Issue 14, August 2021

# Newsletter

*Working in partnership to enable adults in Somerset to live a life free from fear, harm or abuse*

This is the 14th edition of the Somerset Safeguarding Adults Board (SSAB) newsletter, and we hope those who have received copies since its launch continue to find it a useful resource and an interesting read.

It's been over a year since our last newsletter during which time we know that every service and professional working in adult safeguarding will have seen the way in which they work change beyond recognition in comparison to the beginning of 2020. We know that while the last 18 months has been a really difficult time for everyone, it has been especially hard for those involved in keeping the most vulnerable members of our communities safe and we want to take this opportunity to thank you for everything you have done, and continue to do, as we look towards the autumn.

To the new subscribers who've recently signed up to receive copies of our newsletter, a very warm welcome and our thanks for your interest in being part of our local safeguarding community in Somerset.

**We always welcome any suggestions for improvement, requests for future content or any contributions you'd like to make.**

In this issue:



# News from the SSAB

Since the last newsletter was published the SSAB has met three times on 13/10/2020, 09/02/2021 and 11/06/2020. Agenda highlights include:

- Hearing a very moving a description from a care home owner and representative of a domiciliary care provider of the experience of care providers during the pandemic.
- Discussing learning for the adult safeguarding system in Somerset from the COVID-19 public health crisis identified by professionals working for the Local Authority, NHS and Police.
- Receiving an update on the work of the Violence Reduction Unit.
- Considering opportunities for joint working with Devon & Somerset Fire and Rescue Service.
- Receiving updates on work to implement the Domestic Abuse Act (2021).
- Receiving a briefing from Somerset NHS Foundation Trust and Yeovil Hospital NHS Foundation Trust on their responses to the Ockenden Review.
- Agreeing a new set of Terms of reference for the Board and Executive Group following recommendations from the South West Audit Partnership audit of SSAB activity.
- Receiving progress updates on our **Strategic Plan** from the Executive Group.
- Reviewing, and contributing to, our Annual Report, which we expect to publish in September.

While our Independent Chair, Keith Perkin, did not need to make a decision to temporarily suspend the activity of our subgroups in the Spring of 2020, much of the development work of our subgroups was put on hold due to partners understandably needing to prioritise the pandemic response.

At its meeting in October 2019 the Board made a decision to publish the minutes of Board meetings in full from that meeting onwards, with the exception of redacting confidential information relating to an individual (for example where someone has spoken about their experience of being safeguarded). Notes are published on the **SSAB Website** retrospectively following sign-off at the next meeting.

# SSAB Self-Audit 2021

The SSAB launched its self-audit on 12/08/2021. The audit has been designed to help it evaluate the effectiveness of internal safeguarding arrangements, and to identify and prioritise any areas in need of further development. It is designed to support local organisations in their continuous improvement of adult safeguarding work, and in a change to previous years our 2021 Audit tool has been developed in partnership with the Bath and North East Somerset, Bristol, North Somerset and South Gloucestershire Safeguarding Adults Boards.

SSAB partner organisational leads have all been sent a copy of the audit and are required to complete all relevant sections of the self-audit, but other organisations are also actively encouraged to complete the tool as part of benchmarking their current safeguarding arrangements.

## Further information

**Find out more and download the 2021 audit tool**

# Guidance and leaflets

Since our last newsletter we have published the following new guidance:

- **Safeguarding and Medicines Management: Guidance for Providers**
- **Organisational Abuse Procedures**

We have also made some changes to our website to make the information we have produced for the public more prominent, and have also added a series of leaflets on different aspects of adult safeguarding for members of the public:

We intend to expand the leaflets that we have available, including easy read versions of those we have already produced.

- **What is Abuse and Neglect**
- **What happens after abuse or neglect is reported**
- **What is a Planning Meeting**
- **What is a Safeguarding Adult Enquiry**
- **What is a Review Meeting**
- **Preparing for a safeguarding meeting**
- **Mental Capacity**

## What to do if it's not Safeguarding?

A recent serious case has highlighted that some professionals are not aware, or not using, our guidance on "What to do if it's not Safeguarding?"

