Issue 8, August 2018

Newsletter

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

This is the 8th edition of our newsletter, and we hope those who have received copies since its launch continue to find it a useful resource and an interesting read. Since the publication of our last newsletter we have completed work on, and published, our 2018/19 Strategic Plan and will be publishing our Annual Report in early September.

Following on from information about our annual conference in our last newsletter our Learning and Development subgroup has started making plans for a future conference, which we expect to take place in early 2019. Thank you to everyone who made suggestions for future conference content, and if you have any additional suggestions please send them to ssab@somerset.gov.uk.

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 the local safeguarding community.

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

In this issue:

@SomersetSAB

News from the SSAB

Summer 2018/19

The SSAB has met once since the last newsletter was published. Highlights from the Board and Subgroups include:

- Receiving an update on progress made against recommendations since the publication of the Mendip House Safeguarding Adults Review
- Receiving an update on a thematic review of rough sleeping incidents in Taunton
- Considering changes to the format and structure of the Board
- Signing off the 2018/19 Strategic Plan and reviewing the first draft of the 2017/18 Annual Report
- Signing off a new Information Sharing Agreement and Guidance
- Endorsing the Somerset Think Family Strategy
- Publishing updated versions of Adult Safeguarding Risk Assessment tool and Service Monitoring Checklist
- Agreeing and publishing a revised annual organisational self-audit and Adult Safeguarding Guidance for the county.

SSAB Annual Self-Audit Launched

To support local organisations, the SSAB has adopted an Organisational Adult Safeguarding Self Audit Tool to help it evaluate the effectiveness of internal safeguarding arrangements, and to identify and prioritise any areas in need of further development. The tool has been reviewed by our Quality Assurance subgroup which added new questions relating to the implementation of learning identified from local Safeguarding Adult Reviews.

The tool is designed to support local organisations in their continuous improvement of adult safeguarding work.

We do not publish the results of individual organisations or use the information provided to compare organisations. Instead, areas of generic learning are identified to inform the SSAB's strategic development of safeguarding. The tool is an important component of the SSAB's Quality Assurance framework.

SSAB partner organisations are required to complete the self-audit on an annual basis and submit to the Quality Assurance subgroup for monitoring and assurance purposes. In a change to previous years the Quality Assurance subgroup is in the process of agreeing arrangements for a new 'peer challenge' element to the process that will take place during the autumn following the receipt of returned audits. This is intended to take a constructive approach to ensuring that the results are consistent and that any variations in responses are understood.

We actively encourage other agencies / bodies to complete the tool to support their adult safeguarding arrangements and identify both strengths and areas requiring development.

Further information

Read more about the audit

New Somerset Adult Safeguarding Guidance Launched

The SSAB's Policy & Procedures Subgroup has developed new web-based guidance to support adult safeguarding. This guidance replaces Somerset's Multi-Agency Adult Safeguarding Procedures and has been developed following the publication of our revised overarching Adult Safeguarding Policy in January 2018.

We all share a responsibility to act as good neighbours and citizens, and to prevent situations that can lead to abusive situations or put adults at risk of harm. The guidance sets out clearly how individuals and organisations will work together. It is for those who work with adults who may be at risk of harm, including paid or unpaid colleagues, carers, family members and members of the public. It provides information to enable adults to be kept safe from abuse or neglect and what immediate action must be taken, when required, to achieve this. All individuals and organisations who work with, or support, adults experiencing, or who are at risk of, abuse and neglect can be called upon to lead or contribute to a safeguarding concern and need to be prepared to take on this duty.

When harm does happen, it needs to be dealt with effectively, promptly and proportionately. The adult in need of safeguarding and protection should be kept at the centre of decision-making and be in control as much as is possible. Their views should be heard and respected throughout the safeguarding process.

The guidance is intended for anyone to use. We appreciate that we have at times used terms used mainly by health, social care or law enforcement professionals and have therefore added a link to our "common terms and definitions" glossary at the bottom of each page. However, if there is something that we haven't explained, or that you think we could explain better, please let us know.

