Richmond and Wandsworth Safeguarding Adults Board

Aubrey
Safeguarding Adults Review

May 2026

Reviewer: Sian Carter-Jones
Independent oversight: Dr Sarah Hutton

Contents

1. Introduction

Richmond and Wandsworth Safeguarding Adults Board commissioned this Safeguarding Adults Review (SAR) under Section 44 of the Care Act 2014[1] following the death of *Aubrey* (a pseudonym), a 38-year-old White British woman who died in June 2025. The statutory criteria for a SAR were met on the basis that there was reasonable cause for concern regarding how agencies worked together to safeguard Aubrey during the period preceding her death, and that she was an adult with care and support needs who appeared to have experienced self-neglect, substance dependency, exploitation, homelessness and deteriorating physical and mental wellbeing.

Aubrey's life was characterised by significant adversity and trauma from an early age, including bereavement, experiences of abuse and longstanding substance misuse involving alcohol and illicit drugs. Throughout adulthood, she experienced periods of homelessness, instability, poor mental health, vulnerability within relationships and repeated contact with health, criminal justice, housing and substance misuse services.

During the review period, Aubrey was living in supported accommodation and was involved with a range of agencies including homelessness services, Adult Social Care, probation, acute health services and community substance misuse services. Her presentation fluctuated over time, with periods of increased engagement alongside periods of significant instability, repeated hospital presentations and ongoing concerns relating to self-neglect, exploitation and vulnerability.

This review seeks to understand how local systems recognised, assessed and responded to escalating vulnerability in the context of her complex needs, fluctuating engagement and increasing complexity. The review adopts a systems-learning approach[2] focused on professional practice, organisational conditions and multi-agency working, rather than attributing blame to individual practitioners or agencies.

2. About Aubrey

Practitioners consistently described Aubrey as intelligent, articulate and thoughtful, with a strong interest in history and current affairs. Staff reflected that she was often insightful, able to engage in deep conversation and capable of building meaningful relationships with those supporting her. Hostel staff described how she would often come into the office to chat and spend time in conversation with them. She was viewed as personable and someone with whom it was possible to build a positive rapport. Despite experiencing significant adversity throughout her life, practitioners described Aubrey as warm, humorous and resilient, particularly during periods where she felt emotionally safe and supported.

Records and practitioner discussions suggested that Aubrey valued trusted relationships and often engaged most positively where professionals demonstrated persistence, flexibility and genuine relational care. During periods of increased stability, she spoke openly about recovery, future plans and wanting aspects of her life to feel different. Practitioners consistently emphasised the importance of understanding Aubrey as more than the difficulties she experienced, recognising both her strengths and the complexity of her lived experience. This review also seeks to recognise Aubrey as a person beyond the challenges and vulnerabilities described within agency records, acknowledging her strengths, relationships, experiences and individuality throughout her life.

These reflections highlight the importance of recognising Aubrey not simply through the lens of her care needs, but as an individual who valued relationships, social interaction, and meaningful connections with those around her.

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[1] Care Act 2014; c.23 statutory guidance on SAR criteria

[2] SCIE (2026) *Learning Together* (systems approach and analytic tools for case reviews). Learning Together to safeguard adults and children: a multi-agency systems approach - SCIE

3. Methodology

This Safeguarding Adults Review (SAR) has been undertaken under Section 44 of the Care Act 2014 to identify learning that may strengthen multi-agency safeguarding responses to adults experiencing homelessness, trauma, substance dependency, exploitation, self-neglect and multiple disadvantage.

The Review focuses on understanding how agencies worked together to recognise, assess and respond to Aubrey's needs over time, including how safeguarding concerns, mental capacity, executive functioning, non-engagement, exploitation, risk management and multi-agency coordination were understood and addressed within practice. Particular consideration is given to the interaction between trauma, substance dependency, homelessness, fluctuating engagement and cognitive deterioration, and how these factors shaped both Aubrey's lived experience and professional decision-making.

The purpose is not to reinvestigate events or attribute blame to individual practitioners or agencies. Rather, the SAR adopts a systems-learning approach consistent with, Making Safeguarding Personal principles and the SCIE Safeguarding Adults Review Quality Markers[3]. The Review seeks to understand how organisational structures, professional frameworks, service pressures, legal duties and inter-agency working shaped responses at different points in time. The Review acknowledges the complexity of working with adults experiencing chronic trauma, addiction, homelessness and fluctuating engagement, particularly where risks emerge cumulatively over extended periods and where professional responses are shaped by legal, organisational and resource constraints.

Throughout, the analysis seeks to balance respect for autonomy and lived experience with consideration of how safeguarding systems recognised and responded to cumulative harm. The Review also highlights examples of persistent and compassionate frontline practice, alongside opportunities for strengthening multi-agency coordination, escalation and systems oversight.

