Swindon Safeguarding Partnership

SAR Ariadne

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1 Introduction

A Safeguarding Adults Review (SAR) is a multi-agency review process that seeks to determine what agencies could have done differently that could have prevented harm or death.

Safeguarding Adults Board (SAB) has a statutory duty to arrange a SAR when:
a) An adult with care and support needs has died, and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect, and
b) when there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

Board members must cooperate with and contribute to the SAR to identify lessons learnt and ensure that learning is shared and applied in the future.

1.1 The Care Act 2014: Section 44

The three statutory partners determined that a SAR using the Rapid Time methodology would aid in gaining the key learning from this SAR in a timely way, so that the learning can be identified and embedded in practice with minimal delay. The review will also be mindful of the recommendations and findings from previous and ongoing SARs.

Where the review identifies repeated learning that does not appear to be embedded in practice, the reviewer will be mindful of what the Safeguarding Partnership can do differently to support this change in systems and practice.

This mandatory Safeguarding Adults Review is commissioned with due regard to the Care Act 2014 in response to the harm experienced by Ariadne, with a focus on alcohol and drug dependency, exploitation, domestic abuse, physical health needs and self-neglect.

2 Purpose and Aim of the Safeguarding Adults Review

The objective of a SAR is to encourage effective learning and improvement to prevent recurrence of similar issues in the future.

2.1 Scope of the Review

The SAR panel agreed that the review should focus on Ariadne's life between 2024 – 2026. Relevant events prior to this have been considered.

2.2 Key Chronology

Ariadne's circumstances show a repeated pattern of escalating risk, crisis response, referral, partial engagement, closure or drift, followed by further crisis.

The chronology identified key points at which multi-agency review, escalation, welfare and safety planning, or strengthened safeguarding oversight could have been considered.

It has been intentionally omitted from this report; however, it has informed the learning and recommendations.

The key issue was not a lack of professional contact or concern, but the failure to convert repeated concerns into sustained, coordinated, multi-agency risk management. Opportunities to convene an MDT, complete a Welfare and Safety Plan, formally assess capacity, consider coercion and control, and maintain oversight of cumulative risk were either missed or not followed through.

3 Ariadne's lived experience

Little is known about what life was like for Ariadne as a child; however, it is known that when she was an adolescent, she attempted suicide. This was the first of many instances of self-poisoning and drug overdoses. At the time of her death, Ariadne had lived with mental health needs, trauma, physical pain, deteriorating physical health, drug dependency, mobility difficulties, and domestic abuse, both as a victim and a source of harm, for decades.

She had contact with many agencies, including the criminal justice system but repeated professional involvement did not result in a trauma-informed approach, underpinned by coordinated engagement and a multi-disciplinary plan.

She had several periods in hospital, and during some of these she said she was much calmer and had a good laugh with nurses on the ward.

She also talked about feeling overwhelmed, scared, anxious that she was being watched and wanting to make changes.

Practitioners described her as polite and caring.

4 Scope and methodology

This SAR was completed using a Rapid Time methodology.

4.1 Key lines of enquiry

1. Why were resources, such as the Welfare and Safety Plan not utilised, what were barriers to implementation?
2. What lessons were learnt from SAR Sally and what impact and progression has taken place in practice since publication?
3. How was the consideration of coercion and control and the possible impact of this on Ariadne understood in practice?
4. Were there any missed opportunities or were basic expectations met around collaborative working?
5. 'What would good look like' when working with those experiencing multiple disadvantage, including expectations on the partnership around shared risk and defensible decision making?

4.2 Previous SARs completed in Swindon to be considered

- Sally September 2024
- Kathy July 2026

4.3 Evidence and information sources

The SAR is based on triangulated evidence from the following primary sources.

- Multi-agency chronology
- Practitioner focus group
- Manager focus group
- Drugs and Alcohol Related Deaths Review (DARD)

4.4 Glossary

ASC	Adult Social Care
The Charity	Charity supporting those experiencing multiple unmet needs
CMHS	Commissioned Mental Health Services
GP	General Medical Practitioner
KLOE	Key Line of Enquiry
MARAC	Multi-agency Risk Management Conference (to address high risk domestic abuse)
MDT	Multi-disciplinary Team
PPN	Public Protection Notification (sent by police regarding safeguarding concerns)
SAR	Safeguarding Adults Review
SSP	Swindon Safeguarding Partnership
DARD	Drugs and Alcohol Related Deaths Review

5 KLOE 1. Why were resources, such as the Welfare and Safety Plan not utilised, what were barriers to implementation?

5.1 Overarching issue

The Welfare and Safety Plan was not used because risk was not held as a shared multi-agency responsibility.

5.1.1 What the evidence shows

Multiple agencies identified risks relating to self-neglect, drug dependency, deteriorating wounds, domestic abuse, non-engagement and possible exploitation, but there was no sustained MDT or shared risk management plan.

The absence of an MDT aligns with the findings of the Self-Neglect Audit Report 2025-26, which found that MDTs remain inconsistently used and, where in place, are convened late, with variable attendance, inconsistent recording, and silo working.

5.1.2 Why this mattered

Without a shared plan, agencies responded episodically and no single professional or agency maintained oversight of cumulative risk.

5.1.3 Learning

Welfare and Safety Plans should be used as a mechanism for shared risk ownership, escalation and contingency planning, even where the adult does not fully engage.

5.2 Risk became normalised

Ariadne was known to services and had lived with chronic risk for a long time; to some degree, professionals became used to her pattern of disengagement. Repeated crises, missed appointments, substance use, domestic violence and abuse, poor mental

health and criminal justice involvement became Ariadne's usual baseline rather than being viewed as cumulative risk factors and escalating safeguarding indicators. Importantly, her escalating physical health concerns, which were linked to her leg wounds and leg ulcers, were related to her drug dependency and this contributed to a professional view of Ariadne as non-compliant.

Cumulative risk was underestimated because no single incident felt new.

5.3 Framing of lifestyle choices

There is evidence that Ariadne's circumstances were, at times, framed through a lens of lifestyle choice. Ariadne's drug dependency and repeated disengagement led professionals to frame her needs as personal choice rather than recognising:

- addiction
- trauma
- coercion or exploitation
- mental ill-health
- domestic abuse
- impaired executive functioning
- fluctuating capacity
- fear of services

This resulted in less protective action than would have been provided if she had been perceived as more vulnerable or more compliant.

5.4 Professional fatigue and pessimism

Where someone has been known for many years, agencies may feel that:

- "nothing works"
- "they won't engage"
- "they will go back to the same situation"
- "there is no point making another plan"

This can produce practice fatigue. The person becomes a revolving-door case, rather than someone whose repeated presentations evidence unresolved need and risk. Professional fatigue, pessimism, and low expectations for Ariadne contributed to the professional response and the absence of a Welfare and Safety Plan.

5.5 Disengagement was misunderstood

Adults experiencing multiple disadvantage often do not engage in conventional ways. They may miss appointments, avoid professionals, decline formal support or prioritise immediate survival needs. Disengagement was consistently framed as non-engagement and interpreted as informed refusal; familiarity with Ariadne lowered professional curiosity and raised thresholds.

Engagement was not explored through a person-centred, trauma-informed lens, which would have contextualised Ariadne's disengagement, for example:

- mistrust of authority
- shame

- fear of consequences
- coercive control
- cognitive impairment
- substance dependency
- previous poor experiences with services

Framing it as disengagement rather than non-engagement might also have helped professionals develop a structured communication and engagement plan that considered when Ariadne did engage and when she or her partner reached out for help.

