dysfunction, and addiction shape capacity, safety, and engagement is central to preventing individuals like Martin from falling between service boundaries and experiencing escalating risks out of view.

²⁹ [CSAB Safeguarding Adults Escalation and Resolution Guidance.pdf](#)

³⁰ [Co-occurring mental health and substance use delivery framework - GOV.UK](#)

20. Findings

20.1. Finding 4 – Cumulative risk was not recognised due to fragmented oversight

20.2. Whilst a Care Act assessment was completed, no documentation, eligibility decision, plan or followup was recorded on the electronic system. This created the impression that needs had been considered and found ineligible. The reality was no such record existed. Over time, concerns about self-neglect, alcohol dependence, and deteriorating home conditions became familiar to agencies. They were interpreted as longstanding behaviours rather than indicators of escalating risk. This normalisation reduced urgency and contributed to missed opportunities for safeguarding escalation.

20.3. The Home Group chronology demonstrates 10 separate crisis indicators over a period of 18 months. These include self-harm disclosures, rough sleeping, exploitation indicators, distress texts, and escalating fear within the tenancy. Although some individual concerns did result in referrals to ASC or police, these were not synthesised into a cumulative safeguarding picture

20.4. Local self-neglect guidance emphasises the importance of shared responses. Environmental assessment, and joint action should be considered even where a person appears to have capacity. The absence of these joint processes highlights a gap between policy clarity and frontline practice. No single agency or lead professional held responsibility for coordinating or maintaining oversight of cumulative risk. Information sharing remained reactive and incident specific. A clearly identified coordinating role supported by joint assessments and shared contingency planning, may have enabled earlier recognition of deterioration and escalating vulnerability.

20.5. Finding 5 – System capacity pressures limited proactive intervention

System capacity pressures including staffing shortages, reduced face-to-face contact and closure of local offices. COVID19 operational constraints shaped the form and frequency of earlier support offered. These pressures contributed to increased reliance on digital based contact and reduced opportunities to observe risk directly or review concerns holistically. While capacity limitations did not cause safeguarding gaps, they interacted with threshold uncertainty and fragmented coordination. This made proactive intervention more difficult, limiting the system's ability to recognise accumulating risk or adapt support when engagement fluctuated.

20.6. Finding 6 – Safeguarding thresholds were narrowly and inconsistently applied

20.7. Indicators of hoarding, exploitation risk, alcohol related harm and environmental hazards were present in Martin's case. He made multiple disclosures to housing staff about self-harm, fear of intruders, and an unsafe home environment. His case did not progress to a Section 42 enquiry. Practitioner responses suggest uncertainty about how safeguarding thresholds apply in situations involving self-neglect, fluctuating engagement and chronic vulnerability.

20.8. Risk was often viewed as being managed by housing, HAWC or police, rather than requiring a coordinated safeguarding response. This resulted in agencies holding risk in isolation that exceeded their remit. This in turn contributed to a false sense that risk was lower than it was, combined with the perception that safeguarding thresholds had not been met. This limited opportunities for coordinated multi-agency safeguarding intervention.

20.9. During this review, CSAB has removed the previous Self-Neglect Threshold Tool from its suite of resources and is currently undertaking a review of self-neglect thresholds and decision making.

21. Recommendations - Theme 2

Recommendation 3 - Develop a Proportionate Multi-Agency Risk Management Process (MARM/VARM)

Relevant CSAB partners should build on the thematic review's MARM/VARM development work to implement a multi-agency risk process for adults below formal thresholds. This process should include:

- A shared multiagency formulation with ASC consistently integrated into multi-agency planning for people experiencing multiple disadvantage.
- Set review intervals with mandatory escalation points.
- Clear “step-up/step-down” pathways to/from safeguarding.
- Alignment with Threshold Tool and Self-Neglect Guidance.
- Mechanisms to involve Police, Acute Trust, Housing and Substance Use services.
- Have clear routes into voluntary and faith based community organisations.
- Include options for flexible, outreach based and incremental assessment.
- Incorporate NICE guidance on family involvement in alcohol related safeguarding into cross agency training. This should include how to balance consent, confidentiality and family insight.
- Include a named “trusted professional” responsible for:
 - Relational continuity.
 - Maintaining contact.
 - Coordinating information flow.
 - Spotting escalation.

21.1. Discussions relating to MARM/VARM learning, risks and system issues should be routinely reported back to CSAB, acknowledging the Board's governance responsibilities.

21.2. Recommendation 4 - “Accumulating Risk Trigger” for Care Act Reconsideration.

Relevant CSAB partners should develop and implement a local “Accumulating Risk Trigger”, building on the MARM/VARM development work identified in the CSAB thematic review. The trigger should require:

- Reconsideration of Care Act eligibility where it appears an adult may have care and support needs.
- Review of any previous “no eligible needs” decisions to determine whether circumstances have changed.

- Automatic escalation to a multi-agency meeting (e.g., MARM/VARM, Complex Risk Panel or equivalent oversight function) when risks span health, housing, substance use, criminal exploitation or self-neglect.
- Alignment of the accumulating risk trigger with the single supported housing gateway, ensuring that repeated homelessness, rough sleeping or accommodation related safety concerns automatically prompt coordinated multi-agency review in line with current Cumberland pathways.
- A specific self-neglect pathway within the trigger process, enabling early practitioner consultations where patterns of concern are emerging but not yet meeting formal safeguarding thresholds.