4. Scope

The review period considered within this review spans March 2024 to June 2025, focusing on the period during which Aubrey was residing within supported accommodation and engaged with local safeguarding, housing, health, substance misuse and criminal justice services. Earlier historical information has also been considered where relevant to understanding Aubrey's lived experience, trauma history, patterns of vulnerability and interaction with services over time.

The Review draws on multiple sources of information and practitioner reflection in order to understand the circumstances surrounding Aubrey's care and support. These include:

- agency chronologies and information returns;
- safeguarding records and Adult Social Care documentation;
- records from homelessness, substance misuse, probation and health services;
- relevant mental health, hospital and community health information;
- practitioner discussions and multi-agency learning event reflections;
- family contribution and contextual information where available;
- and relevant national safeguarding guidance, SAR learning and research literature relating to homelessness, self-neglect, trauma, exploitation and multiple disadvantage.

[3] SCIE (2026) *Learning Together* (systems approach and analytic tools for case reviews). Learning Together to safeguard adults and children: a multi-agency systems approach - SCIE

Practitioner contribution formed an important part of the review process and provided opportunities for reflective discussion regarding frontline practice, inter-agency working, safeguarding escalation, professional challenge and system pressures across the review period.

5. Key practice episodes (KPEs)

This Review organises the chronology and analysis around a series of Key Practice Episodes (KPEs). These represent points during the review period where professional decision-making, safeguarding responses, inter-agency coordination or changes in Aubrey's presentation were particularly significant in shaping her experience and support.

The KPE structure is intended to support examination of how agencies understood and responded to changing circumstances over time, whilst also identifying broader systems learning across the review period. The episodes should not be viewed as isolated incidents, but as interconnected parts of a wider picture involving trauma, homelessness, substance dependency, fluctuating engagement and increasing vulnerability. The summary below provides an overview of each KPE and the themes explored within the subsequent analysis:

Table 1 Summary of Key Practice Episodes (KPEs)

KPE	Period	Focus	Key Features
KPE 1	March–July 2024	Transition into supported accommodation and early service involvement	Aubrey moved into supported accommodation following a period of homelessness. Early concerns emerged regarding substance use, physical health, vulnerability, safeguarding risk and engagement with services. Multiple agencies became involved during this period.
KPE 2	August–October 2024	Escalating vulnerability and safeguarding concerns	Repeated incidents relating to intoxication, exploitation, violence, missing episodes and self-neglect. Safeguarding concerns were raised by a number of agencies alongside increasing health and wellbeing concerns.
KPE 3	Nov – January 2025	Periods of engagement and ongoing complexity	Periods of improved engagement with substance misuse and support services alongside continuing instability. Discussions took place regarding recovery, detoxification and longer-term support planning.
KPE 4	Feb - April 2025	Escalating health and safeguarding concerns	Increasing concerns regarding physical health, memory and cognitive concerns, self-care, financial vulnerability and safeguarding risk. Agencies remained involved in assessment, safeguarding and support planning.
KPE 5	May–June 2025	Final period prior to Aubrey's death	Completion of Care Act Assessment and introduction of support planning alongside ongoing safeguarding concerns, hospital presentations and ongoing discussions regarding detoxification and longer-term support planning.

KPE1 — Transition into supported accommodation and early emerging vulnerability (March – July 2024)

Aubrey moved into supported housing, a specialist women-only supported accommodation service for women experiencing homelessness and multiple disadvantage, on 18 March 2024 following a transfer from homelessness services in Lambeth. Records indicate that Aubrey had longstanding experiences of homelessness, substance dependency, trauma, poor mental health and instability, and had previously been known to multiple services over a number of years.

During the early months of her placement, practitioners across accommodation, substance misuse and health services began identifying concerns regarding Aubrey's alcohol and drug use, physical vulnerability, fluctuating presentation and periods of disengagement from support. On 19 April 2024 Aubrey attended an initial assessment with Drug and Alcohol Services alongside a support worker from her supported accommodation. She self-reported heroin, crack cocaine and alcohol use and was accepted for treatment and allocation. Hostel records demonstrate that engagement with services during this period was sporadic and that Aubrey often struggled to access support consistently.

Agency records also indicate increasing concerns regarding Aubrey's safety and vulnerability within the community. On 12 July 2024 Adult Social Care received a referral from hostel staff requesting a Care Act Assessment alongside safeguarding concerns relating to Aubrey allegedly being given fentanyl without her consent and being the victim of robbery. Further police information received on 15 July 2024 described Aubrey being found barefoot and dishevelled in Kingston town centre, alongside continuing concerns regarding vulnerability and welfare.

