

Cumbria Safeguarding Adults Board

Safeguarding Adults Review: Martin

Learning Briefing

This learning briefing summarises the key learning and recommendations following a Safeguarding Adults Review (SAR) undertaken by Cumbria Safeguarding Adults Board (CSAB). The SAR commissioned by CSAB considered the case of Martin, a 44-year-old white British man who died in May 2024. Martin had a trauma history and literacy difficulties. Substance use shaped his ability to interact with services and take up support. Procedural system factors including limited face-to-face contact, the absence of home based assessment, and a lack of coordinated multiagency oversight reduced opportunities to identify emerging risks related to self-neglect, exploitation and environmental deterioration.

A SAR takes place where there is reasonable concern about how the Safeguarding Adults Board or members of it worked together to safeguard the adult, the adult has died, and the SAB knows or suspects the death resulted from abuse or neglect. The SAR combined agency significant event chronologies with a learning event for practitioners who had been directly involved with Martin. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice.

Martin

Martin lived in Cumbria at the time of his death; he was living alone in a social landlord tenancy. He had long standing vulnerabilities rooted in childhood learning difficulties, attendance at a special educational school, bereavements, eviction, and periods of rough sleeping. 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. 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.

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.

Finding 1

The engagement model relied on help seeking behaviours and appointment based pathways. These did not align with trauma impacted needs.

Context

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, increasing reliance on digital contact, and the rural requirement to travel long distances on public transport did not consider Martin's trauma history, learning needs, or avoidance patterns.

Recommendation

Strengthen the application of the existing trauma-informed practice framework¹ specifically for adults experiencing multiple disadvantage. This should align with the Cumberland Joint Local Health and Wellbeing Strategy 2023-2028²) recognising the barriers which prevent adults from seeking help or attending appointments.

Finding 2

A coordinated trauma-informed response was not established.

Context

Agencies responded to individual issues as they arose, but there was no mechanism for bringing together the full picture of Martin's vulnerability. Without coordinated review, his cumulative risks were not recognised as requiring a more structured safeguarding response.

Recommendation

Align the strengthened trauma-informed pathway with the Cumberland MEAM Strategy, further recognising people experiencing multiple disadvantage require flexible assessment and coordinated support. CSAB should seek assurance that the objectives of MEAM are being progressed and embedded consistently across the partnership.

¹ [Trauma-informed resources | Cumbria Safeguarding Adults Board](#)

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

Finding 3

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

Context

Martin's literacy needs were known within the system, but executive functioning was not adequately considered within capacity assessments. There was limited evidence that practicable steps were consistently applied to support Martin's understanding or ability to act on decisions. Professional confidence to complete complex capacity assessments was not realised.

Recommendation

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.

Finding 4

Cumulative risk was not recognised due to fragmented oversight and normalisation.

Context

Multiple agencies held important information about Martin's circumstances. No process, agency or professional held responsibility for coordinating or maintaining oversight of cumulative risk.

Recommendation

Relevant CSAB partners should build on MARM/VARM development work to implement a multi-agency risk process for adults who fall below statutory thresholds.

Finding 5

System capacity pressures limited proactive intervention.

Context

System capacity pressures reduced opportunities to observe risk directly or review concerns holistically. This limited the system's ability to recognise accumulating risk or adapt support when engagement fluctuated.

Recommendation

Relevant CSAB partners should develop and implement a local "Accumulating Risk Trigger", and crossagency "need to know" alerting system when building the MARM/VARM work. Together, these would ensure escalating risks are visible to all relevant partners.

Finding 6

Safeguarding thresholds were narrowly and inconsistently applied.

Context

Indicators of hoarding, exploitation, alcohol-related harm and environmental hazards did not progress to a Section 42 enquiry. This contributed to a false sense that risk was lower than it was due to statutory thresholds not being met.

Recommendation

The MARM/VARM development work should consider a shared multi-agency formulation. ASC should consistently be integrated into multi-agency planning for people experiencing multiple disadvantage. It should set review intervals with mandatory escalation points and clear “step-up/step-down” pathways to/from safeguarding.

Finding 7

Professional narratives shaped practice and reduced professional curiosity.

Context

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. This limited opportunities to identify disguised distress or emerging harm.

Recommendation

CSAB should seek assurance that each partner agency has an identified safeguarding lead with the capacity, confidence and competence to support staff in recognising, escalating and appropriately challenging safeguarding concerns. As part of this assurance, CSAB should also seek clarity on the visibility and accessibility of safeguarding leads.

Finding 8

Preventative services were relied on beyond their remit and this impeded sustained relational continuity.

Context

Martin frequently sought support from the foodbank and similar voluntary or faith-based community resources. These were often providing the only predictable point of relational contact for him. The SAR identified a system-wide dependence on voluntary and faith communities to meet basic needs in an increasingly pressured landscape of service reform and reduced capacity. However, these organisations are not systematically connected into wider MDT arrangements, safeguarding narratives, training, and escalation routes.

Recommendation

Partners developing the MARM/VARM should consider clear routes of access to and from community, voluntary and faith services. 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.

Finding 9

Disclosures of significant risk were not consistently explored or escalated.

Context

Martin repeatedly disclosed high-risk information which was acknowledged. Responses tended to focus on the immediate issue rather than prompting safeguarding escalation, multiagency risk review or coordinated planning.

Recommendation

Relevant CSAB partners should build a named “trusted professional” responsible for relational continuity, maintaining contact, coordinating information flow, and spotting escalation into the MARM/VARM development work.

Finding 10

Environmental risk and home based assessment were insufficiently recognised as safeguarding evidence.

Context

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 home based assessment within safeguarding practice.

Recommendation

CSAB should strengthen environmental risks into the new self-neglect threshold tools and risk assessment. This must ensure environmental concerns are treated as primary safeguarding indicators. It should consider triage, home based assessment (and challenges around refusal), escalation processes and clear documentary tools that evidence indicators of hoarding, home invasion and self-neglect risks.

Finding 11

Family insight was valuable but not consistently integrated into multiagency understanding.

Context

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.

Recommendation

Incorporate NICE³ guidance on family involvement in alcohol-related safeguarding into crossagency training. This should include how to balance consent, confidentiality and family insight.

You can read the full SAR report [here](#).

Information and resources for practice can also be accessed via the CSAB website [here](#).

Practitioners and managers are invited to attend a SAR learning session where Kristy Atkinson, Independent Reviewer will present the findings including learning for practice. This will take place on **Friday 20th November 2026, 10 – 11.30am**. To book your place click [here](#).

³ [Clinical guidelines for alcohol treatment - Guidance - GOV.UK](#)