This guidance was developed by the Somerset Safeguarding Adults Board to promote a joint approach to the assessment and management of risk to adults with care and support needs across organisations where the person has complex needs, but use of the Somerset Safeguarding Adults Board **Adult Safeguarding Decision Making Tool** has determined that a safeguarding referral is not required or where, following referral, it has been determined that a statutory or non-statutory safeguarding enquiry under the Care Act (2014) is not required.

Please note that this guidance should only be used within the circumstances laid out within it and does not replace normal referral rotes and escalation processes.

## Further information

View the **What to do if it's not Safeguarding?** Guidance

# Your Adult Safeguarding Experience: Feedback Form

Somerset County Council's Adult Safeguarding service would like hear feedback not just from people who have been supported by adult safeguarding services, and their carers, but also from those who advocate or support them on a professional basis.

The forms below have been developed with support from Healthwatch Somerset, and Somerset County Council's Adult Safeguarding service will offer support to people in completing these if they are unable to access electronic versions.

- **Adult Safeguarding Service Questionnaire for adults who have been supported by safeguarding services**

- **Adult Safeguarding Service Questionnaire for carers, relatives or friends**
- **Adult Safeguarding Service Questionnaire for Advocates, IMCAs and Providers)**

The information received by the County Council will be reported regularly to the Somerset Safeguarding Adults Board and will inform its performance scorecard.

# Save the Date: Stop Adult Abuse Week and Joint Online Conference Workshops

Stop Adult Abuse Week will take place from Monday 15th to Friday 19th November with a theme of Creating Safer Cultures.

As part of this week long campaign, which is aligned with the National Safeguarding Adults Week, there will be series of jointly held online workshops that will be free to access for any practitioner working with adults across Somerset, North Somerset, South Gloucestershire, Bristol and Bath & North East Somerset. We will send further details once booking opens, but please save the date for the following opportunities:

- Monday 15th at 12.30pm – Emotional Health and Wellbeing
- Tuesday 16th at 12.30pm – Trauma informed Practice
- Wednesday 17th at 12.30pm – Gambling Awareness
- Thursday 18th at 12.30pm - Exploitation of Adults
- Friday 19th at 12.30pm – Safer Cultures

# NICE guideline on Safeguarding Adults in Care Homes

In February 2021, **NICE published a new guideline on Safeguarding Adults in Care Homes**. The guideline makes action-orientated recommendations to improve safeguarding for residents of care home.

The Care Quality Commission encourages providers to use NICE guidance to improve the quality of care provided, with evidence of use and compliance helping services achieve or maintain a Good or Outstanding rating.

On the back of this new guidance, the Somerset Safeguarding Adults Board and Somerset Strategic Care Sector group are keen to encourage as many local care homes as possible to complete the associated **Baseline Assessment Tool** to help you evaluate whether your practice is in line with the recommendations in safeguarding adults in care homes. It can also help you plan activity to meet the recommendations.

We recognise how busy your services currently are, so this is not a mandatory requirement but is actively encouraged given the benefits this awareness will have on local practice as well as supporting our Safeguarding Adults Board to develop a picture of activity across our county.

## The ask

For Somerset Care Homes to complete the **Baseline Assessment Tool** to support internal audit and service improvement activity, and submit a copy of this to **ssab@safeguardingsomerset.gov.uk** by no later than **Friday 17 September 2021** to benefit local quality assurance monitoring. **The tool also includes sections for Local Authorities and Safeguarding Adults Boards and these do not need to be completed by care homes**.

In the event that less than 50% of Homes submit a response, the SSAB will be exploring other options to secure assurance in this area which will likely include random dip sampling of selected services.

**Any submissions received via the SSAB mailbox will be taken into account by local Contract Review and Quality Assurance activity.**

# Dementia Safeguarding Scheme (Herbert Protocol)

The Dementia Safeguarding Scheme (Herbert Protocol) is a national scheme encouraging carers, family and friends to provide useful information which can be used in the event of a vulnerable person going missing. The information is captured in a form and is used by the police to help locate vulnerable individuals, and includes:

- medication required
- mobile numbers
- previous addresses and employer details
- places previously located
- a photograph

Providing these details in advance means:

- you do not need to remember vital information if you need to report a missing person, helping to reduce stress at an already anxious time
- the police are aware of any locations an individual may have gone so they can start their search sooner, as often those with dementia return to meaningful locations such as childhood homes or places of work.