Records show that agencies were simultaneously attempting to respond to immediate safeguarding concerns whilst also considering longer-term support needs. A Care Act Assessment referral was initiated during this period; however, records demonstrate emerging uncertainty regarding ordinary residence and local authority responsibility. On 2 August 2024, Adult Social Care records note queries regarding whether Aubrey remained the responsibility of another borough due to her previous accommodation history and pathway placement.

Records from accommodation staff and partner agencies suggest that Aubrey's presentation fluctuated significantly, with periods of engagement interspersed with absence from services and intoxication.

KPE2 — Escalating harm, safeguarding concerns and delays in statutory intervention (August – October 2024)

During the second half of 2024, there were increasing concerns regarding Aubrey's safety, physical vulnerability, exposure to harm and deteriorating wellbeing. Practitioners across housing, social care, police, health and substance misuse services documented repeated incidents involving assault, intoxication, exploitation concerns, missing episodes and self-neglect. In August 2024, a safeguarding referral was submitted following an incident in which Aubrey was reportedly struck over the head with a bottle by another resident, resulting in head injuries and attendance at Accident and Emergency services. Records indicate that concerns were raised regarding both physical safety and ongoing vulnerability within the hostel environment.

Agency records demonstrate that safeguarding concerns were repeatedly raised throughout this period in relation to exploitation, violence, and self-neglect. At the same time, practitioners were attempting to balance safeguarding responses with Aubrey's autonomy, fluctuating engagement with services and presentations in which she was assessed as having mental capacity. Records also indicate that the Care Act Assessment process was paused whilst ordinary residence enquiries continued. Alongside these concerns, practitioners documented

changes in Aubrey's presentation following the assault, including emerging memory difficulties and increasing vulnerability.

KPE3 — Increased engagement, trauma disclosure and opportunities for coordinated support (November 2024 – January 2025)

From late 2024 into early 2025, there was a period of relatively improved engagement with support services and greater professional involvement across a number of agencies, from Aubrey's perspective. During this period, Aubrey engaged more consistently with substance misuse services, probation appointments and psychological support. Practitioners described improvements in attendance, communication and relationship-building, alongside increased willingness to discuss aspects of her lived experience and support needs.

In October 2024, probation records noted that Aubrey disclosed experiences of sexual abuse in her past. This was disclosed during an assessment process that takes place for community orders. Substance misuse service records also indicate ongoing engagement regarding alcohol and drug use, treatment planning and discussions relating to recovery and stabilisation. During this period, practitioners documented Aubrey's increasing openness regarding trauma, exploitation and emotional wellbeing, alongside continuing concerns regarding substance dependency.

Records demonstrate that multi-agency meetings and discussions took place regarding accommodation, safeguarding concerns, treatment options and longer-term planning. Discussions also began regarding detoxification, psychological support and possible future move-on arrangements. Accommodation staff and partner agencies continued to provide regular practical and emotional support during this period, with records describing ongoing efforts to maintain engagement and stability. At the same time, agency records show that concerns regarding exploitation, alcohol use, self-neglect and fluctuating presentation remained present despite periods of improved engagement.

KPE4 — Re-escalation of risk, sexual violence concerns and emerging cognitive impairment (February – April 2025)

From February 2025 onwards, there was a renewed escalation in concerns relating to Aubrey's safety, wellbeing, cognitive presentation and vulnerability. Practitioners across accommodation, safeguarding, health and support services documented increasing intoxication, emotional distress, self-neglect and repeated safeguarding concerns during this period. In February 2025, a safeguarding concern was raised following Aubrey's disclosure that she had been raped by two men in the street. Records indicate that liaison took place with police and attempts were made to engage Aubrey regarding safeguarding and forensic processes. Practitioner discussion during the learning event also clarified that police investigation activity remained ongoing during this period; however, professionals reflected that sustaining engagement with investigative and safeguarding processes was complex within the context of Aubrey's fluctuating presentation, history of trauma, substance dependency and wider vulnerability. Documentation suggests that engagement with the investigation and support processes remained inconsistent during this period.

Alongside ongoing safeguarding concerns, practitioners increasingly documented concerns regarding Aubrey's memory, cognition and executive functioning following the earlier head injury and ongoing alcohol use. A neuropsychological assessment completed in March 2025 identified significant cognitive impairment relating particularly to memory and attentional functioning, alongside evidence consistent with alcohol-related brain damage and neurological deterioration. The assessment also noted the impact of longstanding trauma, chronic alcohol use and homelessness on Aubrey's overall functioning and wellbeing. The neuropsychological assessment recommended ongoing support around abstinence, nutrition, self-care and

structured support. It also highlighted Aubrey's strengths, including her ability to build meaningful relationships and her motivation to improve aspects of her life.

Throughout this period, records indicate continued multi-agency involvement regarding safeguarding concerns, accommodation, substance misuse, physical health and longer-term support planning.