By publishing this guidance as a web-based resource, we hope will be much easier and intuitive to use and give easy access to the relevant information when it is needed, and update it as a result of development of best practice and emergence of learning.

Guidance is often criticised for over-standardising practice and undervaluing the skills required when applying policies in diverse circumstances. The guidance we have published in these pages is intended to provide a 'framework' for managing safeguarding interventions that are fair and just, through strong multi-agency partnerships that provide timely and effective prevention of, and responses to, abuse and neglect, with a key focus always on using professional skills to gain a real understanding of what the adult wants to achieve and what action is required to help them to achieve it.

Further information

Read the guidance

Somerset Think Family Strategy 2018-2019

The SSAB was pleased to endorse the Somerset Think Family Strategy 2018-2019 which was formally presented to our June Board meeting.

Families are the building blocks of our communities. As well as providing for the current generation, families bring up the children who will be the future of Somerset.

In the majority of cases, families provide the positive nurturing, learning and care needed to enable children to lead healthy and happy lives. Good parenting leads to improved attainment, resilience, healthy lifestyles, confidence and feelings of self-worth. Through the provision of effective universal services in the community, such as GP and other community health services, good child care, nursery and school education, most families will flourish.

Some families, however, need extra support. Too often cycles of intergenerational disadvantage can become established in families. Children and young people's problematic behaviour in school or the community has traditionally been treated as a child-specific issue, rather than one caused by unmet parental need such as mental health, substance misuse, domestic abuse (hidden harm) or broader social circumstances such as housing and debt. This strategy focuses specifically on the needs of these families.

What is Think Family?

It is recognised that where families have multiple and complex needs, historically services have worked in isolation of each other. 'Thinking Family' means taking a broader view by ensuring that all members of the household and their wider community are able to get the support they need, at the right time, to enable them to achieve positive changes and improve their lives. It means making sure that families receive integrated, coordinated, multi-agency, solution focused support. By identifying problems early, all services can work closely together to help prevent a family's needs escalating and requiring more intensive, specialist intervention. This means breaking down multi-agency barriers, facilitating better communication between professionals and smoothing the journey for families with complex needs. By taking an integrated approach, we will meet needs in a more effective and efficient way. Practitioners who work in partnership with families are able to recognise their strengths and promote resilience to build their capabilities.

The aim of the strategy

The aim of the strategy is to encourage all partners to 'Think Family' and actively work together to secure better outcomes for children, young people and their families across Somerset.

Think Family: The Principles

- early Intervention and 'no wrong door'
- good inter-agency working
- promotion of resilience and wellbeing to improve their lives
- build on families' strengths
- practitioners have the knowledge and confidence to support families with a range of issues without having to 'refer on' to others

Further information

Read the strategy

Business Manager Blog

As a partnership the SSAB rightly puts a big emphasis on learning. I am pleased, therefore, that we have been able to include information about the new National Safeguarding Adults Review library that has been launched in this issue of our newsletter, and which I hope will grow and develop as SABs across the country contribute their learning to it.

Our learning also helps us develop and refine guidance and I am really grateful that after a lot of hard work from colleagues in the SSAB Policy and Procedures Subgroup we have now published a web-based version of our local guidance. This guidance is for anyone to use and we hope that we have made it as user-friendly as possible through the use of flowcharts that link through to other documents and processes as you follow them through. We intend to further develop our guidance with additional information, and regularly update it based on emerging learning and best practice. Please let me know your thoughts or feedback.

June saw the annual 'Stop Adult Abuse Week' take place across the Avon & Somerset Constabulary area, which the SSAB once again contributed to, this year focusing on information on identifying abuse and making referrals. Other SABs in the area highlighted areas of work ranging from modern slavery to coercive control, with colleagues in North Somerset including their own local learning from the Mendip House SAR that the SSAB published earlier this year. Since this publication we have been working hard to pursue the national recommendations, including writing to the Department of Health and Social Care which resulted in a meeting in June. In terms of our response locally, we have continued to pursue seek assurance in relation to placements made by or on behalf of Somerset commissioners. We will also be writing to all regulated providers of residential and nursing care services operating in Somerset in September requesting information on placements made by commissioners external to Somerset.

