Safeguarding Case Session

Notes from an online Safeguarding Case Session held by the London Network of Nurses and Midwives Homelessness Group (LNNM)

12 October 2026

Welcome and context

The session opened with an overview of the safeguarding masterclass programme. Six previous masterclasses had been delivered, exploring complex safeguarding situations involving people experiencing multiple disadvantage. The work has consistently highlighted systemic rather than individual practitioner failures.

The report from the second series of masterclasses, covering sessions in November 2025, December 2025 and March 2026, was being published on the day of the meeting. Key themes from that work included:

- inappropriate use or interpretation of the Mental Capacity Act;
- insufficient recognition of executive dysfunction, addiction/compulsion and coercion;
- fragmentation between multidisciplinary partners and difficulties escalating concerns;
- inappropriate housing and environmental circumstances not being sufficiently recognised as safeguarding risks;
- risks surrounding hospital discharge; and
- moral distress experienced by staff working with people facing significant and persistent risks.

The continuation of the masterclass programme was confirmed following positive feedback from participants.

Expert guests

Professor Michael Preston-Shoot is Emeritus Professor of Social Work at The University of Bedford. He also serves as an Independent Chair for Greenwich, Somerset and Lewisham Safeguarding Adult Boards, is Joint Co-ordinator at the National SAB Chair's Network and an Independent Adult Safeguarding Consultant.
Michael is a qualified social worker with huge experience of child and adult protection, mental health and family therapy practice. He has an international reputation for research and publications in the fields of law and ethics in social work education and practice, working with families, and people experiencing homelessness. Michael recently completed research for the Department of Health on adult safeguarding and has undertaken detailed reviews of multiple homelessness SARS. He is also co-editor of Adult Safeguarding and Homelessness, a one stop resource which highlights evidence-informed practice for those working with individuals experiencing multiple exclusion homelessness and adult safeguarding.

Mike Ward has worked in the alcohol field for over 30 years as a provider, service manager and commissioner. He is a senior consultant and trainer at Alcohol Change UK providing guidance and expertise across the alcohol treatment spectrum. Together with Mark Holmes, Mike developed the Blue Light Project, Alcohol Change UK's ground breaking initiative to develop alternative approaches and care pathways to improve the response to change resistant, dependent drinkers. The project shows that there are positive strategies that can be used with this client group to help turn their lives around.

Update from Professor Michael Preston-Shoot

Section 42 safeguarding: criteria rather than thresholds

An important clarification was made concerning Section 42(1) of the Care Act. The three elements within Section 42(1) were described as criteria, not thresholds:

1. Does the person have care and support needs?
2. Are they experiencing, or at risk of, abuse or neglect, including self-neglect?
3. Because of their care and support needs, are they unable to protect themselves from that abuse or neglect?

Participants were encouraged to challenge language suggesting that somebody "does not meet the safeguarding threshold".

It was also emphasised during the discussion that mental capacity is not one of the Section 42(1) criteria and that capacity should therefore not be used as a reason in itself for rejecting an adult safeguarding referral.

Role of Safeguarding Adults Boards

Discussion considered the balance between the assurance function of local Safeguarding Adults Boards (SABs) and their responsibility to ensure that learning from Safeguarding Adult Reviews translates into changed practice and system improvement.

The meeting heard that assurance is legitimately part of SAB activity, but should be balanced against learning, improvement and demonstrating outcomes from recommendations arising from Safeguarding Adult Reviews.

National Adult Safeguarding Developments

Participants received an update on the newly established National Adult Safeguarding Board and three developing national workstreams:

Care Act statutory guidance

A review of Care Act statutory guidance, particularly Chapter 14 on safeguarding, was reported as commencing in October 2026 and expected to conclude in spring 2027. Homelessness and its interface with safeguarding was identified as an area requiring attention.

Accountability

Work was underway to assess how SABs demonstrate that they make a difference, including consideration of outcomes from Safeguarding Adult Reviews. SAB annual reports for 2025/26 were being requested for national analysis, with an analytical report anticipated in spring 2027.