KPE5 — Care Act Assessment, ongoing vulnerability and final period prior to Aubrey's death (May – June 2025)

During the final months of the review period, records show continuing concerns regarding Aubrey and overall wellbeing alongside increasing multi-agency involvement in support planning and assessment. In May 2025, a Care Act Assessment[4] was completed and a care package was subsequently introduced. Discussions were taking place regarding longer-term support needs, safeguarding vulnerability, cognitive impairment, detoxification and accommodation stability. The neuropsychological assessment completed earlier in 2025 had also recommended ongoing intervention and practitioners were continuing to consider how best to support Aubrey within the context of increasing complexity.

Agency records also continued to document repeated hospital presentations, intoxication, safeguarding concerns and concerns regarding exploitation and financial vulnerability. Records show that a substantial back payment of benefits was received during this period, following which practitioners documented concerns regarding the potential for financial exploitation by others. Support workers and practitioners continued to attempt engagement with Aubrey around health appointments, treatment options, practical support and safeguarding concerns. Records demonstrate ongoing efforts to maintain contact and provide support despite continuing fluctuations in engagement, periods of absence from accommodation and ongoing alcohol use.

Aubrey was found deceased in her room within supported accommodation on 28 June 2025. At the time of this review being produced, the cause of death remains subject to coronial process.

6. Commendations

There is consistent evidence throughout the review period that staff at supported housing demonstrated sustained commitment, persistence and compassion in their work with Aubrey. Hostel staff repeatedly attempted to engage services, advocate for Aubrey's needs, coordinate support and raise safeguarding concerns in response to escalating risks and incidents of harm. They supported Aubrey to attend appointments, access healthcare, engage with substance misuse services and report serious incidents to the police.

The review particularly highlighted the importance of relationship-based practice in supporting adults experiencing trauma, homelessness and multiple disadvantage. Aubrey appeared to engage most positively when trusting and consistent relationships were established with professionals, particularly hostel staff, her community substance misuse service keyworker and the hostel psychologist. During periods of relational consistency, Aubrey demonstrated improved engagement, increased openness regarding trauma and greater willingness to consider support and recovery options.

There was also evidence that professionals across services continued attempting to support Aubrey despite repeated setbacks, fluctuating engagement and significant system complexity. The persistence shown by frontline staff in maintaining contact, advocating for intervention and attempting to coordinate support should be recognised within the context of an extremely complex and high-risk case.

[4] Care Act 2014, s.9 Assessment of an adult's needs for care and support.

7. Analysis & Findings

This section explores the key themes, patterns and systemic issues identified through analysis of the chronology, agency material and practitioner learning event. It considers how organisational processes, safeguarding systems and professional practice shaped responses to Aubrey's escalating vulnerability over time, alongside examples of positive and committed practice across agencies.

7.1 Recognition of cumulative harm

Throughout the review period, agencies and practitioners consistently recognised and responded to individual safeguarding concerns relating to Aubrey's vulnerability, including incidents involving physical assault, sexual violence, exploitation, intoxication, self-neglect and repeated welfare concerns. Records demonstrate sustained efforts by frontline practitioners to respond to presenting risks, maintain engagement and seek support for Aubrey within the context of significant complexity. At the same time, the review raises questions regarding whether there may have been further opportunities for agencies to collectively recognise and formulate the cumulative nature of Aubrey's experiences over time.

The Care Act 2014[5] places emphasis on wellbeing, prevention, partnership working and proportionate safeguarding responses for adults experiencing abuse and neglect, including self-neglect. Care and Support Statutory Guidance further recognises that safeguarding concerns may emerge cumulatively over time, particularly where adults experience homelessness, trauma, exploitation, addiction and multiple disadvantage.[6] This is similarly reflected in the National Safeguarding Adults Review learning, where risks emerge gradually across numerous agencies and over extended periods of time.[7] Research relating to homelessness, self-neglect and multiple disadvantage has also highlighted the risk that adults can remain highly visible to services whilst simultaneously lacking coordinated safeguarding oversight and sustained multi-agency intervention.[8] Aubrey's presentation reflected many of these intersecting factors.

Despite repeated safeguarding concerns, it was not always clear from records whether the wider pattern of cumulative harm was consistently brought together into coordinated multi-agency safeguarding planning. Safeguarding concerns often appeared to be considered within the context of the presenting incident, safeguarding criteria and immediate risk at that particular point in time. Records also indicate that concerns were frequently concluded where Aubrey was assessed as having mental capacity, where engagement fluctuated, or where it was anticipated that needs would be addressed through other pathways, including Care Act[9] processes and ongoing support from partner agencies. This included repeated incidents involving violence, exploitation and significant safeguarding concern.