21.3. The trigger should activate in response to patterns such as:

- Repeated presentations to drop-ins, housing, emergency services, police or community teams.
- Cycles of case closure and rereferral across services.
- Ongoing homelessness, unsafe accommodation or persistent unmet basic needs.
- Multiple indicators of deteriorating mental or physical health.
- Consistent concerns raised by family, neighbours or practitioners.

21.4. This mechanism would move the system from single episode, threshold based decision making to a longitudinal understanding of vulnerability. It would enable earlier recognition of accumulated harm and ensuring timely multi-agency response. It would also support statutory duties under the Care Act (sections 9³¹ and 11³²) by ensuring assessment is reconsidered whenever it appears needs may exist.

22. Theme 3: Professional Practice and Multi-Agency Working

22.1. Throughout the timeline, Martin disclosed multiple serious safeguarding concerns to several agencies. These included assault, intimidation, suspected cuckooing³³, and financial exploitation. The scope identified several periods of rough sleeping, sometimes despite having accommodation.

22.2. Police contacts across 2019–2020 incidents involved assault, coercion for money and association with individuals involved in substance use. Police contact relied heavily on telephone calls, limiting their ability to form meaningful dialogue. Family later explained that Martin rarely answered unfamiliar numbers, meaning that agencies did not have access to a reliable picture of his safety or circumstances. Practitioners generally responded to each presenting issue but did not consistently explore within a wider safeguarding framework. As a result, risks were often managed in isolation and did not trigger a Section 42 enquiry.

³¹ Section 9 – Needs Assessment. Local authorities must assess anyone who appears to have care and support needs, involve the person (and carer if appropriate), consider wellbeing and outcomes, and provide advocacy if required.

³² Section 11 – Refusal of Assessment. Adults with capacity may decline an assessment, except in limited circumstances such as risk of abuse or neglect, where an assessment may proceed without consent.

³³ The term cuckooing originates from the cuckoo bird which takes over other bird's nests. In the context of housing, cuckooing refers to the process whereby a person or people take over another person's home. The cuckoo-er (person doing the cuckooing) may use the property as a place to stay, for financial benefit, or to operate illegal activities.

- 22.3.** Information sharing gaps further contributed to fragmented responses. A safeguarding referral considered by police in May 2020 was not forwarded to ASC. The focus at that time centred on practical issues, such as shopping difficulties during the pandemic. Key intelligence points from this episode, exploring potential exploitation or reduced capacity to manage safely, were not consistently shared or synthesised across the system.
- 22.4.** No single service had a complete picture, and no process existed to bring these perspectives together. This structural gap meant that the cumulative risk picture did not prompt a coordinated safeguarding response. Viewed collectively, these accounts demonstrated a growing level of complexity across multiple domains. These could have prompted a more coordinated response.
- 22.5.** During the scoping period, Cumbria Police had implemented a preventative practice in parts of Cumberland through the 'One Click Team.' This enabled proactive information sharing with households where concerns about home invasion or exploitation were identified. This approach aimed to deter further intrusion, increase awareness of risk, and signpost individuals to available support. While this practice demonstrated positive intent and a preventative focus, it was not consistently embedded or linked into wider multi-agency safeguarding pathways. As a result, opportunities to integrate police held environmental intelligence into shared risk formulation and escalation were limited.
- 22.6.** By 2022, concerns raised by police, housing and community services indicated intersecting risks. These included fear of neighbours using his flat, deteriorating home conditions and rough sleeping. Home Group information reveals Martin's flat being used by two individuals. It is reported they stole his keys, restricted his access to his home and there was evidence of drug use when Martin showed them related paraphernalia within the property.
- 22.7.** Despite the safeguarding relevance of these disclosures, responses tended to remain single agency and task focused. The police removed individuals from Martin's flat. Home Group supported him to remove their belongings further to arranging for the locks to be changed. Family escalation was crucial in alerting agencies to the severity of the situation within his home and his fear of returning.
- 22.8.** Martin raised these concerns during drop-ins at the HAWC. Preventative, community-based services assisted Martin with housing, benefits, and tenancy related tasks. This created a misconception over time that these services were monitoring Martin and managing his risk. Whilst these services provided valued practical support these services were not designed or resourced to hold escalating safeguarding concerns.
- 22.9.** Housing Options described regular intensive support over six weeks periods when Martin met statutory homelessness thresholds. In parallel, attempts to place Martin in supported accommodation repeatedly broke down due to his difficulty coping with shared living environments and with rules prohibiting alcohol use. There is no "wet hostel" provision in the area. This limited the suitability of placement options for someone whose alcohol dependence was closely linked to physical stability. As a result, the accommodation model itself could not meet Martin's needs. This illustrates a structural gap between available provision and the realities of chronic alcohol dependence.
- 22.10.** Housing Options went on to provide bespoke support including daily 1:1 contact, supporting Martin attend appointments to secure a property, furnish properties, shop, and pay bills.

Calderwood House³⁴ provided him with tents, warm clothing and crisis support when he was living outdoors.