### What happens when someone joins the Scheme?

You will be asked to provide personal information about the individual. It is important you make sure this information is accurate and that the individual is aware you are completing the form on their behalf.

This information is stored on our police database and will be used if you raise a concern about the individual's wellbeing or to report them missing.

## Further information

**Find out more and register**

# Business Manager Blog


Stephen Miles SSAB Business Manager

It's been a while since our last newsletter, and for that I can only apologise, and say that I'm hoping that we will move back to our normal quarterly issues as well as increasing our wider communications work going forwards.

As has been the case for most people it's been an odd 18 months for both the Board and me personally, with long periods of home schooling even when the schools were open as my son seemed to keep finding himself in a bubble that needed to be sent home to self-isolate. However, even in the moments when we've been trying to grapple with schoolwork set with instructions in a language I don't speak, I've been continually mindful of the huge challenges

that our hospitals and care providers have been facing, and some of the heart-breaking situations they have faced. This was really brought home when representatives from two care providers joined the Board's last meeting in June to speak about their experiences over the previous year.

While I have been working to ensure that the Board's statutory duties have been met throughout the period, much of my time has been spent supporting the system's response to the pandemic, including in relation to PPE, grant funding for care providers and coordinating the development of the Local authorities Winter Plan. The Board has also hosted a **webpage** providing information for providers that I've been checking and updating every day, and I've also been writing the weekly Adult Social Care provider brief. Over the last week I've handed the provider brief and webpage over to colleagues to manage so I can once again concentrate on work for the Board.

Since our last newsletter we have published two Safeguarding Adult Reviews – Luke and Damien – both of which you can read more about later in this newsletter. We are also in the process of completing two other reviews and, unfortunately (as it usually means that something awful has happened to someone), have further referrals at different stages. Luke was the first Review that we completed using our local process which involved me writing the report. I can't say that it was an easy experience, and I have only greater respect for independent authors who work on Reviews every day having done so, but I hope that what we published did right by Luke. Damien was a very different Review – with a long history as the original Review that was completed in 2016 needed to be revisited by a new independent author following new information emerging at inquest. It was also very different because Damien's family was actively involved in the process, passionately advocating for him and determined that the recommendations should be a catalyst for change. It's now up to the Board to make sure those recommendations are implemented, and our Independent Chair, Keith Perkin, is regularly checking progress.

We have refreshed our annual plan, which will be the last year of our current 3-year plan, and we'll therefore be looking at how we involve people and organisations in developing our plan for 2022 onwards during the autumn. We have also launched our self-audit, which we have developed in partnership with Bath and North East Somerset, Bristol, North Somerset and South Gloucestershire Safeguarding Adults Boards in order to reduce duplication for organisations that work across more than one board, and we hope to expand this approach in the future. If your organisation isn't a member of the Board it can still compete it, and you can read more about doing so on our **website**.

While we have not seen any significant patterns of concern emerge locally during the pandemic one area we remain concerned about is people who have been self-neglecting during the various lockdowns, and are continuing to do so now that restrictions have eased. We also know that, despite this easing, the virus has not gone away and much uncertainty remains about what will happen as we move into the autumn and winter, so please, if you can, get vaccinated and keep following the basic precautions even if you don't legal have to anymore as each and every one of us continues to only be as safe as the least safe person we come in to contact with.

# Learning Lessons

## National: Analysis of Safeguarding Adult Reviews: April 2017 - March 2019

In November 2020 the first national analysis of Safeguarding Adult Reviews (SARs) in England was published by the Care and Health Improvement Programme, supported by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). Its purpose was to identify priorities for sector-led improvement.

The report makes a total of 28 improvement priorities nationally, and for each Safeguarding Adults Board. The Somerset Safeguarding Adults Board has conducted a gap analysis to identify those recommendations that requires local development and is also contribution to national work.

### Further information

- **Read the Briefing for practitioners**
- **Read the Summary**
- **Read the full report**

## Local: 'Luke'

### Background

Luke (pseudonym), aged 67 at the time of his death in 2018, had been a resident in a care home for about 18 months, and had a long history of neglecting his own health and well-being before he moved there. Luke had Type 2 Diabetes and had experienced a number of traumatic events in his life and, although Luke died from a diabetic foot ulcer, the focus of the report was on how agencies worked together in their approach to Luke and concerns about his mental capacity and neglect of his own wellbeing. When Luke moved to the care home he weighed 47.3kg with a Body Mass Index (BMI) of 19[1], and weighed 30.8kg with a BMI of 11[2] when he was admitted to hospital prior to his death.