Finally, we look forward to presenting our annual report to Somerset County Council's Scrutiny for Policies, Adults and Health Committee on 05/09/2018, for which papers will be published at the end of August, and beginning the process to develop our new Strategic Plan during the autumn.

I look forward to continuing to work with you and the Board

Stop Adult Abuse Week 2018

As in previous years each Safeguarding Adult Board in the Avon and Somerset Constabulary area undertook to promote a different area of safeguarding work to maximise the reach of this work during 'Stop Adult Abuse Week'

with the SSAB focussing on information for care and support providers. This included:

- Learning from serious cases
- Spotting the signs, symptoms and indicators of abuse
- Information on how to Recognise, Respond, Record and Report abuse
- Information about the types and locations of risk seen in Somerset.

During the week we also promoted

- Presentations from our recent conference
- Our risk threshold tool
- Our service monitoring tool

Highlights from other SABs included:

- Bath and North East Somerset: Think Family
- Bristol: Mate Crime, which included the launch of a useful leaflet
- South Gloucestershire: Coercive Control
- North Somerset: Domestic abuse, modern slavery and local learning from the Mendip House Safeguarding Adults Review

Learning Lessons

National: National Safeguarding Adult Review Library Launched

A new national library has been launched for Safeguarding Adults Reviews (SARs). The library currently contains 96 reviews and will be updated regularly to contain reports and associated resources to support those involved in commissioning, conducting and quality assuring SARs. All Safeguarding Adult Boards have been asked to provide copies of Reviews and information that supports their categorisation.

SARs are a statutory requirement for Safeguarding Adults Boards which are intended to inform adult safeguarding improvement. They can identify what is helping and what is hindering safeguarding work, to tackle barriers to good practice.

Most of the reviews of serious incidents that the SSAB has published were Serious Case Reviews, which have now been replaced by SARs. This means that currently the library contains one review from the SSAB, Mendip House. We are committed to supporting the library as well as making use of the resources it contains to supporting local learning as it continues to develop. We will also continue to publicise Reviews that are undertaken nationally that we feel have particular relevance for local learning.

Commissioned by the Department of Health and Social Care, the library has been developed jointly by Research in Practice for Adults (RiPfA) and Social Care Institute for Excellence (SCIE), working closely with colleagues from the sector.

Further information

Register to access the library (free)

Regional: 'Kamil and Mr X' SAR published by Bristol Safeguarding Adults Board

Background

In 2016, Kamil Ahmad, a Kurdish male who arrived in the UK as an asylum seeker, was murdered by Mr X, a white British male. Both men were residents in the same supported accommodation provided for individuals with mental health needs.

Kamil had been living in the shared accommodation since 2013. In the years they had lived in the same provision, Mr X had racially abused and physically assaulted Kamil on a number of occasions. The fatal assault occurred soon after Mr X had been discharged from hospital where he had been detained under Section 2 of the Mental Health Act after Mr X had made an application for a Mental Health Tribunal to review his detention. The Tribunal made its decision without receiving reports reflecting the views of Mr X's brother, the Community Psychiatric Consultant, or the supported accommodation. The decision was made that Mr X was to be discharged with a week's notice – this date was chosen to allow for accommodation arrangements to be made.

In the event discharge planning was only initiated by Mr X's Care Coordinator the day before and so the landlords were unable to coordinate the legal paperwork for an injunction or begin the eviction process before his discharge. The accommodation provider was not informed of the timing of Mr X's discharge from hospital until an hour before it happened. Contingency plans were rapidly put in place to advise female tenants (but not Kamil) of his potential return and alert the on-call manager. The Police were not informed and had not received any information regarding Mr X's progress since he moved hospital. Mr X was formally discharged on 6th July. That evening he visited several pubs and consumed a large quantity of alcohol before returning to the accommodation. At 1:30am he telephoned the AWP Crisis Team stating that he had drunk a litre of rum and felt like punching an Asian resident who lived in the same accommodation. Mr X became angry when told he would be held responsible for his actions and said that he was 'insane and wasn't responsible' before ending the call. The Crisis Team contacted the Police using the 101 non-emergency number just after 2:00am, less than 10 minutes later Mr X called the Police stating that he had murdered Kamil.

