



Safeguarding Masterclasses Report 2025 – 2026

Learning from three sessions held by the London Network
of Nurses and Midwives Homelessness Group (LNNM)

19 November 2025 | 16 December 2025 | 5 March 2026



Executive Summary

This brief report consolidates the learning from three London Network of Nurses and Midwives (LNNM) Safeguarding Masterclasses held on **19 November 2025**, **16 December 2025**, and **5 March 2026**.

The sessions brought together practitioners, safeguarding leaders, academics, and voluntary sector organisations to examine complex safeguarding cases involving adults and children experiencing **multiple disadvantage**, including homelessness, substance dependence, neurodiversity, mental ill health, violence, exploitation, and systemic exclusion.

Across all three sessions, consistent evidence emerged that safeguarding failures are **predominantly systemic rather than individual**, driven by the misapplication of mental capacity law, organisational culture, fragmentation across agencies, and the under-use of existing legal powers. This report sets out the types of cases discussed, synthesises themes, and provides **recommendations explicitly mapped to statutory duties** under current English law.

Introduction

This report aims to:

- Provide a synthesis of learning arising from the three Masterclasses
- Consider how this report can be used to support **statutory compliance, professional assurance, and system improvement**
- Assist Safeguarding Adult Boards (SABs), Integrated Care Systems (ICSs), local authorities, and partner agencies to consider how to support better alignment of practice with legal duties
- Evidence the value of the LNNM Safeguarding Masterclasses and provide an argument for them to continue

Safeguarding Masterclasses

The LNNM Safeguarding Masterclasses commenced in 2023 as a logical extension of the LNNM's prior work in this area. LNNM members expressed a desire to be able to get expert advice and guidance on live cases at two conferences.

The following reports and guidance informed the development of the Safeguarding Masterclasses.



[Making Sense of Self Neglect – 2022 Conference report](#)



[Identifying and Working with Self Neglect in People experiencing Homelessness – 2023 guidance](#)



[Organisational neglect – Where is the Line – 2023 Conference report](#)



[Report on LNNM's first, successful, Safeguarding Masterclasses \(2023/2024\)](#)

The success of the initial three sessions led to continued funding.

The sessions are chaired by **Samantha Dorney-Smith, LNNM Trustee and Queen's Nurse**. Expert safeguarding and legal advice and guidance is provided by **Professor Michael Preston Shoot, Independent Safeguarding Adult Board Chair and Safeguarding Adult Review (SAR) Reviewer** and **Mike Ward, Independent Consultant, Alcohol Change UK, Blue Light Project**.

The sessions are held online for 1.5 hours. Participation is open to all, and participants are asked to bring cases for discussion. Sessions start with recent and relevant updates.

All sessions are recorded, summarised and analysed in order to be able to report high level themes.

Although the sessions were set up primarily to support practitioners working with single homelessness people experiencing homelessness with multiple complex needs e.g. addiction, mental health and behavioural challenges, cases involving more statutory homelessness and families are discussed. Homelessness is the main underpinning criteria for case inclusion.

Demographics of participants in these sessions

19 November 2025: 19 + 3 facilitators

16 December 2025: 24 + 3 facilitators

5 March 2026: 23 + 3 facilitators

Practitioners were primarily a mix of front-line workers from Voluntary, Community, or Social Enterprise organisations and Clinical Nurse Specialists from both inclusion health and safeguarding backgrounds.

63% of attendees were from the Greater London area, with external attendees coming from Brighton, Hastings, Oxford, Leeds and Manchester.

Relevant legislation

This report references the following relevant legislation throughout in order to provide context:

- Adult safeguarding (Care Act 2014)
- Children's safeguarding (Children Act 1989)
- Mental capacity and best interests (Mental Capacity Act 2005)
- Housing duties (Housing Act 1996; Homelessness Reduction Act 2017)
- Use of inherent jurisdiction and multi-agency risk management

Summary of Key Cases discussed across the 3 sessions



The 'Joe' Safeguarding Adult Review (Adult Self-Neglect)

A SAR of a man with severe alcohol dependence and extreme self-neglect was outlined. He was repeatedly assessed as having mental capacity, and allowed to discharge himself from hospital, despite overwhelming evidence of an inability to care for himself. He died shortly after a discharge. Cambridgeshire and Peterborough Safeguarding Adult Board Safeguarding Adult Review Joe

Statutory relevance:

- Care Act 2014, s42 (self-neglect)
- Mental Capacity Act 2005 (decision-specific, executive capacity)



Hostels as High-Risk Safeguarding Environments

Several cases showed hostels functioning as environments of concentrated harm rather than protection, with staff feeling anxious about the safety of residents placed within them.