- 22.11.** Under the Homelessness Reduction Act 2017 sections 4 and 5, individuals may be owed a main housing duty if significantly more vulnerable than an ordinary person when homeless. Housing Options reported that Martin consistently triggered both the prevention³⁵ and relief³⁶ duties at various periods. Albeit parallel referrals to ASC did not result in a Care Act assessment. This inconsistency between homelessness and safeguarding thresholds meant that Martin's vulnerability was recognised in one part of the system but not acted upon in another.
- 22.12.** National analysis³⁷ highlights that unsuitable or restrictive supported accommodation can contribute to "revolving door" homelessness. This is particularly relevant for people with trauma histories or substance dependence who cannot meet strict accommodation rules. The Dying Homeless Project identifies increasing deaths in temporary and supported accommodation and highlights the health risks associated with unstable or inappropriate housing. Martin's repeated placement breakdowns are consistent with this national pattern.
- 22.13.** CSAB has since strengthened its governance arrangements for homelessness since this scope. This includes identifying senior housing leads on the SAB and committing to Board level oversight of rough sleeping, in line with ministerial expectations. These improvements sit alongside the wider Cumberland Homelessness prevention and rough sleeping strategy³⁸ 2025 to 2030. This prioritises early intervention, and multi-agency pathways for people experiencing multiple exclusion and brings stronger mechanisms for information sharing and coordinated risk management. Together, these developments provide opportunities to address several of the system gaps identified within this review.
- 22.14.** Several Practice Learning Event attendees noted that voluntary, community and faith based services, including the foodbank he attended, were providing relational continuity at this time but were not connected into safeguarding pathways or information sharing structures. This meant that early signals of distress or deterioration may have been disclosed, missed or not escalated into statutory systems. There is limited evidence of risk reassessment, multi-agency meetings or use of formal safeguarding pathways.
- 22.15.** Family insight provided retrospectively to the reviewer offered additional context about Martin's experiences. His sister described him as physically slight, non-assertive, very isolated, and increasingly frightened in his own home. He found it difficult to challenge his aggressors who were coercing him to steal alcohol for them. The absence of further home visits from partners across the system reduced opportunities to verify concerns or assess whether Martin could keep himself safe.

³⁴ Calderwood House provided emergency homeless services during the period scoped during the SAR
[Calderwood House - Time To Change](#)

³⁵ Under the Homelessness Reduction Act 2017, local authorities must take reasonable steps to prevent homelessness for anyone at risk within 56 days. This includes assessing needs, creating a Personalised Housing Plan, and working with the individual to maintain or secure accommodation.

³⁶ Where a person is already homeless, the relief duty requires local authorities to help them secure suitable accommodation for at least six months. Support continues through the Personalised Housing Plan and applies regardless of priority need or intentionality.

³⁷ [MoH_DHR2025.pdf](#)

³⁸ [Strategic priorities | Cumberland Council](#)

- 22.16.** A consistent practice theme was how Martin's obstacles with engagement was interpreted across agencies. Further to his experiences with housing and community-based services, RSC attempted engagement through an initial telephone assessment. They also offered a later face-to-face appointment. Delays between these two contacts was driven by high service demand. Martin did not attend his subsequent face-to-face appointment. When his contact reduced, Martin's case was often closed.
- 22.17.** The delay between RSC contacts provides a significant context that may have affected Martin's ability to sustain engagement. It reflects the value of relational practice that is required for individuals with trauma histories or fluctuating capacity to engage. The later development of RSC's Engagement Pathway and Reach Team demonstrates organisational learning. It is an improved recognition that flexible, assertive outreach is essential for people whose engagement varies due to trauma, substance use, or unstable living circumstances. The development and implementation of the 'How Safe Do You Feel?' tool at the point of referral and assessment also reflects progress, offering an earlier opportunity to identify individuals who may be at risk and enabling concerns to be recognised sooner in the pathway.
- 22.18.** Collectively, these episodes show the system's reliance on Martin's capacity to articulate his needs and navigate services independently. Information about the complexity of his needs remained dispersed across services. There was no shared forum to combine insights. This again highlights the value of multi-agency information sharing, coordinated decision making, and the effective use of safeguarding frameworks. In this case, the gap led to an incomplete understanding of cumulative risk.
- 22.19.** Patterns of missed appointments, avoidance, and withdrawal were often viewed as personal choice. This pattern reflects national learning³⁹ recognising the "rule of optimism." This is where longstanding alcohol use or inconsistent engagement becomes normalised. It results in reduced professional curiosity, lower perceived urgency, and missed escalation opportunities. Seen through a different lens, Martin's engagement may have been explored as potential indicators of trauma, shame, cognitive overload, or executive impairment.
- 22.20.** Contemporary research⁴⁰ indicates that avoidance and non-attendance often reflect emotional overwhelm, shame or trauma rather than deliberate refusal. This is more prevalent when service models do not actively promote safety, trust and accessibility. Edelman (2023⁴¹) highlights trauma and social inequalities can reduce both the accessibility and acceptability of interventions. This means that people may disengage due to emotional and cognitive demands exceeding their coping capacity.
- 22.21.** These patterns were evident in Martin's presentation. His vulnerabilities including a home environment he may have felt unable to disclose, all align with pathways in which shame can become a barrier to engagement. Heavy reliance on telephone contact and time limited drop-in support, resulted in the system being unable to fully take account of how Martins trauma history shaped his ability to engage. This resulted in his risk indicators not being consistently identified or escalated.