5.6 Criminal justice and perpetrator history obscured vulnerability

Ariadne had previously come to the attention of services as a perpetrator of domestic abuse and had previous involvement with the criminal justice system; professionals may have unconsciously viewed her primarily through a risk-to-others or offending lens. This obscured her own victimisation, trauma, exploitation, mental health needs and safeguarding risks.

Ariadne's and her partners' history in part contributed to assumptions that they were "able to cope," when in fact their history indicated significant adversity and trauma; Ariadne's partners needs as a carer were not considered or assessed.

There were multiple indicators that she needed help. For example, police officers observed her struggling to meet Ariadne's basic needs. Ariadne's partner also told officers that she was anxious, stressed and overwhelmed. They completed a PPN but this did not result in consideration of need for either Ariadne or her partner.

Professional record identify Ariadne's partner as her carer, but consideration was not given to a Carer's Assessment

5.7 Procedures were seen as not applicable

Swindon has specific resources that are relevant to Ariadne's circumstances, including multi-agency meeting guidance for working with adults, self-neglect guidance, adult safeguarding and domestic abuse guidance, the Safeguarding Adults Team Decision Support Tool, suicide prevention guidance, and the Adult and Children Resolution Policy/Escalation Process[1]. These resources provide the context and tools for professionals to consider complex adult risk through structured, multi-agency processes.

Professionals did not use tools such as the Welfare and Safety Plan because the perceptions of Ariadne and her circumstances were that:

- she did not meet safeguarding thresholds
- she had capacity and understood what she needed to do in relation to wound care
- her partner was providing wound care
- wider issues were less relevant than wound management.

[1] SSP policies and guidance for working with adults

Professionals believed that a Welfare and Safety Plan required Ariadne's full engagement or consent. In practice, even if Ariadne did not fully participate, agencies could still have developed a multi-agency risk management plan that set out:

- known risks
- warning signs
- agency responsibilities
- outreach attempts
- information-sharing arrangements
- contingency actions
- escalation routes
- what would trigger safeguarding, further escalation to MARAC, mental health crisis response or police action

The plan is not just a document for the adult. It is also a mechanism for shared risk, shared accountability and defensible decision-making.

Professional perception was that the initiation and application of the above process and tools sit with social care, either through safeguarding or care management.

MDTs are not an embedded way of working; this finding correlates with those set out in the Self-Neglect Audit Report 2025-26. This report also demonstrates that the scale of improvement is minimal. Completion of plans is not yet coordinated.

The term MDT is used interchangeably to describe internal meetings within agencies that are attended by people of differing professional backgrounds working for that agency, as well as meetings of statutory safeguarding partners and relevant agencies coming together to undertake person-centred assessments and responses.

5.8 Mental capacity was oversimplified

At multiple points in her journey, professionals concluded that Ariadne had mental capacity, so no further action was possible. This was too simplistic. A defensible approach would have been to consider capacity for the specific decision at the specific time and whether:

- capacity is fluctuating
- substance use, trauma or mental illness affects decision-making
- coercion, exploitation or domestic abuse is influencing choices
- the adult understands cumulative risk
- executive capacity is impaired, meaning that a person may be able to articulate a decision but may be unable to act on it

Professionals are still unclear that capacity does not remove the need for risk assessment, planning, information sharing, or multi-agency coordination.

5.9 Mental capacity and blue light services

SAR Kathy, a local SAR completed in July 2026, reflected on the Ambulance Service and the Mental Capacity Act.

In Ariadne's case, paramedics recognised the safeguarding need and made multiple referrals. The last of these was when paramedics attended after a low-priority call was

made to 111. At their initial call, Ariadne did not respond; eventually, she answered the phone and told paramedics it was an inappropriate time. A follow-up call to Ariadne was made the same day. The front door was open. Ariadne refused all observations and admission to hospital. Their assessment was that Ariadne had mental capacity to refuse care and there were no reasons to doubt capacity.

In reference to SAR Kathy, Ambulance Service practitioners reflected that the Mental Capacity Act does not adequately address situations where they have a professional view that assessment or care is needed in hospital, but the person states they do not need this care.

In Ariadne's case, there were occasions when both the Ambulance Service and her partner had this view, but this conflicted with Ariadne's perspective.

This poses an important question for the partnership: whether greater weight should be given to the combined professional and carer judgement within a mental capacity assessment; if this is the case, it should be escalated to the Department of Health and Social Care for consideration in any revision of the legislation or guidance.

5.10 Mental capacity, executive functioning and drug and alcohol dependency

Multi-agency partners reflected that the Mental Capacity Act does not adequately address situations where executive functioning is impacted by drug and alcohol dependency, particularly opiates.

In Ariadne's case, opiate dependency was a significant factor in her decision-making and her capacity to act in her own interests and care.

This poses an important question for the partnership; should opiate dependency be given more weight in a mental capacity assessment in relation to executive functioning. If so, it should be escalated to the Department of Health and Social Care for consideration in any revision of the legislation or guidance.

5.11 Risk ownership and reduction

No single agency appeared to maintain ownership of the cumulative risk picture.

Multiple agencies were involved and undertaking high volumes of activity, both planned and in response to crises and escalating needs, but no one was responsible for coordinating the overall picture and plan. This correlates with the Self-Neglect Audit Report 2025-26, which found that:

- In most cases, the risk had not reduced or had increased. This was in part due to short-term crisis intervention, rather than a preventative approach.
- There was a lack of a lead agency leading next steps and a lack of shared ownership of risk and information sharing.
- No outcome-focused practice or clearly detailed risks in order to evaluate how effective the intervention had been.
- Consistent cyclical patterns of behaviour from those audited and responses from partners not seeking to understand and disrupt those patterns of behaviour through trying something new, taking more time to build a relationship and ensuring the person was at the centre of the intervention and a part of these discussions.

5.12 Fluctuations in demand, agency capacity and duality

CMHS described a context of high demand in Swindon in relation to adults with overlapping needs relating to drug and alcohol dependency, mental health and trauma. This was recognised across professionals as a key challenge.

Capacity within CMHS fluctuates almost daily, which, in practice, means that decisions about support are affected by the levels and severity of need on any given day. For Ariadne, this meant that decisions about support and follow-up were relative to the demand at the time.

Changes in commissioning have resulted in limited input within CMHS for drug and alcohol dependency; input from drug and alcohol services is twice a week, but their capacity means that is not always possible. Across both agencies, there is no dual diagnosis offer. For Ariadne, this meant that her mental health issues were not given priority because of her drug and alcohol dependency, and her drug and alcohol dependency was cyclical because mental health and trauma were not being addressed. CMHS reflected on the importance of providing initial interventions and lower-level mental health support as a bridge to engagement and recovery, for example, supporting with coping mechanisms and mood management.

6 KLOE 2: What lessons were learnt from SAR Sally and what impact and progression has taken place in practice since publication?

6.1 Impact of learning from SAR Sally

SAR Sally is a local SAR published in 2024. It can be accessed here:

- SAR Sally Final Report
- SAR Sally 7 Minute Briefing
- SAR Sally Executive Summary

Learning from SAR Sally has led to revised policies, procedures, tools and resources, but these were not sufficiently embedded in frontline practice for Ariadne. The partnership could evidence activity in response to SAR Sally, but there was limited evidence that this had translated into consistent changes in multi-agency safeguarding practice.