Practitioner discussions during the learning event reflected the challenges of maintaining collective oversight in cases involving chronic and overlapping vulnerability. Accommodation staff described observing the "interlinking risks" surrounding Aubrey's presentation on a daily basis, including trauma, substance dependency, exploitation, deteriorating cognition and repeated exposure to harm. There was also reflection around the realities of busy operational systems in which referrals may be managed episodically and where presentations involving homelessness, addiction and repeated crisis are commonly encountered across frontline practice.

[5] Care Act 2014, s.1 Wellbeing Principle.
[6] Department of Health and Social Care. (2024). *Care and Support Statutory Guidance*, Chapter 14: Safeguarding. London: DHSC.
[7] Preston-Shoot, M. (2020). *Analysis of Safeguarding Adults Reviews April 2017–March 2019*. London: Local Government Association.
[8] Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F., & Watkins, D. (2015). *Hard Edges: Mapping Severe and Multiple Disadvantage in England*. London: Lankelly Chase Foundation.
[9] Care Act 2014, s.42 Safeguarding Enquiries.

The review therefore raises broader questions regarding how safeguarding systems recognise and respond in these circumstances; in particular it identified the importance of professional curiosity, shared risk formulation and operational escalation pathways that enable agencies to collectively hold patterns of escalating harm, rather than primarily responding to incidents in isolation.

7.2 Fragmentation and case ownership

Throughout the review period, Aubrey was involved with a wide range of services spanning homelessness support, substance misuse treatment, safeguarding processes, probation, acute health services and Adult Social Care. Records demonstrate ongoing attempts by practitioners to share information, coordinate support and respond to safeguarding concerns as Aubrey's presentation became increasingly complex. The Care Act 2014 places emphasis on partnership working, wellbeing and cooperation between agencies in supporting adults with care and support needs.[10] Statutory guidance further highlights the importance of timely information-sharing and coordinated responses where adults experience abuse, neglect, self-neglect or escalating vulnerability across multiple agencies and systems.[11]

However, of particular significance is the further opportunities there were for agencies to develop a coordinated and shared understanding across organisational and geographical boundaries. This also involved different funding responsibilities, safeguarding pathways and service criteria, alongside the realities of fluctuating engagement and repeated crisis presentation. Aubrey moved between boroughs, services and emergency healthcare settings over an extended period, meaning that information relating to complex safeguarding and support needs was often held across multiple systems rather than consistently brought together into a shared formulation of risk and need.

Agency records indicate that uncertainty regarding ordinary residence and statutory responsibility contributed to delay within Care Act processes following referral for assessment in July 2024. Internal discussions took place regarding which local authority held responsibility for assessment and intervention due to Aubrey's previous homelessness pathway placement and accommodation history. During this period, practitioners across accommodation, safeguarding, substance misuse and health services continued to respond to repeated concerns relating to assault, exploitation, intoxication, missing episodes and deteriorating wellbeing.

However, practitioner discussions during the learning event reflected the challenges of maintaining oversight and continuity in cases where adults present repeatedly across multiple services and geographical areas. Discussions suggested that information-sharing frequently occurred in response to immediate operational issues, including accommodation, detoxification planning, safeguarding concerns and funding arrangements, while there were fewer opportunities for agencies to collectively step back and formulate the wider trajectory of escalating vulnerability.

National safeguarding learning has similarly identified the risks of fragmentation for adults experiencing severe and multiple disadvantage, particularly where needs span traditional organisational boundaries and no single agency holds ongoing oversight of the wider safeguarding picture.[12] Research relating to self-neglect and homelessness has also highlighted how adults engaged with numerous services may nonetheless experience discontinuity and reduced opportunities for coordinated long-term intervention where systems remain organised around individual episodes, criteria or service-specific responsibilities.[13]

[10] Care Act 2014, ss.1, 6 and 7.
[11] Department of Health and Social Care. (2024). *Care and Support Statutory Guidance*. Chapters 1 and 14. London: DHSC.
[12] Preston-Shoot, M. (2020). *Analysis of Safeguarding Adults Reviews April 2017–March 2019*. London: Local Government Association.
[13] Braye, S., Orr, D., & Preston-Shoot, M. (2015). *Learning lessons about self-neglect? An analysis of serious case reviews*. Journal of Adult Protection, 17(1), 3–18.

The review therefore raises questions regarding how safeguarding systems support shared ownership, continuity and coordinated oversight for adults experiencing overlapping homelessness, trauma, addiction, exploitation and deteriorating wellbeing across multiple agencies and boroughs. In particular, the review identified the importance of clear escalation pathways, coordinated Care Act intervention and operational structures that support agencies to maintain collective understanding.