The SAR found that Kamil's murder could have been avoided.

Learning identified by Bristol Safeguarding Adults Board

- Multi-agency safety plans should consider impact of medication changes on behaviour particularly considering previous reactions to medication change
- Alcohol use should be robustly assessed and reviewed as part of care plan even if the individual is refusing to engage with specialist services
- Safeguarding enquiries and care act assessments should include relevant voluntary and community sector services including, where relevant, services for refugee and asylum seekers
- Hate crime assessments should recognise the increased risk when victims of hate crime live within same provision as a perpetrator
- Perpetrator/s of hate crime using language such as 'paedophile' or 'terrorist' should be warning signs of increased risk to victims
- Victim care services should offer a flexible tailored approach to enhanced victims, particularly recognising the needs of those for whom English is not their first language or where there may be additional barriers such as in the case of refugees and asylum seekers

Best practice identified by Bristol Safeguarding Adults Board

Multi-agency safety plans should consider impact of medication changes on behaviour particularly considering previous reactions to medication change

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Further information

Read the Review

Local: Jointly commissioned Safer Somerset Partnership / Safer Communities Torbay Domestic Homicide Review

Background

The review examines the circumstances surrounding the death of Eleanor (pseudonym) who was 53 years of age and had lived in Somerset for many years. Eleanor was a single lady who took her own life. She had been known to Mental Health services in the Somerset area since 1993 and the Somerset Drug and Alcohol Support Service for a number of years also.

Safer Somerset Partnership
Feel Safe, Be Safe

Eleanor had been in a relationship with Harry (pseudonym) for 8 months and the relationship ended in September 2014. Eleanor expressed to her support workers at the Somerset Drug and Alcohol Service that she felt she was being stalked. Paladin, a national stalking support service, became involved because Eleanor was signposted to this agency by her support workers. She told these two services that Harry was leaving her notes, knocking on the door pressurising her to answer the door, breaking into her property and tampering with her personal items.

Eleanor's accommodation at the time of her death was a safe house provided by Torbay Domestic Abuse Service in Devon. Before moving to Torbay Eleanor completed a course with the Somerset Drug and Alcohol Support Service and had abstained from taking any substances. Eleanor had difficulty in registering with a GP in the Torbay area because she did not have any identification. As a result of this the Mental Health service; Devon Partnership could also not offer her support immediately until a referral had been made by a GP in Torbay.

At the end of July 2015 Eleanor drove to Somerset to visit some family members. Whilst in the area she attended a Somerset Drug and Alcohol Service office. Professionals from this service alerted Devon Partnership with concerns over her wellbeing because she seemed 'dishevelled and acting out of character'. They had concerns over her drug and alcohol misuse. On the same day Harry attended the court assessment and advice service where he was re-bailed for an offence where

Eleanor was not the victim; however it is understood by agencies supporting Eleanor that she knew about this offence.

On 21/07/2015 Eleanor voluntarily agreed to go to hospital where a mental health assessment was undertaken. The outcome of this assessment was that she did not meet the criteria for admission, however would be kept in overnight to be re-assessed in the morning because she was still experiencing the effects of a psychoactive substance. Eleanor was discharged on 01/08/2015 and advised that the Crisis Resolution Home Treatment Team would be supporting her from now on, and which visited her on 02/08/2015 and 03/08/2015. On 04/08/2015 the Crisis Resolution Home Treatment Team attempted to make contact with Eleanor via phone on two occasions. The same team also attempted to visit Eleanor also but to no avail. Torbay Domestic Abuse Service also attempted to make contact several times on this day. On 05/08/2015, due to no successful contact being made by either service, the Torbay Domestic Abuse Service gained entry to undertake a welfare check and found Eleanor deceased