Consideration was also being given to whether the National Adult Safeguarding Board should ultimately have a statutory footing.

Legislative review

A further workstream would examine possible changes to legislation, including: strengthening prevention;

- possible adult safeguarding powers of entry;
- consideration of protection orders;
- transitional safeguarding; and
- whether elements of the Care Act require revision.

This was described as a significant opportunity for practitioners and organisations to influence the future adult safeguarding framework in England.

Update from Mike Ward

Engagement and “non-engagement”

A substantial discussion focused on people routinely being described as “not engaging” with services. Work is underway on four-nations guidance designed to put engagement at the centre of practice. Participants heard that Safeguarding Adult Reviews frequently identify difficulties around engagement, but that describing someone as “not engaging” can become an endpoint that leads services to withdraw.

The emerging guidance is intended to address:

- definitions and language;
- lived-experience perspectives;
- trauma-informed approaches;
- governance;
- identifying barriers to engagement;
- deciding when a more intensive response is required;
- multi-agency management and escalation;
- relevant legal frameworks;
- safe cessation of involvement; and
- organisational learning.

Key learning

Participants strongly supported reframing the question from:

“Why won't this person engage?” towards consideration of “What is preventing services from successfully engaging with this individual?”

Examples were shared where individuals were labelled as non-engaging despite maintaining substantial contact with other professionals or organisations. This reinforced the importance of multi-agency working and identifying **which practitioner or service has established the strongest relationship with the individual.**

Communication skills were seen as central. Participants emphasised that services should adapt approaches to the individual rather than repeatedly use unsuccessful methods of engagement. The discussion highlighted the value of relationship-building, psychosocial interventions and practical opportunities for staff to develop communication skills.

Case discussion: housing, support and escalating risk

A case discussion highlighted concerns about people with high and complex needs being placed in private accommodation offering relatively low levels of support.

Concerns included:

- accommodation providers accepting people whose support requirements exceeded their capacity;
- difficulties obtaining sufficiently rapid mental health responses when somebody deteriorated;
- eviction during periods of acute illness;
- people returning to street homelessness;
- fragmented housing pathways; and
- housing/environmental risk not being sufficiently integrated into safeguarding responses.

Discussion and learning

It was recommended that systemic concerns of this nature should be brought to the relevant Safeguarding Adults Board, rather than being treated solely as individual adult social care or safeguarding cases.

The meeting also discussed the need for a strategic framework around accommodation for people with complex needs rather than simply responding case by case.

There was discussion about whether describing these circumstances as “organisational neglect” was necessarily the most productive starting point. An alternative approach was to identify the underlying multi-level, multi-agency system problem and use SAB governance arrangements to address it.

Lack of suitable accommodation for people with complex needs

Participants described circumstances where an individual's needs could be clearly identified but **no suitable service or placement appeared capable of meeting them.**

One approach discussed was the use of senior-level complex case panels bringing together services and budgets to co-create bespoke responses where existing provision is insufficient.

The importance of raising unmet need before a death or serious incident results in a Safeguarding Adult Review was strongly emphasised.

The group also discussed the need to think about accommodation as **a system rather than a single placement**. Such a system would recognise that people experiencing multiple disadvantage may move backwards as well as forwards and therefore require flexible levels of support rather than repeated exclusion when a placement breaks down.

Behaviour, distress and staff support

Discussion considered how accommodation services respond to behaviour described as aggressive, antisocial or challenging.

The meeting emphasised the importance of understanding behaviour as communication and considering the circumstances behind it. Participants also highlighted the need for staff working in accommodation settings to receive appropriate support and training so that eviction does not automatically become the response to difficult incidents.



Case discussion: alcohol dependence, cognitive impairment and self-neglect

An anonymised case concerned an adult experiencing severe alcohol dependence, suspected cognitive impairment/alcohol-related brain injury and significant self-neglect. Previous safeguarding referrals had been closed and concerns were raised over attempts to assess capacity while the individual was intoxicated and the description of their situation as “lifestyle choice”.