³⁹ [adults_professional_curiosity_sb_web.pdf](#)

⁴⁰ [Beyond a trauma-informed approach and towards shame-sensitive practice](#)

⁴¹ [Trauma and resilience informed research principles and practice: A framework to improve the inclusion and experience of disadvantaged populations in health and social care research](#)

- 22.22.** Non-attendance or reluctance should prompt professional curiosity and adapted engagement. National SAR⁴² learning further highlights this tension, with systems often requiring individuals to navigate structured, appointmentbased pathways. Trauma informed approaches, which recognise how past adversity affects a person's ability to engage, therefore need to anticipate these barriers and adapt practice to avoid perpetuating exclusion. In such contexts, engagement is not a behavioural choice and is shaped by a person's capacity to cope, their emotional readiness and their level of trust in services.
- 22.23.** Seen through this lens, Martin's behaviours indicated underlying vulnerability rather than resistance. This highlights the importance of trauma informed interpretation and flexible engagement approaches. A more trauma informed system, considering how trauma affects trust, communication and engagement, may have prompted professional curiosity and adapted engagement rather than assumptions about choice.
- 22.24.** Records suggest that some professionals viewed his long-term alcohol use and inconsistent engagement as stable or typical. Some records indicate Martin's lifestyle, including periods of homelessness was a matter of choice and preference. Practitioners reflected on how professional curiosity had been unintentionally reduced by an emerging narrative that "this was just Martin." This was assumed from his homelessness history, linking to the demands and responsibilities a tenancy bring.
- 22.25.** The narrative recorded at the time was that Martin "preferred to be homeless" because it avoided the expectations required of a tenancy. This was considered by the panel to be a misreading of his presentation. This perception likely reflected unrecognised trauma, anxiety, cognitive difficulties, and a pattern of masking that obscured his unmet need for safety, connection and support. His behaviours were better understood as expressions of distress and overwhelm rather than a genuine preference for homelessness.
- 22.26.** Such dynamics are well recognised within the homelessness evidence base⁴³. This emphasises that disengagement is frequently a signal of distress rather than a lack of willingness to engage. The Blue Light approach⁴⁴ underpins the importance of persistent, flexible and nonjudgemental engagement supported by coordinated risk management. While some elements of this approach were visible in practice, its consistent, systemwide application was not evident.
- 22.27.** Practitioners highlighted the need to challenge these assumptions, recognising that a trauma-informed approach requires asking why a person presents in a certain way, rather than accepting behaviours as fixed or inevitable. This demonstrates how normalisation of vulnerability can mask deterioration. It highlights the importance of consciously resisting narratives that minimise or explain away risk.
- 22.28.** Practitioners reflected further as to whether Martin was able to ask for the help he truly needed. They noted that he tended to request only low level, practical support. He rarely articulated deeper worries about safety, exploitation, fear or coping. Practitioners recognised that no one consistently explored whether these seemingly simple requests masked more complex needs.

⁴² [Adult safeguarding and homelessness: experience informed practice | Local Government Association](#)

⁴³ [The capacity to act?](#)

⁴⁴ [About the Blue Light Approach | Alcohol Change UK](#)

- 22.29.** This perceived masking behaviour, combined with a lack of sustained professional curiosity may have contributed to wider concerns being overlooked or misinterpreted. Over time, his patterns of distress, avoidance, and fluctuating engagement became normalised within parts of the system. This led to practitioners attributing these behaviours to personality or lifestyle rather than indicators of trauma, fear or escalating need.
- 22.30.** Consequent gaps emerged regarding financial vulnerability. Family raised concerns that his Personal Independence Payment (PIP) might have increased exposure to exploitation. Although PIP is not a safeguarding mechanism, the lack of coordinated consideration of financial risk reflects wider multi-agency gaps in understanding how trauma, addiction, capacity and financial decision making intersect.
- 22.31.** Throughout the timeline, the absence of Section 42 enquiries, or a structured multi-agency risk process (e.g. MARM/VARM) meant that risks were addressed episodically rather than through coordinated safeguarding planning. Without shared oversight or proportionality review, Martin's cumulative vulnerability remained dispersed across services rather than forming a coherent safeguarding picture.
- 22.32.** Practitioners across the system discussed the challenges in using the escalation policy to challenge decisions not to progress to Section 42 enquiries. They described limited confidence, particularly within preventative, housing or provider services, to escalate concerns or question threshold decisions. This often resulted in safeguarding findings being accepted at face value, reinforcing the misconception that a 'no Section 42' decision meant the situation was less serious. This emphasises the importance of each agency having a clearly identified safeguarding lead, able to support staff in navigating escalation processes, building confidence, and ensuring proportional safeguarding oversight when concerns persist.

23. Lessons Learned

- 23.1.** This case demonstrates the importance of recognising how trauma and repeated losses can shape a person's engagement with services. Martin's fluctuating or limited contact with services was often interpreted as personal choice. Understood within a broader context, it was a potential indicator of diminished coping, emotional overwhelm or impaired executive functioning. A trauma informed approach, sensitive to avoidance, shame and cognitive overload, supports practitioners to interpret these patterns differently and adapt engagement strategies accordingly.
- 23.2.** The Second National Analysis of SARs emphasises how safeguarding practice is shaped by the professional narratives used to make sense of risk. This in turn can influence decision making. In this case, the language recorded in agency notes and the practice learning event reflections mirrored this learning. Where complex behaviours are described in ways that appear to suggest preference or choice, this can unintentionally obscure the role of trauma, literacy needs, exploitation, or impaired functioning. This makes indicators of escalating vulnerability less apparent and affects the timeliness of safeguarding responses.
- 23.3.** At the same time, safeguarding practice must balance autonomy and protection. Overemphasising autonomy risks minimising danger. Overemphasising vulnerability risks undermining MSP principles. MSP requires decisions to be understood within the person's lived context. It must not be interpreted solely through surface level compliance or refusal.