Prior to moving to the care home, Luke's self neglecting behaviours were being described in documentation as a "lifestyle choice", and that Luke was making "informed decisions" to live in the way that he did. Following the move to the care home Luke was considered to have the capacity to make decisions that were clearly having a negative impact on his health without exploration, resulting in referrals not being made to health professionals that would otherwise have been.

Shortly after moving to the care home Luke made a disclosure about alleged incident of historical child on child sexual touching to his social worker. They discussed this with their manager, but it was not referred to Somerset County Council's Children's Social Care Services.

[1] Body mass index is a value derived from the mass and height of a person. The BMI is defined as the body mass divided by the square of the body height, and is expressed in units of kg/m², resulting from mass in kilograms and height in metres. If an individual has a BMI below 18.5 then they are considered to be underweight.
[2] A BMI of 11 is considered to be dangerously low.

## Key considerations for practice identified in the review

### 1. Luke's history of self-neglect and assessments of his mental capacity

- Luke was placed in a care home to protect him from self-neglect, which he had a long history of, and the impact this was having on his health. It appears to have been assumed that, by virtue of being placed in a registered care environment, he would be protected from his behaviours.
- Assessments undertaken at the time of Luke's move to the care home gave only brief summary information about his history. These summaries were then appended to with new information which, though referring to Luke's history of self-neglect, did not provide the level of detail that would be necessary to provide context to the care staff and other professionals now attempting to support him.
- It is unknown as to the extent to which Luke's history of traumatic loss and mental ill-health impacted on his decision making both before and after he moved to the care home. The combination of all of these factors could well have had an impact on his day-to-day life and may have been part of the reason he self-neglected. However, this doesn't appear to have ever been explored in any depth or discussed with Luke.
- While the Mental Capacity Act is clear that capacity should be assumed unless someone has concerns otherwise, concerns should have been identified about Luke's decision making by some of his responses, in particular to treatment for his ulcers. It is inappropriate for Principle 1 of the Act to be used to avoid considering whether someone may need help to make a decision where there is evidence that they may be struggling with their capacity. In addition, consideration should also be given as to whether further exploration is required where an adult appears to be making repeated unwise decisions.
- In Luke's case his capacity was described as fluctuating on multiple occasions by multiple professionals, and in this type of situation it can be beneficial to consider a longitudinal approach in order to establish a better understanding of the person and how they can be best supported to make a decision.
- Giving care that is restrictive (as long as it is the least restrictive available) is not a breach of human rights - but is a mechanism to uphold them, of which the right to life is one. The state may interfere with one human right if it can demonstrate through evidence that by doing so it is upholding another (e.g. the right to life). In Luke's case the care home's staff defaulted to upholding one right without adequately considering the impact on another, or attempting to explore or evidence why a different decision should be made in Luke's best interests.

### 2. Luke's wound Care

- Almost every aspect of Luke's care seemed to be 'owned' by the care home and, to a lesser extent, his General Practitioner with little involvement from other professionals or organisations. As a result, there did not appear to have been any concerns raised, conversations with or the involvement of, other professionals and specialist services in order to better support Luke until his health had deteriorated very significantly.
- Overall, the documentation of Luke's wound care by the care home was poor leading to gaps in records. Recording practice should be founded on a position that if something hasn't been recorded it didn't happen, and tested through auditing processes.

- The dressings on Luke's wounds should have been applied in a way that made it less likely that he would access the wounds given the known risks of his picking at/infecting them.
- The Somerset Diabetes Foot Integrated Pathway should be followed at all times. During the autumn of 2017 Luke's wound was deteriorating, but no referral was made, and this was a missed opportunity for specialist input into Luke's care.