7.3 Relationship-based practice and trauma informed care

The review identified many examples of compassionate, persistent and relationship-based practice throughout Aubrey's involvement with services. Records and practitioner discussions consistently highlighted the efforts made by frontline staff to maintain engagement, build trust and support Aubrey, whose history included significant adversity, trauma and instability across her life and exploitation across adulthood. During the review period, records indicate that she also experienced further assaults, sexual violence, intimidation and ongoing vulnerability within the community. Practitioners described how these experiences appeared to affect Aubrey's emotional wellbeing, sense of safety, trust in professionals and ability to engage consistently with support services over time. Aubrey's voice was clearly reflected throughout the practitioners' learning event, where professionals spoke warmly of her as a sociable, friendly, and engaging person. Staff consistently described how she would often come into the office to chat and spend time in conversation with them. She was viewed as personable and someone with whom it was possible to build a positive rapport. These reflections highlighted the importance of recognising Aubrey not simply through the lens of her care needs, but as an individual who valued relationships, social interaction, and meaningful connections with those around her.

The review identified that periods of more sustained engagement often appeared linked to the development of trusted professional relationships and flexible approaches to support. Records indicate that Aubrey engaged most positively where practitioners maintained persistence, continuity and regular contact over time, particularly within accommodation, psychology and substance misuse services. During these periods, Aubrey demonstrated greater openness regarding trauma, recovery, emotional wellbeing and future planning, including discussions relating to detoxification and longer-term support. The Care Act 2014 emphasises wellbeing, person-centred practice and partnership approaches when supporting adults with care and support needs.[14] Making Safeguarding Personal similarly highlights the importance of working collaboratively with adults in ways that recognise individual experience, strengths, wishes and relationships.[15] In Aubrey's case, practitioners were frequently attempting to balance safeguarding concerns and risk management alongside respect for autonomy, fluctuating engagement and the importance of maintaining trusted relationships.

Practitioner discussions during the learning event also reflected the challenges of sustaining relationship-based work within systems often organised around appointments, service pathways and episodic intervention. Professionals described the importance of persistence, flexibility and continuity, whilst also recognising the pressures created by staffing changes, operational demands and fragmented systems. The review identified that some periods of positive engagement and developing stability were difficult to sustain over time. Changes in staffing, delays relating to assessment and detoxification planning, and wider organisational complexities at times appeared to disrupt continuity of support and therapeutic momentum. This was particularly relevant in the context of Aubrey's fluctuating engagement, trauma history and increasing cognitive difficulties, where consistency and relational trust appeared especially important.

National safeguarding learning and trauma-informed research have increasingly highlighted the importance of relational and psychologically informed approaches when supporting adults

[14] Care Act 2014, s.1.

[15] Local Government Association & Association of Directors of Adult Social Services. (2014). *Making Safeguarding Personal Guide*. London: LGA/ADASS.

experiencing homelessness, multiple disadvantage, addiction and exploitation.[16] Such approaches recognise that engagement may fluctuate over time and that trust, consistency and emotional safety can be central to effective safeguarding and long-term intervention. The review therefore raises broader questions regarding how safeguarding systems create and sustain the conditions necessary for trauma-informed and relationship-based practice, particularly within services supporting adults experiencing multiple disadvantage and chronic vulnerability. Aubrey's case highlighted the importance of continuity, flexibility and coordinated multi-agency support in maintaining engagement and responding to escalating vulnerability over time.

7.4 Mental Capacity, Executive Functioning and non-engagement

Throughout the review period, professionals were frequently required to balance respect for Aubrey's autonomy and expressed wishes alongside escalating concerns regarding vulnerability, safety and engagement with support. Across the review period, mental capacity considerations were present within decision-making; however, it was not always clear how the cumulative impact of trauma, intoxication, cognitive impairment and fluctuating executive functioning was consistently understood within safeguarding responses and wider risk formulation.

Workshop discussion highlighted significant professional uncertainty regarding the interaction between Aubrey's intersecting needs and decision-making. Hostel staff described Aubrey's presentation as fluctuating considerably, at times appearing insightful and motivated, while at other times appearing highly intoxicated, disorganised, confused or unable to follow through on actions intended to promote her safety and wellbeing. Professionals also described difficulties understanding how Aubrey's memory problems, emotional instability and cognitive deterioration affected her ability to sustain engagement with services over time.

At the same time, professionals appropriately reflected the importance of respecting autonomy and avoiding overly paternalistic intervention. However, the review identified a risk that apparent capacitous refusal and non-engagement may at times have reduced professional curiosity regarding the wider context of vulnerability, coercion, executive dysfunction and cumulative harm. Safeguarding and mental capacity considerations were often approached separately, rather than as interacting dimensions of escalating risk. National safeguarding learning has increasingly recognised the challenges practitioners face when applying traditional concepts of capacity, choice and self-determination in cases involving self-neglect, trauma, addiction and executive functioning difficulties.[17]

The review highlighted the difficulty of assessing mental capacity where substance use, trauma, cognitive impairment and fluctuating executive functioning were present. Although Aubrey could often express her wishes and future intentions, professionals also described periods of intoxication, confusion and poor follow-through. This created uncertainty about not only her ability to understand and weigh information at a given moment, but also to turn decisions into action and sustain engagement with protective support over time. Executive functioning difficulties may affect a person's ability to plan, organise, start and maintain actions needed to stay safe, even when they can describe risks. Intoxication and alcohol-related cognitive impairment may also cause fluctuating capacity, requiring ongoing reassessment rather than reliance on isolated assessments.