- 23.4.** Practitioners at the Practice Learning Event reflected that voluntary, community and faith sector organisations, such as the foodbank Martin attended regularly, often held the most consistent relational contact with him. These organisations were sometimes the only services he was able to approach. Practitioners recognised that such organisations play a vital function in the lives of people who face barriers to engagement. Particularly where complex needs or accessibility make it hard to seek help through formal routes. However, these services are not always fully connected into multi-agency safeguarding structures.
- 23.5.** The system currently lacks clear mechanisms to “reach into” voluntary and faith based organisations, and equally to empower them to “reach out” when they identify emerging concerns or patterns of escalation. Strengthening these connections would support earlier identification of risk, improve relational continuity, and ensure that important safeguarding information held within community settings is not lost to the wider system.
- 23.6.** The review identified examples of positive practice, including accessible drop-in services, relational contact and immediate practical support. It was reported their role was not always recognised within multi-agency safeguarding processes or routinely included in coordinated risk planning. This left preventative services bridging gaps that exceeded their remit.
- 23.7.** Shame competent approaches are critical when supporting individuals affected by Martin’s experiences. Shame can drive withdrawal, minimise help seeking and lead individuals to hide risks. Shame sensitive practice includes accessible communication, normalising requests for help and avoids judgement. It also involves reducing power imbalances and providing graded practical support. This involves creating flexible options within the current standard appointment based pathways.
- 23.8.** When viewed in this context, behaviours recorded as preference or disengagement may be understood as consistent with patterns described in national self-neglect and trauma research, where shame, fear, and emotional exhaustion commonly influence help seeking and avoidance. While it is not possible to determine Martin’s internal experience, recognising that such behaviours can reflect underlying vulnerability supports more flexible, persistent and enabling responses.
- 23.9.** Family insight offered valuable information about Martin’s daily functioning, emotional distress and exposure to intimidation. This knowledge was not consistently recorded or integrated into assessments. Systems must create space to incorporate familyheld knowledge, particularly where individuals struggle to articulate needs or minimise risk⁴⁵.
- 23.10.** Practitioners highlighted considerable variation in awareness of family involvement. Some were unaware that Martin’s sister was engaged or providing support, while others were unsure what this support consisted of or how to incorporate it into assessment and planning. Practitioners reflected that family members often hold critical contextual information such as changes in routine, deterioration in functioning, escalation of fear or uncharacteristic behaviour. This can provide an essential early warning of risk.
- 23.11.** They also recognised the challenges of balancing confidentiality, consent and autonomy. This is particularly when adults do not routinely share information about family relationships or when practitioners fear overstepping boundaries. However, staff emphasised that this

⁴⁵ The Care Act 2014 Statutory Guidance requires local authorities to involve the adult, their carer, and anyone else who can contribute to understanding the person’s needs and circumstances within assessments and safeguarding enquiries.

balance should not prevent proactive exploration of family links or the safe, proportionate inclusion of family insight within safeguarding processes. Strengthening mechanisms to identify, record and meaningfully integrate family held knowledge would support more accurate risk formulation, reduce missed opportunities and enhance shared decision making.

- 23.12.** Practitioners also reflected those important aspects of Martin's wider family network, including support previously offered by his nephew and brother-in-law were not widely known across agencies. They noted that, unlike children's services where family mapping is routine, adult services do not consistently identify or record relational networks, despite their importance in cases where an individual masks need or minimises risk.
- 23.13.** National guidance reinforces the importance of involving family members in the care and safeguarding of adults with alcohol dependence. NICE⁴⁶ highlights that, where a person consents and it is appropriate, practitioners should actively involve family members or carers, agree together what information will be shared, and ensure families receive support in their own right.
- 23.14.** NICE emphasises that family involvement improves treatment outcomes and that services should offer information and support to family members even when the person with alcohol problems is not consistently attending treatment. This includes recognising when carers may be entitled to their own assessment.
- 23.15.** In Martin's case, valuable insight held by his sister and extended family was not consistently identified, sought, or integrated into risk formulation or assessment, despite its relevance to understanding his daily functioning, vulnerabilities and escalating risk.
- 23.16.** Although PIP is not a safeguarding mechanism, concerns raised by his sister highlight the need to consider how financial arrangements intersect with vulnerability, risk, capacity, exploitation and addiction. Multi-agency discussion should explore whether budgeting support, advocacy or protective mechanisms are appropriate.
- 23.17.** Overall, agencies tended to respond to discrete tasks such as housing issues, benefit queries, welfare checks, and health concerns without constructing a cumulative risk picture. The absence of coordinated risk planning meant escalating vulnerability was not systematically reviewed or acted upon. This reinforces the need for shared ownership of safeguarding concerns and the use of formal multi-agency risk management processes (e.g., MARM/VARM) for individuals experiencing persistent, complex or escalating risk.

24. Findings

24.1. Finding 7 – Professional narratives shaped practice and reduced professional curiosity

- 24.2.** Martin's circumstances were at times framed as lifestyle choice or disengagement, rather than potential signs of trauma, impaired coping, exploitation or cognitive difficulty. These assumptions reduced professional curiosity and contributed to repeated underestimation of risk. When support was declined, there was limited exploration of 'why', including whether he felt safe, understood the offer or needed adjustments. This limited opportunities to identify disguised distress or emerging harm.