### 3. Multi-agency involvement in Luke's care and support

- Opportunities were missed to initiate a multi-disciplinary discussion. This would have allowed concerns to be shared which don't appear to have been, as well as alternative approaches to be considered and specialist referrals made as required.
- There will always be the inherent risk of an individual 'falling through the cracks' in any process that assumes that another professional and/or organisation will take-over responsibility for a case where there has been no hand-over. While such a hand-over need not be bureaucratic there does, as a minimum, need to be a discussion between the releasing and accepting professionals/organisations. Confirmation that hand-over has been agreed and the date on which it takes place should then be recorded.
- NHS Somerset's Continuing Health Care (CHC) Team do not provide a care management function for people who are in receipt of Funded Nursing Care and the responsibilities of the registered nurses within a care home therefore include the identification of any new or changing health need, along with making an onward referral to the appropriate health service; either directly with that service or where appropriate through the general practice. If the care home is not content with the response from a health service, they can escalate to the manager of a service, General Practitioner or where appropriate through the Patient Advice and Liaison Service (PALS).

### 4. Luke's weight

- When recording information about an individual's weight, all providers of residential care and nursing care operating in Somerset should record the actual weight and the unit of measurement at the time of documenting the calculation, as well as the BMI, in order to mitigate against the potential for mathematical errors in calculations. Where someone cannot be weighed physically, and the Measuring mid-Upper Arm Circumference (MUAC) is used in place of the individual's weight, the measurement should be recorded. In addition, if an adult's BMI is requested by a General Practitioner or other health professional, their weight should also be provided alongside the BMI, or if the MUAC has been provided in place of the BMI then this should be clearly stated.

### 5. Disclosure made by Luke

- The disclosure should have been referred to Somerset County Council's Children's Social Care Service at the time. While the ages of the children allegedly involved and the small amount of information which Luke provided does not indicate whether this was persistent harmful or exploratory childhood behaviour, a referral should have been made so that it could be considered in context with any other information available and assessed.

## Further information

- **Read the Review**
- **Read the one-page briefing**

# Local: Damien

## Background

Damien (pseudonym) died aged 33. Damien had a long history of contact with mental health services, and had diagnoses of Asperger's Syndrome and Attention Deficit Hyperactivity Disorder (ADHD). He had a learning difficulty, misused a variety of substances, and his vulnerability was exploited by others who stole from him and misused his home for their own purposes. Trying to meet the dual requirements of protecting both the public and Damien from harm, at the same time as allowing him to live his own life with as few restrictions as possible, tested services in Somerset. Damien died in hospital in July 2015 as a result of an attempt to take his own life, and had been discharged from an acute mental health ward to a residential care home two weeks prior to his death. In the last fifteen months of his life, he was detained under Section 2 of the Mental Health Act on three occasions.

A Safeguarding Adults Review was originally completed in 2016, but was never published and an extension was commissioned following new information emerging from a Coronial process in 2018. The new extended report superseded the original and has been published in full.

## Key considerations for practice identified in the review

### 1. Finding appropriate accommodation

It may be difficult to identify appropriate accommodation for people with complex needs who are being discharged from an acute mental health service. The review identified that professionals should consider the following:

- Who decides (or how is a decision made) that a placement is able to provide appropriate care?
- What checks can be carried out to assess suitability and what information is available to guide professionals involved in the process? For example, perhaps with the Care Quality Commission (including reading inspection reports) or with commissioners. How might practitioners assess the suitability of possible new placements?
- What is regarded as good practice in identifying and securing a placement?
- Who should visit possible placements?

Once a placement has been identified the discharge process should not be unnecessarily delayed by the process of securing funding. The pathways for securing funding should be clearly understood and timely. It should also be shared with all those who are relevant including the adult and their family (where the adult agrees, or if in the adult's best interests if they are unable to make a decision about family involvement). The delay and difficulty in finding an appropriate place for Damien to live during his last admission to hospital sits in a context of several different types of accommodation over the years, some of which were more successful than others, and from which learning could have been drawn to inform future placements.

With regard to the involvement of the adult in the process of identifying appropriate accommodation, it will be important to determine the lawful basis on which the person will live there in order that their right to liberty is upheld. Is this with the person's consent? Is the person required to reside in a certain setting because of lawful requirements under the Mental

Health Act? If not, and if there is doubt that the person has the capacity to consent to the living arrangements, it will therefore be necessary to formally assess that person's mental capacity to make decisions when there are signs that their decisional capacity might be impaired and, if the individual is assessed as lacking the capacity to make decisions about their placement, to implement a best interests decision-making process.