Statutory relevance:

- Care Act 2014 (environmental neglect)
- SAB duty to assure system safety (s43)



Coercive Control, Exploitation and Inherent Jurisdiction

In several cases adults experiencing coercive control and exploitation were deemed to have mental capacity, leading to safeguarding services 'withdrawal' or non-engagement.

The possible relevance of inherent jurisdiction was discussed in these cases. Inherent jurisdiction can be applied to adults who do not lack mental capacity, but who are considered, legally, to be 'vulnerable' because of some sort of abuse, neglect, undue influence, or coercion.

Statutory relevance:

- Care Act 2014 (abuse and neglect)
- High Court inherent jurisdiction (coercion regardless of capacity)



Recurrent Hospital Discharge Cases

Multiple cases brought to the sessions also showed individuals as being assessed to have mental capacity to make decisions and to be self-caring within hospital clinical settings, but to be unable to sustain self-care and personal safety following discharge.

Statutory relevance:

- Care Act 2014 (environmental neglect)
- SAB duty to assure system safety (s43)



Pregnant Women Experiencing Multiple Disadvantage

Two cases that were discussed involved pregnant women and exposed tensions between the desire to promote autonomy, and issues identifying coercion, violence, as well as high thresholds for safeguarding intervention.

Statutory relevance:

- Care Act 2014 (adult at risk)
- Children Act 1989, s17 and s47 (unborn children; anticipated neglect)



Child Delayed in Hospital Due to Housing Failure

In one case a child remained in hospital for a prolonged period due to unresolved housing disputes and professional reluctance to escalate.

Statutory relevance:

- Children Act 1989 (significant harm; neglect)
- Homelessness Reduction Act 2017 (duty to refer)

Thematic Analysis

The transcripts of all 3 sessions were analysed to establish overarching themes. Five key themes emerged:

1 Misapplication of the Mental Capacity Act

Mental capacity act assessments were repeatedly used as a **gatekeeping mechanism** to close safeguarding responses, contrary to statute and case law. Lack of capacity is not a criterion for mounting safeguarding response under the Care Act.

2 Lack of system knowledge regarding Executive Dysfunction, Compulsion and Coercion

Participants identified many systemic failures where there had been a failure to recognise that whilst individuals may sometimes be able to express choices, they often lack the ability to **implement or sustain** them, particularly in the context of addiction, trauma, and exploitation. They can ‘talk the talk, but not walk the walk’.

3 Fragmentation and Failure to Escalate

Across the cases there was repeated failure to convene multi-agency risk management meetings contemporaneously, or sometimes even at all, resulting in unowned and unmanaged risk.

4 Marginalisation of Housing as a Safeguarding Factor

Unsafe hostel accommodation was routinely provided under the guise of being protective, despite evidence of harm.

5 Safeguarding ‘Drift’ and Moral Distress

Professionals across sectors experienced moral distress where foreseeable harm was not met with lawful intervention, reflecting organisational risk aversion rather than legal constraint.

These themes mirror a range of other evidence, for example some of the findings in a systematic review of qualitative data on practitioners experiences of the Mental Capacity Act, and many of the findings of the recent NIHR funded Use of the Mental Capacity Act 2005 with people experiencing multiple exclusion homelessness in England. Our report adds additional evidence in a local context based on specific ‘live’ situations. As such these findings have both a local and national significance.

Resulting recommendations

from thematic analysis mapped to Statutory Duties

Post analysis, the issues and concerns raised in the 3 sessions have resulted in the following potential set of wider recommendations:

Practice-level recommendations

Recommendation	Statutory duty supported
Mental capacity assessments should not be used as a threshold to refuse safeguarding.	Care Act 2014 s42
Practitioners need to be reminded that mental capacity assessments need to be decision-specific, and should consider executive functioning issues in complex cases where assessments are needed repeatedly.	MCA 2005 ss1-3
Self-neglect and environmental risk should be seen as safeguarding concerns.	Care Act 2014 s42
Coercion undermines autonomy and could be considered for inherent jurisdiction if other processes are not working.	High Court inherent jurisdiction
Multi-agency risk meetings should be triggered early.	Care Act 2014 s6 cooperation

Organisational and System Recommendations

Recommendation	Statutory duty supported
Invest in further legal literacy training across all relevant partner agencies.	Care Act 2014 s43 SAB assurance
Establish clear escalation pathways within each borough, including to Safeguarding Adult Board Chairs.	Care Act 2014 s43