⁴⁶ [Clinical guidelines for alcohol treatment - Guidance - GOV.UK](https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment)

24.3. Further to this, the absence of formal safeguarding responses was sometimes interpreted as the situation being less serious because a statutory agency had assessed the risk as low. This narrative was recognised as unhelpful potentially unsafe. It also deters practitioners from escalating concerns or seeking alternative pathways for multi-agency review. Practitioners challenged each other on this assumption during the Practice Learning Event. They emphasised the need for shared ownership of risk and the importance of seeking clarification rather than inferring reassurance from a threshold decision.

24.4. Finding 8 – Preventative services were relied on beyond their remit and this impeded sustained relational continuity

24.5. Relationships are central to effective safeguarding.⁴⁷ 'Concerned curiosity', 'psychologically informed practice' and 'relational approaches' help practitioners understand what has shaped a person's circumstances. It also facilitates understanding of what barriers affect their ability to remain safe. These approaches are essential for fostering trust, sustaining engagement and supporting change.

24.6. Whilst several agencies made contact with Martin, outreach was not consistently available through system structure or adapted when contact was lost. National SAR learning consistently highlights relational continuity as a key protective factor in chronic self-neglect. Disengagement often led to case closure rather than revised strategies to maintain involvement. These gaps limited the persistence, flexibility, and curiosity required to support someone with Martin's complexity. This subsequently made conventional service pathways difficult for him to access.

24.7. Martin frequently sought support from the foodbank and similar voluntary or faith based community resources. These services often provided the only predictable point of relational contact for him. This was particularly pertinent as statutory face-to-face access reduced and engagement with formal services became more difficult. The review noted a growing systemwide dependence on voluntary and faith communities to meet basic needs in an increasingly pressured landscape of service reform and reduced capacity.

24.8. These organisations are not systematically connected into wider MDT arrangements, safeguarding narratives, training, and escalation routes. It was recognised that Martin may have shared information with these services that was never brought into formal safeguarding processes. This highlights the need for improved integration and support for community based organisations within the broader safeguarding system.

24.9. Finding 9 – Disclosures of significant risk were not consistently explored or escalated

24.10. Martin repeatedly disclosed high-risk information, including unsafe living conditions, alcohol withdrawal, and fear of neighbours. While these disclosures were acknowledged, responses tended to focus on the immediate issue rather than prompting safeguarding escalation, multi-agency risk review or coordinated planning. Although several indicators of criminal exploitation were present, there is no evidence of formal consideration of cuckooing or associated protective actions.

- 24.11.** The Practice Learning Event identified misunderstanding around General Data Protection Regulation⁴⁸ (GDPR) and information sharing permissions as a significant barrier to effective safeguarding. Staff were often unsure about when they could share information without consent, particularly in situations involving self-neglect or fluctuating capacity. This sometimes resulted in risk relevant information not being shared promptly with other agencies. This uncertainty contributed to fragmentation of the safeguarding picture and reduced opportunities for an early, coordinated response.
- 24.12.** Practitioners emphasised the need for clearer guidance and reassurance on lawful information sharing in safeguarding contexts. They emphasised the need for safeguarding leads within each agency to support staff in navigating these decisions with confidence.
- 24.13. Finding 10 – Environmental risk and homebased assessment were insufficiently recognised as safeguarding evidence**
- 24.14.** Assessments were largely telephone based or conducted in community settings. The absence of routine home visits limited practitioners' ability to understand risk or verify concerns. Significant environmental hazards only became visible at crisis point, demonstrating the importance of homebased assessment within safeguarding practice.
- 24.15.** Unlike many other agencies, Housing staff had been inside his home and were able to see firsthand the conditions he was living in. However, this insight was not routinely shared or drawn into wider safeguarding assessments. Stronger mechanisms are needed to ensure that observations from key agencies, who may be the only agency with access to the home, are actively incorporated into multi-agency risk formulation and escalation.
- 24.16.** During the Practice Learning Event reflected the importance of street based observation as an opportunity to understand an individual's presentation when home access is difficult. Police officers noted that they often saw Martin in public spaces. They could observe changes in his appearance, behaviour or level of distress that were not visible to other agencies working remotely. Practitioners recognised that such street level contact can provide valuable realtime insight into wellbeing, functioning and emerging risk.
- 24.17.** These observations are not routinely shared, recorded or integrated into multi-agency risk formulations. The system missed opportunities to use police visibility as a source of dynamic assessment and early warning, especially when other agencies had limited face-to-face contact.
- 24.18. Finding 11 – Family insight was valuable but not consistently integrated into multi-agency understanding**
- Martin's sister provided detailed information about his vulnerability, fear and exploitation risk. However, her concerns were not consistently incorporated into assessments or shared between agencies. This reflects a wider need for systems to integrate family held knowledge into risk formulation, particularly where individuals minimise their own needs or struggle to articulate concerns.

⁴⁸ The General Data Protection Regulation (GDPR) is a comprehensive data protection law in the EU that enhances individuals' rights over their personal data and establishes strict guidelines for data processing by organisations.

25. Recommendations – Theme 3

25.1. Recommendation 5 – Build an Environmental Risk Factor as Core Safeguarding Evidence into the new self-neglect threshold tools and guidance

CSAB should strengthen environmental risks within the new self-neglect threshold tools and risk assessment to ensure environmental concerns are treated as primary safeguarding indicators. This should include:

1. Required Actions

- A mandatory home based assessment where environmental risk is reported, unless demonstrably unsafe or declined.
- If access is difficult, explore multi-agency environmental visits (ASC, Housing, Fire & Rescue, and Police).