### 2. Discharge/ transfer of care processes

When the care of people with complex needs is transferred to a placement outside of an acute mental health service the following need to be considered:

- Ongoing monitoring/ follow up: who by and when
- The daily activities that the individual needs, and the help that the individual needs in respect of these daily activities
- The pace of discharge and whether a phased discharge would be appropriate to this individual's needs
- Where the individual has agreed to family involvement, or if they lack capacity to make a decision about family involvement and it has been decided that family involvement is in their best interests, how the family (and who in the family) will be included in the process of transferring care.

### 3. Mental capacity assessments

Adults with complex needs and/ or subject to coercion and exploitation may not have the capacity to make some major decisions, and it may be advisable where there is doubt or conflicting information regarding mental capacity in relation to a particular decision to carry out and document a mental capacity assessment. Should assessment find that a person does not have capacity in relation to a particular decision, this does not mean that the person's wishes and preferences will not be respected, as they should be taken account of in Best Interests decisions.

### 4. Risk assessment and risk management processes

The risk assessment process in Damien's case after his care was transferred did not take account of incidents that were happening in the placement. These incidents were not communicated to the relevant mental health professionals.

A contributory factor in this lack of communication may have been that some assessments took place over the telephone.

### 5. Keeping high-risk adults safe from exploitation

Damien's vulnerability to coercion and exploitation was recognised as a risk but there was no plan to safeguard him. While Damien had a learning difficulty rather than disability, these factors and their impact on the behaviours he exhibited should still have been recognised.

The Royal College of Psychiatrists 2014 document[3] "Good practice in the management of autism (including Asperger syndrome) in adults" has a section on offending behaviour which is relevant to Damien and one pertinent point is included below:

"A naive misinterpretation of social relationships may leave an individual open to being drawn into illicit relationships as well as to intimidation and exploitation. Limited emotional

[3] See **https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr191.pdf?sfvrsn=4cd65cde_2&sfvrsn=4cd65cde_2**

knowledge can hinder the development of a mature understanding of adult situations and relationships so that, for example, feelings of social attraction or friendship are misinterpreted as the stronger emotion of love".

6. **Partnership working, communication with/ involvement of family and holistic assessment**
   Damien's family identified a lack of communication with them and were not involved in key decisions, particularly those relating to transfer of care and risk assessment/ risk management. They identified a lack of holistic assessment, in particular that Damien's strengths and vulnerability to exploitation were not addressed, and that care plans did not capture Damien as an individual.
   A learning point for all professionals is to encourage discussions with people with complex needs about who they would like to be involved, and to what extent.

## Further information

- **Read the Review**
- **Read the one-page briefing**

## Local: Domestic Homicide Reviews

Since the publication of our last newsletter that Safer Somerset Partnership has published six Domestic Homicide Reviews and case summaries. You can read the reports here: **Domestic Homicide Reviews – Somerset Survivors**


# Learning from Children's Services

We encourage our readers to have a look at the **latest newsletter** to be issued by the

Their latest Learning Bulletin, **'Things You Should Know'**, focuses on what we can learn from examples of good practice and includes a recent safeguarding conversation, and a case study providing a family with early help.

# Local & National News and Headlines


- **Watch out for scams related to NHS Test and Trace** (July 2021)
- **Scam at first sight: Criminals target those looking for love with bogus investment opportunities** (July 2021)
- Avon & Somerset Police: **New partnership helps police protect victims targeted by fraudsters in gift card scams** (July 2021)
- Somerset County Gazette: **Scammers, pretending to be from Lifeline, target elderly residents in Sedgemoor** (July 2021)