6.1.1 What the evidence shows

Ariadne's case reflected several of the same themes identified in SAR Sally, including limited MDT working, insufficient exploration of mental capacity and executive functioning, weak responses to non-engagement, limited use of self-neglect guidance, and a lack of coordinated risk ownership. Although SAR Sally highlighted the need for assertive multi-agency responses to adults experiencing multiple disadvantage, no safeguarding MDT was successfully convened for Ariadne and Welfare and Safety Planning was not used.

6.1.2 Why this mattered

This meant that previous learning did not operate as a protective factor for Ariadne. The system had already identified the risks associated with multiple disadvantage, self-

neglect, exploitation, substance dependency, trauma, and difficulty engaging with services, but this learning did not sufficiently change the response when similar risks were visible again.

6.1.3 Learning for the partnership

The partnership needs to strengthen assurance that SAR learning is embedded in routine practice, not only disseminated through guidance, tools, or training. There should be clear expectations, management oversight, and audits to ensure that MDTs, Welfare and Safety Plans, escalation processes, self-neglect guidance, and capacity assessments are being used in the cases for which they were designed.

6.2 Practice progression

Practice progression has been set out using key learning themes identified in SAR Sally, and the four KLOEs agreed for that SAR.

Overall, there was limited evidence of practice progression since the publication of SAR Sally in September 2024.

Table 1: Translation of lessons learnt from SAR Sally into practice		
KLOE 1 SAR Sally: Were agency assessments carried out appropriately; were these shared across agencies and was practice consistent with making safeguarding personal and mental capacity act principles?		
Theme	Progression and impact since SAR Sally	
Convening, attending and reporting on outcomes of MDTs	No attempts were made to convene a Safeguarding MDT for Ariadne following the publication of SAR Sally[2]. At the point of publication, a section 42 enquiry was active, and an MDT was unsuccessfully attempted. Following this a Care Act assessment was completed and Ariadne was closed to safeguarding and care management.	MDTs are not part of standardised practice and routinely considered. ASC explained they were seeking to embed MDTs in ways of working. Not all managers or practitioners were aware of the learning from SAR Sally or the requirement for an MDT.
Mental capacity assessment	No formal assessment of capacity including Ariadne's ability to keep herself safe, or ability to act on advice as a person who had experienced trauma or had been/was subject to coercive control. However, there were documented	Training on capacity assessment does not cover executive functioning, fluctuating capacity. Multi-agency network unclear on expectations for different professionals to complete this and in what circumstances – e.g. ambulance call outs. Ambulance crews do not always know about previous trauma and

[2] SAR 'Sally' – Overview Report exploring multiple disadvantage and cuckooing Sept 2024 Bateman

	capacity assessments within ambulance reports.	had no information regarding concerns about domestic abuse.
Opportunities to respond to direct requests maximised and trigger 'team around the person' approach	As with Sally this did not happen for Ariadne and her partner. Late 2025 – Community Nursing Team advise Ariadne's partner she can't have more dressings because Ariadne has been discharged to GP. She is crying and then hangs up. No follow up or view of this as an opportunity to engage. Plans by agencies not followed through – for example in early March 2025 plan for Community Nursing Team to create a care plan – not completed; opportunity to convene MDT not taken. Late 2025 Ariadne in hospital – hospital liaison worker discusses referral to adult safeguarding and Ariadne's partner agrees. Referral is not made. Consideration of carers needs not undertaken – opportunity for carers assessment.	Perceptions of drug-dependent adults with multiple disadvantage including history of custody is not asset based and person-centred.
Self-neglect concerns trigger assertive action	No reference to the Self-Neglect Protocol or evidence of strategic oversight.	

Table 1a: Translation of lessons learnt from SAR Sally into practice	
KLOE 2 SAR Sally: How should the Safeguarding Partnership work more effectively with people who have difficulty engaging with statutory support or sit between many services?	
Theme	Progression and impact since SAR Sally

Problems contacting by letter and phone / knowledge of literacy	Repeated attempts were made over the scoping period to contact Ariadne through letters, phone calls and text messages. It was known that Ariadne did not respond to letters, texts, voice messages, phone calls often went unanswered, on occasions they were answered by her partner. there were multiple police intel reports indicating possible exploitation.	Limited exploration of non-engagement through these mechanisms; possibility that access to her phone, letters was restricted by a third party, partner or another person, not considered. No structured communication or engagement plan, cross-agency implementation. No visible oversight of engagement, effectiveness of reducing risk and supporting better outcomes. Lack of structured escalation for disengagement: although persistent attempts were made to contact Ariadne, there was no clear escalation pathway (e.g. strategy meeting, MARAC reconsideration, coordinated multi-agency risk planning).
Effectiveness of home visits	Persistent attempts were made to engage Ariadne through home visits, and agencies completed many home visits, a number which were joint.	Ariadne would not always be in for planned home visits. Agencies recorded multiple occasions where Ariadne answered but reported being too unwell to engage, where she did not want people into the house because it was untidy, that on previous visits she couldn't open the door because she wasn't in – there was no professional curiosity or attempt to explore these issues with Ariadne or to share this information across the professional network through an MDT. There was no exploration of what support Ariadne's partner might need in her capacity as a carer; there is no record of a carers assessment being discussed or completed.

Communication and language	There is no recorded exploration of Ariadne's or her partner's language and communication needs or preferences. Limited exploration of the reasons for non-attendance at health appointments.	Ariadne was told by Community Nursing Team that if she did not comply with conditions including abstaining from drug use, they would no longer see her, and she would be discharged from the service. Systematic approach to understanding communication not visible for Ariadne. Welfare and Safety Plans not embedded and not utilised for Ariadne.
Attendances in response to crisis and disturbances	Agencies attended the property at points of escalating need and crisis. Observations and engagement at these times did not translate into an MDT response, protective action or initiation of the tools and processes developed by the SSP.	There were multiple occasions when Ambulance Services attended and saw Ariadne, but she refused to go to hospital. There were multiple times when Ariadne was reported by her partner as not willing to go to hospital. Reasons included someone having keys to their home, being scared to leave, not having clean pyjamas, the property not being secure. There were multiple attendances to Ariadne's home by Response Officers, in summary attendances related to conflict with neighbours, robbery, domestic abuse, self-harm and self-neglect. No safeguarding referrals made. A PPN was completed relating to the report of self-harm; it reported that nobody had followed up since Ariadne's discharge from hospital a week earlier. In relation to the domestic abuse incident a further PPN was completed and shared with ASC to consider further support, this was significantly delayed, however it included detailed observations and

		concerns about Ariadne's mental health, the environment, Ariadne's limited mobility, domestic abuse, and drug use. This led to a safeguarding enquiry.