2. Incorporate a clear process for identifying, documenting and responding to potential cuckooing, home invasion or coercive exploitation within self-neglect and front door triage.

3. Front Door / Triage Expectations

- ASC triage must treat environmental reports as risk indicators requiring further assessment.
- Environmental information should feed into MARM/VARM, especially where concerns persist or access is limited.

4. Integration Into MARM/VARM

- Incorporate environmental risk assessment into the core formulation of any MARM/VARM plan.
- Assign a trusted professional role to maintain relational continuity and monitor home conditions over time.

5. Documentation and Review

- Clear expectations for recording environmental observations, attempts at access, and cross agency updates.

25.2. Recommendation 6 - Financial Vulnerability & Benefits Safeguarding Interface

Relevant CSAB partners should strengthen local guidance to ensure financial vulnerability is routinely considered within safeguarding enquiries, MARM/VARM, and Care Act assessments. This is of particular importance where addiction or cognitive impairment is present. Multi-agency planning should:

- Consider PIP/benefits as a potential risk factor (exploitation, purchasing alcohol, coercion).
- Ensure access to budgeting support, advocacy and appointeeship.
- Involve DWP safeguarding leads where appropriate.
- Include financial risk in cumulative risk escalation pathways.

25.3. Recommendation 7- Local Practice Informed Learning Programme

25.4. CSAB should develop a practice informed learning resource to embed learning from this SAR and the thematic review. This should include an evaluation of the MARM/VARM model plus audits of:

- Homebased assessment.
- Executive capacity.
- Practicable steps.
- Multi-agency information sharing.
- Lived experience insight (e.g., people affected by alcohol use/self-neglect).
- Targeted training on self-neglect, executive functioning, trauma, MSP and environmental risk.

25.5. CSAB should consider a learning resource for non-statutory and preventative services on Care Act eligibility, including when a duty to assess is triggered, how to recognise emerging care and support needs, and how to escalate concerns appropriately where eligibility questions arise.

25.6. Learning should to be disseminated through practitioner forums, practice learning events, and locality workshops

25.7. Cross Cutting Recommendation 8 - CSAB Assurance on System Oversight for Adults with Complex Needs

25.8. CSAB should seek assurance from relevant partners that they will jointly develop and implement an appropriate Complex Adults Oversight Function. This should provide a single point of multi-agency visibility for adults whose risks do not meet statutory thresholds, but where concerns persist.

25.9. CSAB's assurance should confirm that partners have agreed and implemented arrangements that enable them to:

- Review cases below statutory thresholds where risk is accumulating.
- Provide consultant style safeguarding advice to practitioners.
- Challenge normalised or minimised risk.
- Ensure timely multiagency escalation whenever any agency is concerned.
- Track escalating or repeated referrals to identify cumulative risk.
- Ensure ASC, Police, Acute Trust, Housing and Substance Use services feed into oversight.

25.10. CSAB should seek assurance that each partner agency has an identified safeguarding lead with the capacity, confidence and competence to support staff. This should include promoting confident use of the escalation policy, supporting practitioners to navigate threshold decisions, and ensuring services have access to guidance and oversight when safeguarding concerns persist. As part of this assurance, CSAB should also seek clarity on the visibility and accessibility of safeguarding leads, including whether practitioners know who they are, how to contact them, and feel supported to seek advice or challenge decisions when required.

- 25.11.** CSAB should seek assurance that all partner agencies provide clear guidance and training on lawful information sharing under safeguarding legislation, including when information can be shared without consent.

26. Conclusion

- 26.1.** This review highlights how Martin's experiences were shaped by a combination of trauma, social exclusion, health needs and fluctuating engagement. Individual practitioners showed care and commitment, but the wider system struggled to recognise accumulating risk, bring together important information, or respond in a coordinated and trauma informed way. Opportunities for earlier intervention were limited by structural pressures, fragmented pathways and the absence of sustained, relational oversight. Practitioner reflections during the Learning Event reinforced how easily vulnerability can become normalised, and how narratives of 'choice' or routine disengagement obscured signs of distress, executive functioning difficulties or escalating harm.
- 26.2.** The learning set out in this report is intended to strengthen practice across agencies and ensure that people living with chronic vulnerability receive responses that are persistent, compassionate and proportionate to the complexity of their circumstances. The recommendations aim to support a more joined up and preventative system, capable of recognising risk early, tailoring engagement to individual need, and offering coordinated protection when harm begins to escalate. Strengthening multi-agency formulation, shared ownership of risk and robust safeguarding oversight will help ensure that adults experiencing multiple disadvantage do not fall between service boundaries in future.

27. Appendix 1 - Key Practice Episodes

27.1.1. Early 2022: Escalating distress and first cluster of referrals

27.1.2. In February 2022, Martin sent a distressed message to Home Group stating he was struggling to cope. Police attended, noted he had been drinking, and supported him to make contact with relevant services. Recovery Steps, the GP and ASC attempted follow-up by telephone, though this was made more difficult by his understandable tendency not to answer calls from unfamiliar numbers.

27.1.3. Home Group also raised concerns about his alcohol use, home conditions and possible exploitation. ASC screened the safeguarding referral but did not progress to a Section 42 enquiry, instead requesting a Care Act assessment via the SAT.