The review also recognises the importance of autonomy and self-determination. Under the Mental Capacity Act 2005 and wider human rights frameworks, including Article 8 of the European Convention on Human Rights, adults may make decisions others see as unwise if they have mental capacity. Professionals appropriately sought to avoid overly paternalistic

[16] Kezelman, C., & Stavropoulos, P. (2012). *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*. Blue Knot Foundation.

[17] Braye, S., Orr, D., & Preston-Shoot, M. (2014). *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: SCIE.

responses. However, the review identified a risk that apparent capacitous refusal or repeated non-engagement may at times have limited professional curiosity about coercion, trauma, executive dysfunction, cumulative harm and deteriorating cognition. This underlines the need for trauma-informed, relational and professionally curious practice when working with adults experiencing multiple disadvantage and fluctuating presentations.

The review also highlighted the limitations of traditional appointment-based and compliance-led service models for adults experiencing similar needs to Aubrey, for example when it came to attending appointments with probation. Although she was often able to articulate wishes and future plans, there was repeated evidence that she struggled to maintain routines, sustain engagement and implement agreed safety strategies. The review highlighted the importance of shared professional understanding regarding executive functioning, relational engagement and non-engagement in adults experiencing multiple disadvantage.

Additionally, there were limitations in the extent to which assessment findings were integrated into a shared multi-agency formulation of Aubrey's needs and risks. Although important assessment work took place during the review period, including neuropsychological assessment identifying significant alcohol-related cognitive impairment and recommending more therapeutic support, there was limited evidence that these findings became fully embedded within coordinated safeguarding planning or wider intervention. Workshop discussion reflected that professionals often held different parts of Aubrey's presentation without these consistently being drawn together. Delays in finalising and sharing assessment outcomes further reduced opportunities for emerging cognitive concerns to inform earlier care planning, safeguarding escalation and multi-agency risk management.

7.5 Safeguarding escalation, operational frameworks and coordinated multi-agency intervention

Throughout the review period, practitioners across agencies repeatedly raised a range of safeguarding concerns to respond to presenting risks, maintain engagement and seek support for Aubrey within the context of repeated crisis presentation. Workshop discussion reflected the challenges practitioners experienced in navigating safeguarding criteria, mental capacity considerations, homelessness pathways, risk management frameworks and organisational responsibilities within complex cases involving multiple disadvantage.

Professionals described uncertainty regarding when concerns should progress into more formal multi-agency safeguarding processes and how cumulative vulnerability could best be held collectively across systems over time. National safeguarding learning has similarly identified the challenges agencies face in sustaining coordinated intervention for adults experiencing homelessness, trauma, addiction, self-neglect and exploitation, particularly where risks fluctuate, engagement varies and no single agency retains clear long-term oversight.[18]

The review therefore raises broader questions regarding how local safeguarding systems support practitioners to escalate, coordinate and sustain intervention in complex adult safeguarding cases involving cumulative harm and multiple disadvantage. Aubrey's case highlighted the importance of clear operational escalation pathways, reflective multi-agency discussion and shared operational ownership and reflective multi-agency decision-making.

Aubrey's circumstance may have been a more nuanced picture than simple non-engagement. While records indicate that she often declined formal safeguarding interventions and processes, practitioners consistently described her as someone who was able to build trusting relationships and disclose highly personal and traumatic experiences over time. This raises questions about whether safeguarding responses can at times become overly binary—acceptance or refusal of support—and whether greater emphasis should be placed on relationship-based practice, allowing practitioners the time and continuity needed to build trust

[18] Preston-Shoot, M. (2020). *Analysis of Safeguarding Adults Reviews April 2017–March 2019*. Local Government Association.

and develop protective plans alongside individuals experiencing chronic vulnerability and trauma.

8. Recommendations

8.1 Strengthening recognition and escalation of cumulative harm

In light of the review's findings regarding cumulative harm, episodic safeguarding responses and escalating vulnerability over time, the SAB should strengthen assurance processes to ensure repeated safeguarding concerns are recognised collectively rather than primarily managed as isolated incidents. This should include improving practitioner awareness and operational use of escalation pathways, complex risk management frameworks and coordinated multi-agency responses for adults experiencing homelessness, exploitation, substance misuse and multiple disadvantage.