- Department of Health and Social Care: **Bridging The Gap: Transitional Safeguarding And The Role Of Social Work With Adults** (June 2021)
- Home Office: **Ask for ANI and Safe Spaces schemes: promotional materials** (June 2021)
- Business in the Community: **Domestic Abuse: a toolkit for employers** (June 2021)
- **Warning about scam calls from "matching" mobile phone numbers** (June 2021)
- **Scams warning for tax credits customers** (June 2021)
- National Institute for Health and Care Excellence: **Good practice in safeguarding training** (June 2021)
- Care Quality Commission: **A new strategy for the changing world of health and social care - CQC's strategy from 2021** (May 2021)
- **New figures reveal victims lost over £63m to investment fraud scams on social media** (May 2021)
- Disclosure and Barring Service: **DBS has created faith-specific guidance around DBS checks** (May 2021)
- **Warning from Action Fraud to #ProtectYourPension as £1.8 million lost to pension fraud so far this year** (April 2021)
- Avon & Somerset Police: **Phone fraud warning after incidents reported in Somerset** (March 2021)
- Local Government Association: **COVID-19 and safeguarding adults: resource pack** (February 2021)
- Somerset County Gazette: **Somerset worst hit area in UK - cybercrime study** (January 2021)
- Business in the Community: **Health and Wellbeing at Work Summary Toolkit** (January 2021)
- University of Bristol: **Findings from LeDeR reviews 2015-2020** (November 2020)
- Social Care Institute for Excellence (SCIE): **Safeguarding adults: Have we learned the lessons from Steven Hoskin's murder?** (October 2020)
- Care Quality Commission: **Out of sight – who cares?: Restraint, segregation and seclusion review** (October 2020)
- Community Care: **Council failed to consider human rights of couple it separated after 59 years together, says watchdog** (September 2020)
- Disclosure and Barring Service: **DBS launches new five-year strategy** (September 2020)
- Safer Somerset Partnership : **Spot 'County Lines' and stop the crime -and the exploitation** (September 2020)
- Ann Craft Trust: **Our Safeguarding Checklist- A Free Assessment** (August 2020)
- NICE: **Decision making and mental capacity** (August 2020)
- **Somerset and Avon Rape and Sexual Abuse Support (SARSAS) publishes easy read guides** (July 2020)
- Which: **Phone scammer stole £80,000** (July 2020)

# Training and Development

It is the responsibility of all organisations to ensure they have a skilled and competent workforce who are able to take on the roles and responsibilities required to protect adults at risk and ensure an appropriate response when adult abuse or neglect does occur. The SSAB does not provide any single or multi-agency training but has published a **Somerset Adult Safeguarding Learning Framework**.

**Social Care Institute for Excellence: e-learning** **(please note that SCIE are now charging for this content)**

- **e-learning: Adult Safeguarding Resource**
- **e-learning: Mental Capacity Act**

**Other resources**

- **FutureLearn Safeguarding Adults Level 3 Training**
- **Friends Against Scams Practitioner E-Learning**
- **Health Education England e-Learning Mental Capacity Act e-Learning**
- **Unseen Modern Slavery training**
- **Home Office Prevent e-learning**
- **Home Office FGM (Female Genital Mutilation) e-learning**

**Real Safeguarding Stories** is a learning tool dedicated to raising awareness of safeguarding issues. By telling compelling stories based upon real life events, it helps professionals understand these complex issues. Understanding and relating to these stories is the first step towards individuals and organisations being better able to support those at risk. On this website you will find a series of videos, each exploring different aspects of safeguarding – including child and adult safeguarding, and domestic abuse. These are based on the experiences of professionals working in the field and from interviews with victims of abuse. The videos are then scripted and filmed using actors in a realistic context, with each video supported by guidance to support wider training or awareness activity. Visit: **http://realsafeguardingstories.com/**

# Useful Safeguarding Adults Links

- **Secure professionals e-referral form**
- **Joint Safeguarding Adults Policy**
- **Somerset Adult Safeguarding Guidance**
- **Practice guidance and resources**
- **Get the SSAB Website on your phone or tablet**
- **National Safeguarding Adults Review (SAR) Library**

## Get in touch

If you have any suggestions for future topics or comments about this newsletter, please contact us via:

**ssab@somerset.gov.uk**

(Please do not use this address to submit safeguarding alerts or case queries)

Alternatively call our Business Manager, Stephen Miles, on: **01823 359157**

**If you are worried about a vulnerable adult, don't stay silent**

**Phone: 0300 123 2224**
**Email: adults@somerset.gov.uk**

Or complete a secure
**Professionals e-referral form**

In an emergency always contact the police by dialling 999.
If it is not an emergency, dial 101

SOMERSET SAFEGUARDING ADULTS BOARD