27.2.2. March 2022: Attempted assessment and emerging concerns about self-neglect

27.2.1. SAT arranged a Care Act assessment at his sister's home. This offered a familiar and comfortable setting, but it meant practitioners could not directly view his living environment, which had been a focus of concern. The assessment was recorded as completed and recommended HAWC support. No assessment documentation or eligibility decision was later found on the system.

27.2.2. During this period, housing staff continued to raise concerns about the flat. A washing machine delivery was arranged to support him, then later cancelled following family discussions about his wellbeing. This left him feeling worried about managing day-to-day tasks.

27.3.3. Spring–Summer 2022: Fluctuating contact and unmet basic needs

27.3.1. Between April and June 2022, he attended HAWC drop-ins and described difficulties with budgeting, anxiety about attending the Job Centre, and concerns about maintaining his tenancy.

27.3.2. In June, he again sought rehousing because he felt unsafe. He was advised that a move could not progress until the condition of the property improved. Decisions referenced a previous Care Act assessment, though no record of this assessment could be located. No reassessment or safeguarding review followed this disclosure.

27.4.4. January 2023: Reporting rough sleeping despite having accommodation

27.4.1. In January 2023, he attended a HAWC drop-in and explained that he had been sleeping in the cemetery because he felt unsafe in his home. Practical advice and reassurance were offered, but no safeguarding referral or multi-agency escalation took place.

27.4.2. Around this time, Recovery Steps staff attempted to reengage him due to concern about his appearance and weight loss. However, difficulties maintaining appointments meant he was discharged from the service.

27.5.5. 2023–Early 2024: Deteriorating physical health and limited coordinated response

27.5.1. Throughout 2023, GP records noted continued alcohol use, challenges establishing contact, and concerns about his health. By January 2024, he presented with symptoms suggestive of liver disease and underwent medical investigations. Standard written and verbal information was provided following his endoscopy, although his literacy needs were known and no practicable steps were recorded.

27.6.6. Final months: Increasing vulnerability and unrecognised environmental risk

27.6.1. During the final period, no home visit was carried out by any agencies. Ongoing concerns continued about his living environment and expressions of worry from family members. His sister became increasingly concerned when she was unable to reach him.

27.6.2. In May 2024, following a period without contact, she requested a welfare check. Police attended and found Martin extremely unwell and needing urgent medical attention. North West Ambulance Service transported him to hospital, where he was admitted for critical care. Despite intensive medical treatment, he sadly died the following day.

28. Appendix 2 - Complete Terms of Reference

28.1. The purpose of the SAR is to use the experience of Martin's case to identify learning about the multi-agency system. The SAR has identified several themes which will act as research questions. This is not an exhaustive list but will help to provide some initial structure to the analysis and findings of the review. The themes identified as terms of reference for this Safeguarding Adults Review are aligned to the 6 key principles which underpin all adult safeguarding work. The review will also draw on relevant learning from previous SARs.

28.2. Self-neglect

Is there learning relating to the self-neglect and hoarding Martin experienced from the CSAB thematic SAR which can be applied to Martin's circumstances?

28.3. Empowerment

Was Martins views, wishes and opinions known to services?

What was important to Martin and how he did he seek support to meet his own needs?

Was there consideration of Martin's executive capacity to understand the risks to his health and his ability to execute changes required to protect himself?

28.4. Prevention

Was Martin involved with any services before harm occurred?

Were there missed opportunities to prevent harm from occurring?

Did services engage and support Martin appropriately to manage his own health and well-being?

28.5. Proportionality

Martin experienced multiple exclusions including mental health issues, physical health concerns, drug and alcohol dependency, self-neglect, hoarding and homelessness at times.

Was Equality, Diversity and Inclusion (EDI) considered appropriate in Martins case?

Concerns were raised regarding Martin's ability to protect himself including from exploitation, was the response proportionate to the risks presented to Martin.

28.6. Protection

Was appropriate support offered to Martin in response to concerns around his declining mental health?

Did Martin respond to services offer of support?

Following safeguarding concerns being raised were safety plans sufficient to manage the risks posed to and by Martin?

28.7. Partnership

Was partnership working effective in Martins case?

Was there formal multi-agency discussions or meetings?

Where MDTs took place, were actions appropriate to Martin's presenting needs. How did and/or could MDTs have supported Martin?

Was information shared appropriately, particularly in respect of escalating concerns and risk?

Was there recognition of the abuse and neglect Martin was experiencing, including consensus with partners regarding level of risk and was this escalated appropriately (internally and to partners). Was information about escalating risks pertaining to his physical health shared?

Were there appropriate and timely referrals to other services to protect Martin and meet his care and support needs. Were all agencies required, involved in protecting and supporting Martin?

28.8. Accountability

Were all agencies accountable and transparent in their safeguarding practice in respect of Martin? Were all actions and decisions open to scrutiny and organisations held responsible for their actions?

Considering the known risks to Martin and his deteriorating physical health what strategies were used to engage with Martin when he missed appointments or assessments were required?

Were there missed opportunities to see Martin face-to-face to engage with Martin and assess increasing need and risks?

28.9. Making Safeguarding Personal

Martin lost his parents by the age of 34 years old, did partners consider previous trauma and the impact this had on him as an adult?

It is understood Martin did not read or write, was this known to agencies or shared and were practicable steps made to support Martin to receive and/or engage with services?

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