Table 1b: Translation of lessons learnt from SAR Sally into practice		
KLOE 3 SAR Sally: How adept are systems in Swindon at addressing intersectionality of complex trauma, addiction, domestic abuse, and exploitation over a significant period?		
Theme	Progression and impact since SAR Sally	
Intersectionality - complex trauma, addiction, domestic abuse and exploitation	Growing prevalence of adults experiencing multiple disadvantage, where trauma, domestic abuse, poor mental and physical health, homelessness and substance misuse intersect to increase vulnerability and safeguarding risk. E Evidence shows that women are disproportionately affected, often experiencing lifelong abuse, social isolation, disability and the loss of children to care. Local data reflects increasing levels of domestic abuse, disability, self-neglect and financial exploitation, indicating that the complexity seen in this case is becoming more common. The learning emphasises the need for safeguarding responses that recognise and address the cumulative impact of	Intersectionality and multiple disadvantage – drug dependency, poor mental and physical health, trauma, domestic abuse. SAR Sally identifies changes to the Section 42 process to introduce a daily safeguarding hub which reviews a daily 'close concerns list' - should now identify if repeated safeguarding concerns have been closed without contact with the adult or evidence of action taken to reduce risk. This did not act as a failsafe for Ariadne. This raises questions about false assurance – for example: cases open as a section 42 enquiry without contact or risk reduced, closed with outcome of care management / MDT oversight / continued monitoring, closure on basis of 'mental capacity'. These were all factors impacting on Ariadne's experience. The merge process was correctly followed for the multiple referrals in 2025.However, the enquiry from 2024 had not been closed and was also merged. Had the outstanding work been completed and the enquiry closed

	multiple, interconnected disadvantages.	as intended, the later concerns would not have been merged into it. Equally, had the omission been identified earlier, there may have been an opportunity for the safeguarding team to be notified that further action was required. The enquiry manager was notified but no additional enquiries or review of risk occurred, resulting in missed opportunities to reassess the cumulative concerns. At the time, merge concerns were not consistently sent to or managed within the duty team.

Table 1c: Translation of lessons learnt from SAR Sally into practice		
KLOE 4 SAR Sally: Are practitioners confident to use local and national tools/ best practice briefings to work with people at risk of exploitation, especially cuckooing?		
Theme	Progression and impact since SAR Sally	
Cuckooing	SAR Sally identifies adults experiencing multiple disadvantage, including substance misuse, mental ill health, disability, social isolation, poverty and histories of abuse or neglect, as being at heightened risk of criminal exploitation and cuckooing. Unclear ownership of risk, limited information sharing outside safeguarding processes, and a lack of coordinated pathways to provide ongoing support, recovery and protection from further exploitation.	Consideration was not given to cuckooing or exploitation. Information and police intelligence indicating this were not pro-actively shared on multiple occasions. PPNs not completed for above and no further action taken. Unclear ownership of risk. Information gathering limited when completing Section 42 enquiries.

5. KLOE 3. How was the consideration of coercion and control and the possible impact of this on Ariadne understood in practice?

5.1 Overarching issue

The impact of coercion, control, dependency, and relational dynamics was insufficiently explored or integrated into the safeguarding analysis of Ariadne's circumstances. Ariadne's partner was seen at different points as both a source of practical support and a possible source of harm, but this dual role was not dynamically assessed.

5.1.1 What the evidence shows

Records identified domestic abuse concerns, physical abuse, reliance on the partner for wound care, the partner speaking or acting on Ariadne's behalf, and Ariadne's concerns about leaving the property. There were also indicators of drug dependency, pain, fear, trauma, poor physical health, social isolation, and possible restricted access to communication. These factors were not brought together through a domestic-abuse-informed safeguarding plan or MDT formulation.

5.1.2 Why this mattered

Without a fuller understanding of coercion, control and dependency, Ariadne's refusals and non-engagement risked being interpreted too narrowly as informed choice. This reduced professional curiosity about whether Ariadne was genuinely able to make and act on decisions freely, whether she was safe to speak openly, and whether reliance on her partner increased or reduced risk.

5.1.3 Learning for the partnership

Where an adult depends on a partner or carer who may also be a source of harm, safeguarding responses must include separate safe conversations, consideration of coercive control, carer stress, neglect, domestic abuse, executive functioning, and the adult's ability to protect themselves. This analysis should be recorded, shared, and reviewed through an MDT or equivalent multi-agency safeguarding process.

5.2 Intersectionality

Table 2. Intersectionality

Areas of strength	System issues
Recording of overlapping need Records of individual agencies identified a wide range of overlapping needs and risks. **Multi-agency communication** Substantial multi-agency communication took place between Community	**Risk factors considered in isolation** Ariadne's ability to engage with health care was likely affected by pain, fear about leaving the property and loss of liberty, substance dependency, mental health, possible coercion, trust in and previous experiences of services and reliance on her partner. A holistic formulation was needed to understand how these factors combined to increase vulnerability, reduce choice and impact patterns of engagement.

Nursing, Drug and Alcohol Services and GP. **Engagement** Single agency and joint agency home visits. Services adjusted to try and engage Ariadne; this included home visits by both the GP and Community Nursing, Probation, The Charity, Drug and Alcohol Services, CMHS, Housing and in response to emergency calls. Police responded to all direct contacts with response officers.	**Engagement** There was not an engagement plan that took into consideration the patterns of Ariadne, the patterns of professionals and the impact of so many professionals being in Ariadne's life, calling, texting, sending letters and visiting her at home. Consideration was not given to what this meant for Ariadne in terms of her lived experience or how communication about non-engagement, expectations of compliance and the consequences of not complying might impact future engagement. **Convening of an MDT** The system appears to have treated issues as separate strands: there was no evidence of one functioning multi-disciplinary team around Ariadne that brought the intersecting risks together, agreed a shared formulation, identified a clear lead professional, and set out who was responsible for coordinating what action and how professionals would engage. Although professional contact and attempted meetings were recorded, this did not become a sustained MDT response. **Welfare and safety planning** A welfare and safety plan was not created, meaning there was no shared plan setting out Ariadne's wishes, feelings and goals, current risks, protective factors, escalation triggers, contingency arrangements, responsibilities, or what agencies should do if Ariadne continued not to engage or her health deteriorated.

5.3 Opiate dependency and relational restraint

Table 3. Opiate Dependency and Relational Restraint	
Areas of strength	**Professionals' reflections and system issues**
Substance misuse was recognised throughout the records and police warning markers were present. Professionals were aware that opiate dependency formed part of Ariadne's broader risk profile.	Opiate dependency should be understood as a safeguarding and health risk factor, not viewed through a narrow frame of a lifestyle issue. It may affect motivation, memory, executive functioning, pain management, appointment attendance, vulnerability to exploitation, domestic abuse dynamics, and ability to prioritise medical care.

	Risk planning should consider withdrawal, overdose, medication routines, missed medication collection, infection risks, and how substance use interacted with self-neglect and domestic abuse. Both parties were drug-dependent, and consideration was not given to the possibility that the relationship was organised around dependency.

5.4 Mental capacity, executive functioning and intersectionality

Table 4. Mental Capacity, Executive Functioning and Intersectionality	
Areas of strength	**System issues**
Capacity was recognised as relevant. The safeguarding scope specifically asked that Ariadne's capacity around care and her ability to seek early medical intervention be established. Health professionals gave a view at points that Ariadne had capacity regarding medical treatment, and practitioners attempted to discuss care and support needs with her.	**Refusal of essential medical treatment** During 2024 Ariadne had a pattern of refusing medical treatment in circumstances that were life limiting and life threatening. However, case notes do not record this as a consideration. **Assessment of mental capacity** There is no record of a capacity assessment for Ariadne; however, ambulance crews undertook capacity assessments and documented where necessary. Despite this the records show repeated assertions that Ariadne had capacity, including statements that she understood the importance of wound care and the risks of non-engagement. however, these assertions do not appear to have been sufficiently tested against the evidence of deterioration, repeated refusal of essential treatment, missed or unsuccessful nursing contact, non-attendance, and the continuing pattern of self-neglect. Ariadne may have been able to say, "I am okay" or acknowledge that wound care was important, but the assessment needed to consider whether she could use and weigh that information and then implement the decision in practice. **Executive functioning** the difference between verbal understanding and executive functioning was central: could Ariadne organise herself to allow access, attend appointments, accept hospital admission, maintain wound care, and act on advice when her health was deteriorating? All the available evidence was that she could not.