Recommendation	Statutory duty supported
Scrutinise and report on repeated safeguarding referral refusals in local areas.	Care Act 2014 s44 (SAR function)
Clarify the limits of supported accommodation in addressing safeguarding concerns – limits on local options for meeting common safeguarding needs should be reviewed.	Care Act 2014; Housing Act 1996

Policy and Strategic Recommendations

Recommendation	Statutory duty supported
Develop guidance on addiction and compulsion in safeguarding.	MCA Code of Practice
Embed the need for appropriate and safe housing within safeguarding governance.	Care Act 2014; HRA 2017
Strengthen accountability for unlawful thresholding.	Public law duties; SAB scrutiny

Implications for Safeguarding Boards and Senior Leaders

Safeguarding Adult Boards and Children’s Safeguarding Partnerships have a statutory responsibility not only to review deaths, but to **identify and challenge unsafe system patterns in real time**. The findings of these Masterclasses indicate repeated lawful opportunities for intervention that were not used.

Failure to address these issues risks continued unlawful practice, preventable deaths, and future adverse findings through Safeguarding Adult Reviews, coronial proceedings, and judicial scrutiny. This report suggests actions that could be taken to improve practice.

Conclusion

This report points to the fact that safeguarding law provides **adequate authority and flexibility** to respond to extreme vulnerability, but that some of the principal barriers lie in interpretation, confidence, and system culture rather than statute.

Safeguarding needs to be reaffirmed as a **whole-system legal and ethical duty**, requiring curiosity, escalation, and shared accountability.

Where harm is foreseeable, non-intervention is not neutrality — it is a decision with legal and moral consequences.

Possible next steps

- LNNM to promote the recommendations from this and the prior safeguarding session report to key partners.
- As the related NIHR funded KCL study Use of the Mental Capacity Act 2005 with people experiencing multiple exclusion homelessness in England is about to release practice guidance (and Samantha Dorney-Smith has also contributed to as a steering committee member to the programme), this guidance should be used within future case review sessions – and these sessions would help to evaluate the use of the guidance and disseminate it.

Recommendations regarding future sessions

Further safeguarding Masterclasses should be funded. In an ideal world there would be funding for more than 3 per year and/or longer sessions (2 hours, rather than 1.5 hours).

With a small amount of further additional funding, it would also be possible to follow up on people that have attended the Masterclasses to see what a difference the advice has made. There is also an opportunity for research to be undertaken on these sessions.

In this set of sessions many more people registered than attended. To enable more people to attend, a diary entry would ideally to be sent into people's diaries that register for the workshops. The Chair could also email attendees one week in advance as a reminder. This happened in the prior set of events, but not this set – and this probably accounts for the lower attendance at these sessions than the prior set.

To promote higher attendance, we could advertise attendance to the distribution list of an extremely well attended set of monthly 1 hour homelessness and safeguarding teaching webinars: <https://www.kcl.ac.uk/events/series/homelessness-series>. These webinars attract about 100 people to each session, but they are experts speaking rather than case reviews. Similarly, the Homelessness and Palliative Care Network have a monthly 1-hour teaching webinar online which attracts about 50 people to each session, and these attendees could also be invited. This would undoubtedly increase the numbers considerably, although many would not be from London.

However, conversely there is a balance to be struck in these case reviews between numbers attending, and the number of people that are realistically able to engage. 20-30 people enables most people to be able to contribute if they wish to. 100 would make it much harder, and the sessions would probably need to be run more formally.

What participants told us

Feedback from attendees across the 3 sessions

““ —

“Really useful to know about Section 42. Thank you”

““ —

“Thank you all and thank you for sharing cases everyone! Everyone is doing great work”

““ —

“All the sessions have been really helpful, thank you. Validating the complexity and importance of continued assessment and advocacy! Also really helpful knowing the specific case law to evidence certain areas”

““ —

“Thank you! So helpful to hear from everyone!”

““ —

“Thanks ever so you are all wonderful!”

““ —

“I’ve found these all really informative and helpful I hope they are able to continue!!”

Further safeguarding sessions

The LNNM Safeguarding Masterclasses will return in October 2026, with a further session planned for March 2027. Please visit the [LNNM website](https://homeleshealthnetwork.net) to subscribe to our newsletter for regular updates on our events.

London Network of Nurses and Midwives Homelessness Group (LNNM)

Registered Charity No: 1183853

Registered office: c/o Pathway Offices, 4th Floor East, 250 Euston Road, London NW1 2PG

Website: <https://homeleshealthnetwork.net>

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