Assessments undertaken with language support had raised concerns about the individual's ability to understand and weigh risks associated with continued alcohol use.

Discussion and learning

Court of Protection

The meeting discussed whether the NHS organisation currently holding the risk should urgently consider an application to the **Court of Protection** where:

- there is evidence suggesting lack of capacity;
- risks are substantial;
- effective assessment cannot otherwise be completed; and
- alternative methods of mitigating the risks have been exhausted.

It was noted that such an application does not necessarily require the agreement of somebody specifically holding a safeguarding role. Where professional disagreement exists, escalation through appropriate resolution-of-professional-differences arrangements was discussed.

The discussion also recognised the value, where appropriate, of making one further clearly documented attempt at an intervention or care plan before legal intervention, particularly where legal advice supports this approach.

Mental Health Act and severe cognitive impairment

The meeting considered whether the Mental Health Act may sometimes be relevant where acquired brain injury or significant cognitive impairment amounts to a mental disorder and there is substantial risk.

Participants acknowledged that this route appeared rarely to be explored for this population. Where compulsory legal intervention is not appropriate or available, assertive outreach, robust multi-agency working and intensive community support were discussed as alternative approaches to managing risk.

Case discussion: mental health, co-occurring conditions and criminalisation

A further case discussion concerned individuals with histories of homelessness, substance use and serious mental health difficulties whose mental health involvement had subsequently ended.

Discussion and learning

Participants expressed concern about circumstances in which behaviour associated with multiple disadvantage and mental health problems may increasingly be responded to through criminal justice mechanisms rather than health and care systems.

For the WS example, participants identified:

- the existing co-occurring conditions protocol/escalation arrangements;
- a co-occurring conditions nursing resource;
- opportunities to escalate concerns through relevant local leadership; and
- the possibility of bringing the person's story to the **WS Safeguarding Adults Board** before a serious incident occurs.

Criminalisation of people experiencing combinations of mental ill-health, addiction and multiple disadvantage was identified as a potential topic for a future masterclass.

Case discussion: multiple capacity and best-interest decisions

The final case concerned an individual with significant alcohol-related brain damage where professionals had concluded that capacity was substantially impaired across a number of areas.

Discussion and learning

Despite weekly multidisciplinary meetings, participants described difficulties translating recognition of incapacity into practical **decision-specific best-interest processes.**

The discussion highlighted a common challenge: complex cases may require numerous separate decisions, while responsibility for initiating or coordinating each best-interest decision can remain unclear across the multidisciplinary team.

Actions and follow up

Action	Lead/Route
Use learning from the masterclasses and associated reports to influence local and national safeguarding discussions.	Masterclass network
Consider correcting future reporting language from Section 42 “thresholds” to criteria.	Masterclass/report leads
Encourage contributions to the national safeguarding statutory guidance review, particularly concerning homelessness, mental health and substance use.	Participants / organisations
Continue development and dissemination of national engagement guidance.	Guidance task-and-finish group
Escalate systemic housing/support concerns through relevant SAB governance arrangements.	Relevant local partnerships
Consider senior complex-case arrangements where existing services cannot meet an individual's needs.	Local multi-agency systems
Explore a future masterclass focus on the potential criminalisation of behaviour associated with mental ill-health, addiction and multiple disadvantage.	Masterclass leads
Share emerging engagement guidance with the group when available.	Masterclass leads
Continue to bring complex anonymised cases to future sessions for shared learning.	Participants
Complete the four-nations guidance on engaging people with complex needs and notify this group when it becomes available, expected around January.	Mike Ward
Take the Luton housing and safeguarding issue involving high-risk tenants, inadequate support, and evictions to the Luton Safeguarding Adults Board.	GA

Session Feedback

From the meeting chat

> Thank you for this. I'm coming up to retirement - yet it seems I need to get my activist placards back out the attic lol. Feel so much for front line staff.

> It's been very useful to hear current issues. Thank you

> Thankyou for that really good information. I will be discussing this with my manager.