Questions for the SAB:

- How does the SAB seek assurance that cumulative harm and repeated low-level safeguarding concerns are recognised and escalated collectively, rather than managed as isolated incidents?
- How does the SAB assure itself that practitioners understand available escalation frameworks (e.g. MARM/complex risk processes) where adults present with multiple disadvantage and repeated safeguarding concerns that may not individually meet s42 criteria?
- How does the SAB test whether safeguarding systems effectively support practitioners to hold and coordinate risk in cases involving homelessness, substance misuse and exploitation?

8.2 Improving cross-borough working, shared ownership and coordinated multi-agency planning

In light of the review's findings regarding fragmentation, cross-borough complexity and shared ownership of risk, the SAB and partner agencies should review cross-borough safeguarding arrangements to ensure effective information-sharing, timely Care Act intervention and coordinated responses for adults who move between local authority areas. Clearer protocols and understanding should support collective ownership of vulnerability and reduce delays associated with ordinary residence disputes and funding responsibilities. This should include improved multi-agency coordination, shared risk formulation and agreed professional oversight arrangements for adults experiencing multiple disadvantage whose needs span organisational and geographical boundaries.

- How does the SAB seek assurance that cross-borough safeguarding arrangements support effective information-sharing and cumulative risk recognition for adults who move between local authority areas?
- How does the SAB assure itself that ordinary residence disputes and funding processes do not delay safeguarding responses or Care Act intervention?
- How does the partnership support practitioners to build a shared understanding of vulnerability where adults have extensive histories across multiple systems and boroughs?

8.3 Embedding trauma-informed and relationship-based practice

Reflecting the review's findings regarding the importance of relational consistency, trust and sustained engagement, partner agencies should strengthen trauma-informed and

relationship-based approaches across frontline services working with adults experiencing multiple disadvantage. Systems should support continuity, flexibility and sustained relational engagement, recognising relationship-based practice as a key safeguarding intervention in complex cases involving trauma, homelessness and substance dependency.

- How does the SAB seek assurance that trauma-informed and relationship-based approaches are embedded across services working with adults experiencing multiple disadvantage?
- How does the partnership support continuity and coordination in complex cases where engagement is dependent upon sustained relational work?
- How does the SAB test whether multi-agency systems create sufficient space for flexible, persistent and relationship-based intervention in high-risk adult safeguarding cases?

8.4 Strengthening understanding of executive functioning, fluctuating capacity and integrated assessment

In light of the review's findings regarding executive functioning, fluctuating presentation and non-engagement, the SAB should support improved practitioner understanding of executive functioning, fluctuating mental capacity and the interaction between autonomy, trauma, cognitive impairment and safeguarding risk. Reflective practice should be promoted to support decision-making in cases where adults repeatedly decline or disengage from services. Assessments should be holistic, multi-agency informed and used to develop coordinated care planning that reflects the interaction between trauma, cognition, substance dependency, safeguarding vulnerability and mental health needs.

- How does the SAB seek assurance that practitioners understand and apply concepts of executive functioning and fluctuating capacity in complex safeguarding contexts?
- How does the partnership support reflective practice regarding autonomy, consent and vulnerability where adults experience trauma, substance misuse and cognitive impairment?
- How does the SAB assure itself that safeguarding responses remain responsive where adults repeatedly decline or disengage from support?

8.5 Improving pathways for adults experiencing multiple disadvantage

Reflecting the review's findings regarding multiple disadvantage, cumulative vulnerability and gaps in coordinated oversight, the SAB and partner agencies should review how local systems identify, coordinate and sustain support for adults experiencing multiple disadvantage who may not meet traditional criteria for ongoing statutory intervention but present with chronic and cumulative safeguarding vulnerability. This should include consideration of pathways for adults experiencing overlapping homelessness, trauma, addiction, exploitation, cognitive impairment and repeated non-engagement, particularly where no single agency holds clear responsibility for long-term coordination and oversight.

- How does the partnership identify and coordinate support for adults experiencing multiple disadvantage who may fall between traditional service criteria and organisational pathways?
- How does the SAB seek assurance that adults with overlapping needs relating to homelessness, trauma, addiction, cognition and exploitation receive coordinated multi-agency oversight?

- How are frontline services supported where they become the primary holders of relational and safeguarding responsibility in the absence of formal statutory frameworks?

9. Conclusion

Aubrey's case reflects the complexity of safeguarding adults experiencing homelessness, trauma, substance dependency, exploitation and multiple disadvantage within fragmented and pressured systems. The Review identified many examples of persistent and compassionate frontline practice alongside opportunities to strengthen coordinated safeguarding responses, cumulative risk recognition and multi-agency oversight. It is hoped that the learning identified within this Review will support continued reflection and service development across the partnership in responding to adults experiencing similar circumstances.

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