	Capacity assessment should have been formally undertaken and in key moments such as Ambulance Service attendance to triangulate Ariadne's account with professional observations, information from previous attendances, the condition of the home, partner involvement, substance dependency and the visible deterioration of her wounds and the context of the attendance. **Organising narrative** The organising narrative of the system was that Ariadne had mental capacity to decline medical interventions including admission to hospital and that she understood the risks. Professionals repeatedly viewed declining or not engaging with medical treatment through this lens including self-discharge from hospital. The records did not consistently triangulate Ariadne's narrative with contradictory evidence, such as worsening wounds, inability, or unwillingness to let professionals in, repeated ambulance refusal, missed dressing appointments, concerns raised by the multi-agency network, and reliance on a partner who was also part of the safeguarding context. This created a risk that the language of capacity became a barrier to intervention rather than a prompt for deeper assessment, executive functioning analysis, legal literacy and multi-agency challenge. The assumption of the caring role of her partner as being effective despite the evidence resulted in potentially avoidable deterioration, increased dependency and reduced access to healthcare and rehabilitation support.

5.5 Carers as both a source of harm and source of protection

Table 5. Carers as both source of harm and source of protection	
Areas of strength	**System issues**
Professionals identified Ariadne's partner as someone present in her life who was involved in practical support.	**Duality** Carers, including carers who are also partners can occupy a dual role and must be assessed dynamically. Reliance on the partner for care should not reduce safeguarding scrutiny where there are domestic abuse concerns, reports of physical harm, or evidence that the partner speaks for the adult.

Domestic abuse concerns were also recognised, with the partner recorded as a potential source of harm following police information.	Ariadne and her partner were known to have a volatile relationship in which domestic abuse was present. Ariadne and her partner were known to be both sources and victims of harm. Ariadne should have been offered safe opportunities to speak separately, and professionals needed to consider coercive control, carer stress, dependency, neglect, and whether the partner's involvement helped or hindered access to health care and services and how help or hindrance fluctuated. **Carers capacity and assessment** The system did not appear to maintain a shared analysis of the partner's dual role. Information from the professional network was not brought together into a domestic-abuse-informed safeguarding plan. There is limited evidence of MARAC reconsideration, separate safety planning, contingency planning if partner support failed, if Ariadne was a source of harm to her partner, or a clear assessment of whether reliance on the partner increased risk for either Ariadne or Ariadne's partner.

6. KLOE 4. Were there any missed opportunities or were basic expectations met around collaborative working?

6.1 Missed opportunities

The missed opportunities fall into three broad areas: failure to sustain safeguarding oversight, failure to integrate repeated new concerns into open enquiries, and failure to use hospital admissions and discharge planning as points for multi-agency review.

6.2 Overarching issue

Basic expectations around collaborative working were not consistently met. There was significant professional contact with Ariadne, but this did not become a sustained, coordinated multi-agency response with shared risk ownership, clear leadership and agreed contingency planning.

6.2.1 What the evidence shows

There were repeated safeguarding concerns, ambulance attendances, health concerns, police intelligence, domestic abuse information, hospital admissions, refusal of treatment, non-engagement, and concerns about self-neglect. However, information was not consistently integrated into open safeguarding enquiries; MDTs were not convened or followed through; case closure was not clearly linked to evidence of

reduced risk; and no Welfare and Safety Plan or structured escalation pathway was put in place.

6.2.2 Why this mattered

The absence of a coordinated response meant that cumulative risk was repeatedly underestimated. Agencies responded to individual incidents, but no part of the system maintained oversight of the overall pattern of escalating harm. This allowed Ariadne to move between referral, partial engagement, closure and further crisis without a sustained plan to reduce risk.

6.2.3 Learning for the partnership

Collaborative working should be triggered by cumulative risk, not only by single incidents or crisis points. Where concerns persist after referral, closure or non-engagement, the partnership should expect MDT review, professional challenge, management oversight and clear recording of who is leading, what the shared risk formulation is, what actions are agreed, and what will trigger escalation.

6.3 Missed opportunity 1: Sustaining safeguarding oversight

Table 6. Missed opportunity 1

Areas of strength	System issues
Professionals in the multi-agency network recognised safeguarding concerns and made referrals. The GP undertook welfare checks when safeguarding concerns were raised. Information gathering by safeguarding included the wider professional network.	Sufficient weight was not given to concerns from the professional network or by them. For example, one referral set out immediate concerns for Ariadne: that she was in danger of serious medical complications that could lead to her death, including sepsis. An MDT meeting was planned but did not take place and no subsequent attempts were made to convene one. The Care Act assessment which took place 9 weeks after the safeguarding referral did not give weight to or include reflections from the professional network. Ariadne's drug dependency and risk of exploitation were not explored. The conclusion minimised the severity of the issues; mental capacity was treated in a simplistic manner and as the end of the safeguarding analysis. Practice focused on what Ariadne and her partner were saying rather than what was happening and the evidence and insights provided by other professionals. Ariadne's history included repeated non-engagement, missed visits, declining or inconsistent treatment, deteriorating health, substance misuse, domestic abuse, and reliance on a partner who was also identified as a potential source of harm. The recommendation for case closure to safeguarding and community led support gave an inaccurate assessment of the

	position that was not grounded in Ariadne's lived experience or reflective of the complexity of her situation. It solely focused on her physical medical needs which were framed as 'now being managed appropriately.' The conclusion of 'no further intervention is required from adult services; this case can be closed from both adult services and safeguarding perspectives' was not challenged within safeguarding or community services or escalated by any of the professional network. Case closure or step-down should have required clear evidence that risks had reduced, that treatment was sustained, and that a contingency plan was in place if Ariadne disengaged again. Safeguarding and community support decisions were not grounded in Ariadne's lived experience. For example, requirements to engage with criminal justice could have been part of a structured communication and engagement approach within a Welfare and Safety Plan. Ending the requirement to engage with criminal justice services reduced the visibility of Ariadne within the professional network.

6.4 Missed opportunity 2: Integration of repeated concerns

Table 7: Missed opportunities 2	
Areas of strength	**System issues**
<u>Recognition of need</u> Safeguarding thresholds were recognised at several key points with referrals made. <u>Initiation of safeguarding enquiries</u> Referral progressed to a Section 42 enquiry because Ariadne had care and support needs,	**Principles of consent for safeguarding** Given the number, level and range of concerns, there are multiple points when the threshold for a safeguarding referral was met but not made. This was largely attributable to professionals understanding of the principles of consent which was contextualised by practitioners' assumption that Ariadne was making a 'lifestyle choice' without further exploring her ability to protect herself. In a health context, over-reliance on patient consent created safeguarding gaps. Greater clarity is needed that safeguarding responsibilities remain even when consent is withheld, where there is reasonable cause to suspect harm. The review raises questions about whether agencies sufficiently considered safeguarding and human rights responsibilities

significant self-neglect risks, open leg wounds and was declining urgent medical treatment. Later concerns, including the domestic abuse PPN and further self-neglect referrals, were also accepted or linked to existing safeguarding pathways. There was evidence that practitioners understood the need to avoid duplication by merging repeated concerns into an existing enquiry. There were attempts to respect Ariadne's autonomy and wishes, and some records show person-centred engagement, including discussion of housing wishes, equipment, health treatment, and her ability to contact services in future.	where there were indicators of serious and potentially life-threatening risk[3]. In addition, the 'ability to protect themselves' rather than the capacity to make decisions is the basis for safeguarding legal duties under Section 42 Care Act 2014. This duty which sits alongside a general duty to carry out all social care functions in a way that promotes an adult's wellbeing was not sufficiently applied in Ariadne's case. **Initiation of safeguarding referrals** Drug and Alcohol Services discussed the need for a safeguarding referral, but a referral was not made. **Decisions to close to safeguarding and community led support** Information gathering and sharing was fragmented. Social care did not appear to understand Ariadne's needs, cumulative risk or a recognition of the severity of need and risk of harm for Ariadne and potentially to professionals visiting her home. Capacity assessment was at times requested by the professional network but not completed. **Intersectionality** The assessment did not consider intersectionality; the reasons Ariadne had unmanaged leg ulcers, including drug dependency, the context of her probation conditions, or the need for a capacity assessment rather than an assumption of it. There appears to be no attempt to speak to Ariadne independently. The completion of a visit by the GP was assumed to mean that her physical health needs were being effectively met. Case closure did not explore any of the above factors, the absence of multi-agency contribution to the assessment, or if any new information received from the multi-agency network indicated that risks had changed. Had this taken place it would have been evident that Ariadne was not engaging with Community Nursing Team, had been admitted to hospital and discharged home in part due to problems with her leg ulcers and that there were indicators that her carer, also her partner, might also be a source of harm as well meeting a number of her needs. **Escalation and consideration of cumulative harm** There was an open Section 42 enquiry when Adriane attended hospital due to respiratory arrest following Class A drug use.

[3] Article 2, Human Rights Act 1998

	In the first instance there was a refusal to attend hospital, and the second Ariadne was aggressive. No escalation or further action was taken and this, as well as other, new information was not integrated into the Section 42 enquiry. **Use of intelligence and information** Information and intelligence were not pro-actively shared and utilised, for example Police intel reports regarding exploitation risks. PPNs not completed and no further action taken (included in SAR Sally comparison). **Risk management and risk reduction** The system appears to have allowed repeated movement between safeguarding and care management without a coordinated long-term plan for sustained risk-reduction. Earlier decisions concluded that risks were being managed because health input had resumed, but this did not adequately address the pattern of relapse, non-engagement, and escalating complexity. There was no clear trigger requiring senior review, strategy discussion, or multi-agency escalation when further concerns are received after an enquiry was already open. **Importance of lead professionals** The absence of a clear lead professional meant that no single agency or practitioner appeared responsible for maintaining oversight of cumulative risk, ensuring follow-through across agencies, or creating a welfare and safety plan. **Acceptance of narrative at face value** Response Officers attended and spoke to Ariadne, notes show observation of Ariadne's ankle wound and confirmation that Ariadne had support from a social worker, recorded as NFA and assertion of support from social worker taken at face value. **Assumptions about engagement** Practitioners should guard against interpreting repeated non-engagement as simply informed choice, lifestyle preference, or non-compliance. The chronology suggests a risk that, once Ariadne was viewed as having capacity and choosing not to engage, later information may have been interpreted through that lens. Alternative explanations should have remained active, including coercion, fear, trauma, addiction, executive dysfunction, depression, pain, poverty, dependency on the partner and fear about property security. **Reflective challenge** The system lacked structured reflective challenge when earlier assumptions were contradicted by repeated relapse.

	Conclusions that Ariadne's needs were managed Ariadne and her partner, or that risks were managed because treatment had briefly resumed, may have reduced urgency. There was limited evidence of supervision or multi-agency challenge asking, "What if our current formulation is wrong?" or "What evidence shows that risk has genuinely reduced?"

6.5 Missed opportunity 3: Multi-agency responses during hospital stays

The Ariadne SAR identifies several opportunities that may have been available during Ariadne's admission. However, it is important to consider these findings within the context of the Acute Hospital's role, remit, and statutory responsibilities.

The primary duty of an Acute Hospital is to assess, treat and manage a person's health needs during an episode of care and to ensure that discharge planning is safe and proportionate. Whilst admission may provide an opportunity to identify unmet health, mental health, housing and social care needs, the hospital does not assume sole responsibility for addressing all aspects of a person's complex circumstances, particularly where multiple agencies already have statutory responsibilities.

Table 8. Missed opportunity 3	
Ariadne's admission represented a relatively stable period during which there was the potential for agencies to come together to consider and explore her wider support needs.	
Areas of strength	**System issues**
Early in Admission 2 Acute Hospital contacted Drug and Alcohol Services to let them know she was an inpatient. Drug and Alcohol Services were in regular contact with Acute Hospital staff and Ariadne during this period and completed visits to her in hospital. Drug and Alcohol Services considered Ariadne's needs within internal MDT meetings.	**Mental capacity as the organising narrative** Known to multiple services over a long period of time, Ariadne was (perceived to be) an adult with agency; this perception may have contributed to limited consideration of a referral to safeguarding. Differing views regarding support needs, safeguarding referral and discharge planning were not adequately explored nor was the SSP Escalation Process utilised. By utilising the SSP Escalation Process the Drug and Alcohol Services could have prompted the acute team to reflect on the rationale for their decision-making and indicators of safeguarding need. **MDT and Care Coordination** Referrals and information sharing took place, but this did not translate into a formal MDT meeting limiting the opportunity coordinated planning. Despite Ariadne's multiple needs and presentations, she did not have a lead professional. This left a gap in a leadership and coordination which contributed to Ariadne remaining in hospital when she was medically fit for discharge.

Drug and Alcohol Services' hospital liaison worker suggested need for package of care, mental health referral, occupational therapy referral. A safeguarding referral was discussed with Ariadne's partner by Drug and Alcohol Services.	Without a formal MDT in place around Ariadne housing issues such as rent arrears and plans made for suitable accommodation were not addressed. Ariadne remained in hospital for an extended period without plans being put in place, she then self-discharged returning to the community without a coordinated plan to meet her needs. **Mental Health Support** No referral was made for Ariadne to access mental health support; this indicates that clinicians did not recognise indicators that would have justified referral during admission. **Carers assessment and partner dynamics** Throughout Ariadne's journey there is no evidence that consideration was given to the need for a statutory Carers Assessment. In this context, there is limited evidence that hospital staff and Drug and Alcohol Services recognised indicators of potential coercion, exploitation, substance misuse or considered that as a carer Ariadne's partner could be both a source of help and harm. **Information sharing and safeguarding** Whilst in hospital the police had several intel reports that indicated exploitation. This was not acted on as a safeguarding or welfare concern.

7. KLOE 5: 'What would good look like' when working with those experiencing multiple disadvantage, including expectations on the partnership around shared risk and defensible decision making?

7.1 Reflections from SAR Sally

Consistent with the findings of SAR Sally, good practice for adults experiencing multiple disadvantage requires assertive, trauma-informed and coordinated multi-agency working, with shared risk ownership and defensible decision-making. In Ariadne's case, the system did not use the SSP resources or consistently work in this way.

7.1.1 What the evidence shows

A 'team around the person' approach, a clear lead professional, shared assessment, Welfare and Safety Planning, dynamic review of risk, timely information sharing, professional challenge, and mental capacity assessments that consider executive functioning and fluctuating capacity are evidenced as effective practice.

Adults with multiple disadvantage need support that meets their needs holistically, not based around or conditional on single-issue pathways, particularly where drug dependency, mental health, trauma, domestic abuse, and self-neglect intersect.

7.1.2 Why this mattered

Ariadne's experience showed that when systems remain organised around service boundaries, referral thresholds or episodic responses, the adult's lived experience can become fragmented across agencies. This increases the risk that no single organisation holds the cumulative picture, and that non-engagement, capacity and lifestyle choice become reasons for reduced intervention rather than prompts for deeper analysis.

7.1.3 Learning for the partnership

The partnership should define and mandate what good looks like in practice for adults with multiple disadvantage. This should include clear expectations for MDTs, lead professional arrangements, Welfare and Safety Plans, capacity assessment, escalation, supervision, management oversight, and evidence of risk reduction before closure. Assurance should focus on whether practice has changed and whether adults are safer, not only whether procedures have been updated.

7.2 The person is the focus, not the service boundaries

Professionals understand that presenting behaviours often reflect trauma, adversity and unmet need rather than non-compliance or lifestyle choice.

Good practice includes:

- Building trusted relationships over time
- Recognising trauma and adverse experiences
- Understanding the interaction between mental health, substance use, domestic abuse and social factors
- Working with the person's strengths, wishes, and outcomes
- Maintaining engagement even when the individual struggles to engage consistently or disengages
- Having a lead professional who coordinates support and interventions, avoiding the person becoming overwhelmed and making engagement manageable.

7.3 No wrong door

Adults with multiple needs should not be excluded from services because another need is viewed as the primary issue, as reflected nationally within England's co-occurring conditions agenda.

Services should be flexible and responsive, maximising opportunities to engage.

7.4 Shared assessment and shared planning

Good multi-agency practice involves:

- A common understanding of the person's circumstances
- Joint risk assessment
- Clear lead professional arrangements
- Shared care/support plans

- Regular multi-agency review meetings
- Information sharing that is lawful, proportionate and timely.

The question should be:
"What is our collective view of risk and what are we doing together?"

rather than

"What is my agency responsible for?"

7.5 Shared risk management

Adults experiencing multiple disadvantage frequently present with:

- Self-neglect
- Suicidal ideation
- Exploitation
- Domestic abuse
- Repeated crisis presentations
- Capacity fluctuations
- Risks to others

In these situations, good practice recognises that risk cannot be removed. The goal is to manage risk rather than eliminate it. Partners should avoid:

- Risk transfer
- Defensive referrals
- Closing cases because another service is involved
- Making services conditional for example, we can't offer support for mental health until drug dependency is resolved or vice versa

Instead, agencies should use the Welfare and Safety Plan to agree:

- The key risks
- The evidence informing decisions
- Which agency is taking which action
- Trigger points for escalation
- Contingency plans

7.6 Avoiding crisis

The Care Act, Human Rights Act and Mental Capacity Act require professionals to balance:

- Safety
- Autonomy
- Least restrictive intervention
- Proportionality

Swindon's Safeguarding Adults Decision Support Guidance explicitly highlights self-determination and proportionality alongside professional judgement, and notes that concerns should be managed through robust multi-agency processes rather than waiting for crisis escalation.

7.7 Defensible decision-making

A defensible decision is not necessarily one that prevents harm. It is a decision that can be shown to be reasonable and professionally justified based on the information available at the time.

Good documentation would demonstrate the professional considered:

- The adult's views, wishes, and goals
- Mental capacity, including fluctuation and executive functioning
- Risks and protective factors
- Historical patterns
- Information from partner agencies
- Strengths to build on
- Potential impact of intervention and non-intervention

Records should answer:

- What is the concern?
- What evidence supports this view?
- What alternatives were considered?
- Why was this course of action chosen?
- What residual risks remain?
- Who has accepted responsibility for follow-up actions?

Healthy challenge should be encouraged. Where agencies disagree:

- Escalate through the partnership resolution processes – see Adult and Children Resolution Policy.
- Record differing professional opinions.
- Seek management oversight.

7.8 Supervision and management oversight

Cases involving substance dependency, executive functioning concerns, self-neglect, domestic abuse and caring relationships require particularly robust supervision and management oversight. Practitioners can easily become drawn into a single narrative for example, viewing a partner solely as a caring support, or alternatively solely as a source of harm. Effective supervision creates the reflective space needed to challenge assumptions, identify disguised risk and maintain professional curiosity.

The purpose of supervision is not simply to review actions taken, but to support critical analysis of how risk, power, dependency and capacity interact within the individual's lived experience.

Managers should promote professional curiosity, challenge assumptions, consider domestic abuse alongside self-neglect and ensure that practitioners focus on outcomes rather than appearances. The central supervisory task is to understand how power, dependency and care interact within the relationship and whether the current arrangements are enhancing the person's wellbeing or contributing to avoidable harm and increased vulnerability.

Managers may find the following questions useful:

- What evidence do we have about the quality of care actually being delivered?

- How is the caring relationship influencing the person's autonomy and decision-making?
- Are we relying too heavily on information provided by one individual?
- Is deterioration being explained as self-neglect when other forms of abuse or neglect may be present?
- What role do addiction and executive functioning difficulties play in the person's ability to protect themselves?
- How are power and dependency operating within the relationship?
- What would we be worried about if this caring relationship did not exist?
- What is the trajectory of risk - improving, static or escalating?

8. Recommendations

The recommendations are framed as partnership recommendations because the learning relates to the way the system identifies, owns, coordinates, and assures safeguarding responses for adults experiencing multiple disadvantage, rather than to isolated single-agency practice.

8.1 Recommendation 1: Workforce understanding and values

The partnership should invest in improving workforce understanding of adults with multiple disadvantage, the impact of opiate dependency, the impact of judgemental values and assumptions, co-occurring needs.

Intended impact: Equality of support.

Evidence of impact: Equality analysis of data for safeguarding.

8.2 Recommendation 2: Establishing clear triggers and standards for multi-agency meetings

The partnership should implement a consistent framework for multi-agency meetings across safeguarding and care and support pathways. The framework should support the duties of cooperation, wellbeing and safeguarding under the Care Act 2014 and define when cumulative risk, complexity or fragmented agency involvement requires a coordinated multi-agency response.

The framework should specify:

- clear triggers for convening an MDT;
- who is responsible for convening and chairing it;
- required agency attendance and information sharing;
- lead professional arrangements;
- shared risk formulation and person-centred planning;
- actions, timescales, contingency plans and review arrangements;
- escalation where agencies disagree, do not attend or fail to complete actions; and
- recorded reasons and management oversight where a trigger is met but an MDT is not convened.

Triggers should include repeated or escalating concerns; multiple agency involvement without a coordinated plan; serious self-neglect or health deterioration; difficulty

engaging alongside unresolved risk; concerns about capacity or executive functioning; domestic abuse, coercion or exploitation; unsafe or unsustainable caring arrangements; repeated hospital admissions or unsafe discharge; new concerns during an open section 42 enquiry; and proposed case closure where risk has not demonstrably reduced.

Intended impact: Adults experiencing cumulative or complex risk receive a timely, coordinated, and person-centred multi-agency response, with shared risk ownership, clear leadership, and defensible decision-making.

Evidence of impact: Audit demonstrates that cases meeting the agreed triggers are identified and considered for an MDT; reasons are recorded where an MDT is not convened; relevant agencies attend and contribute; lead professionals, shared plans and contingency arrangements are established; agreed actions are completed; and adults' safety, wellbeing and outcomes improve.

8.3 Recommendation 3: Improve mental capacity assessments

The partnership should ensure the application of mental capacity assessments.

This should include:

- Management oversight of assertions of mental capacity without a clearly recorded assessment that takes account of executive functioning, fluctuating capacity and, where relevant, how opiate dependency interacts with executive functioning.

Intended impact: Capacity assessments are accurate and capacity is not a shortcut to closure of cases.

Evidence of impact: Audit identifies effective use of capacity assessments that are of a high quality.

8.4 Recommendation 4: Strengthen supervision and safeguarding advice

The partnership should ensure that all professionals have consistent access to reflective supervision and safeguarding advice.

Intended impact: Increased practitioner confidence, earlier escalation, improved analytical practice.

Evidence of impact: Practitioner feedback, supervision audit and case audit should show improved confidence, clearer language, better use of tools and stronger decision-making.

8.5 Recommendation 5: Develop safeguarding oversight and recovery plans for Section 42 enquiries

The partnership should ensure recovery plans for Section 42 enquiries and oversight of safeguarding and care and support timeliness, compliance, effectiveness and impact.

This should include:

- timeliness and outcomes of Section 42 enquiries
- professional escalations

- MDTs for open cases
- management oversight of case closure safeguarding, and care and support
- timeliness and quality of Welfare and Safety planning
- risk reduction
- impact of new process for merging concerns
- equality analysis to test whether adults from different communities and primary need are equally protected and supported

Intended impact: Improved strategic understanding of safeguarding and care and support effectiveness, better targeting of resources and stronger assurance about equity and impact. The majority of section 42 enquiries and Care Act assessments are completed in a timely manner, to a good standard and reduce risk.

Evidence of impact: Leaders should receive a regular dataset with clear caveats where data remains incomplete. Recovery plans in place and making a difference. Quality and impact improvement.

8.6 Recommendation 6: Strengthen recovery and therapeutic pathways for adults with multiple disadvantage

The partnership should review the sufficiency and accessibility of recovery and risk reduction support for adults affected by alcohol and drug dependency, mental health, and trauma, including support for carers.

This should include:

- Ensuring support is structured around and responsive to needs.
- Strengthening links between safeguarding planning and recovery planning.
- Reviewing support for adults who disengage, decline services, or fall out of pathways.

Intended impact: Adults with multiple disadvantage receive timely, trauma-informed, and sustained support that addresses the co-occurring and intertwined nature of drug and alcohol dependency, mental health, and trauma.

Evidence of impact: Data and audit should show improved access and outcomes.

6.3 Recommendation 7: Strengthening the identification, assessment and support of carers

The partnership should establish and implement a consistent multi-agency approach for identifying unpaid carers and referring them for a carer's assessment where it appears that they may have needs for support. The approach should reflect the statutory duties under the Care Act 2014 and apply across care and support, safeguarding, hospital discharge, and other relevant pathways.

Practice guidance should make clear that a carer's assessment is an assessment of the carer's needs in their own right. It should consider the carer's ability and willingness to continue caring, the sustainability and impact of the caring role, the outcomes the carer wishes to achieve, and the support that may be required.

Where safeguarding concerns are present, including domestic abuse, coercion, exploitation, self-neglect, substance dependency or mutual vulnerability, practitioners should consider and record whether the person providing care may also be experiencing harm, contributing to harm, or both. The need for a carer's assessment should be considered alongside, but not as a substitute for, the adult's care and support assessment and any enquiry under section 42 of the Care Act 2014.

Intended impact: Unpaid carers are identified at the earliest opportunity and consistently offered an assessment of their own needs. Care and safeguarding planning is informed by a clearer understanding of the carer's ability and willingness to provide care, the sustainability of the caring arrangement, and any risks affecting the carer or the adult receiving care.

Evidence of impact: Audit demonstrates that carers are consistently identified and offered assessments; assessments address ability, willingness, wellbeing, sustainability, and risk; eligible needs lead to appropriate support planning; and safeguarding records show that the dynamics of support and harm have been explicitly considered.

6.4 Recommendation 8: Inpatient period as time of opportunity

The partnership should ensure that periods of inpatient admission are used as opportunities for multi-agency assessment, information sharing and planning for adults with complex needs. Acute and community partners should work together to identify unmet need, support safe discharge, and facilitate appropriate onward referrals and support arrangements.

This should include:

- Early discharge planning involving relevant agencies
- Timely referral to Adult Social Care, safeguarding, mental health and substance misuse services where indicated
- Multi-agency discussions where complexity, cumulative risk or discharge concerns are identified
- Consideration of welfare and safety planning and Carer's Assessments by the responsible statutory agencies
- Clear identification of the lead agency responsible for ongoing community coordination following discharge

Intended impact: The inpatient period is maximised by multi-agency partners to understand need, build relationships that can be sustained in the community, and develop person-centred plans.

Evidence of impact: Data demonstrates patients are safely discharged once medically fit. MDTs are in place for people with complex needs who have had two or more inpatient periods.

8.7 Recommendation 9: Governance, assurance and impact monitoring

The partnership should ensure there is a focused adults with multiple disadvantage 'what good looks like' improvement plan with named owners and timescales which brings together learning across local SARs relating to self-neglect and complex needs,

the recommendations and strengths from the multi-agency self-neglect audits in 2023-24, 2024-25 and 2025-26.

Governance should test whether actions are changing frontline practice and improving adults' experiences.

This should include:

- Clear impact measures for each priority
- Regular dip-sampling of practice
- Feedback from practitioners and adults with lived experience
- Reporting to SSP Executive on progress, barriers, and impact
- Explicit tracking of risks that remain unresolved

Intended impact: Stronger leadership grip, clearer accountability and demonstrable improvement in practice and outcomes. Closure of audit recommendations not yet completed.

Evidence of impact: Partnership reporting should show not only what has been delivered, but what has changed in practice and how this has improved safety, support, and recovery for adults with multiple disadvantage.

8.8 Recommendation 10: Escalation to the Department of Health and Social Care

The partnership should consider completing an engagement process relating to Mental Capacity Assessments to establish practitioners' views on legislative gaps, in addition to the issues raised in this review and SAR Kathy. It should then determine which are appropriate to escalate to the Department of Health and Social Care.

Intended impact: Practitioners' experience influences legislation. The partnership has an in-depth understanding of the issues related to Mental Capacity that impact practice and can formulate actions to address them.

Evidence of impact: Mental Capacity Assessments are consistently completed, recorded, and demonstrate consideration of executive functioning.

9. Closing Reflections

The review indicates that the central issue was not an absence of professional concern, but the failure of the multi-agency system to convert repeated concerns into a sustained, coordinated and risk-reducing response. Ariadne's circumstances were complex, but the risks were visible. The learning for the partnership is therefore about how earlier learning, policies and tools are embedded into routine practice, particularly where adults experience multiple disadvantage, are difficult to engage, and where capacity, consent and lifestyle choice risk becoming barriers to safeguarding action.