Conclusions of the Review Panel

- Was Eleanor's death predictable?
  - Eleanor had a history of self harming, misusing alcohol and taking overdoses, which could be regarded as suicide attempts, and this was known by the numerous agencies; GP practice in Somerset, the Somerset Drug and Alcohol Service and Somerset Partnership NHS Foundation Trust.
  - Eleanor's mental health diagnosis was that of bipolar disorder and that she experienced paranoid delusions when depressed. Between June 2015 and August 2015 when she moved from Somerset to Torbay there was no evidence to suggest that Harry was still in touch with Eleanor, however Eleanor's behaviour on 31/07/2015 following a visit to Somerset on 30/07/2015 was described as 'out of character' and the report states that 'one might argue that some contact may have taken place either directly or indirectly during this time'.
  - There was a deterioration of Eleanor's mental health at the end of July 2015. A number of mental health assessments were undertaken by Devon Partnership Trust, however these concluded that there was no acute mental health illness.
  - The Review Panel concluded that given the information above and her history it was predictable Eleanor would attempt to take her own life again quite soon, however it was not foreseen that she would do so in the way that she did.
- Could Eleanor's death have been prevented?
  - The Review Panel concluded that 'following the robust mental health assessments undertaken Eleanor was not deemed to have such mental ill-health that she required in-patient services therefore her death could not have been prevented. Had Eleanor been deemed suitable for inpatient mental health services this may have reduced the likelihood of it happening of her taking her own life but the Panel believe it would not have eliminated the risk completely. Communication could have been improved between the two main service providers supporting Eleanor during this difficult time; Torbay Domestic Abuse Support Service and Devon Partnership Trust however the Panel did not feel that this communication could have prevented Eleanor taking her own life'

Recommendations of the Review Panel

- Torbay Domestic Abuse Service
  - This agency should link with the local GP practices in close proximity to their safe houses/refuge and build a rapport with the practice in order that the domestic abuse service

can become more familiar with the practice. The aim is also so that the GP practices can assist new arrivals with GP registration at the earliest opportunity, recognizing that the individuals may not always have personal identification with them and that this should not impact on their access to healthcare. This recommendation is also applicable to Somerset Integrated Domestic Abuse Support Service also.
    - This agency and the Devon Partnership should develop a joint working protocol outlining how they will work together when they are supporting the same individuals.
    - All referrals into their service for temporary accommodation should be advised to bring identification with them and at least one month's supply of medication (If medically safe) or a record of the medication in order that support can be ascertained from the new local GP practice for assistance to prevent a deterioration in their health.
- Somerset Integrated Domestic Abuse Service
    - When making a referral, which involves a victim with multiple needs, the referring agency must ensure that as much detail is shared with the new agency in order to support the transition including consideration for travelling to the new service with medication, identification etc... In addition this would include details of any drug and alcohol related misuse and mental health issues and the contact details of these services, in order that the new agency can directly link with the support worker from the old service for information. Within Somerset, this is part of a Joint Working 'Multiple Needs' Protocol which needs revising in order to reflect the importance of key information, contact details and to enable a seamless transition between services.
- MARAC (Somerset)
    - MARAC Protocol to be refreshed and circulated to all partners reminding them that their agreement to this process stipulates that actions should be completed in a timely fashion. Where actions are not completed; the MARAC Chair and Coordinator should be informed of the rationale at the earliest opportunity.
    - An action should only be given to those agencies physically present at the MARAC meeting who understand the context and ask of the action. Where this is not possible, actions can be suggested and then followed up outside of the MARAC meeting by the MARAC Coordinator to the proposed action owner.
- MARAC (Somerset and Torbay) OFFICIAL
    - Both forums to consider what processes are in place to discuss high risk victims of stalking when they are not familial or partner/ex-partner cases e.g. consideration of the Hampshire model. Avon and Somerset Constabulary
    - To consider developing and implementing a training scheme relating to stalking and harassment in order to ensure that officers and staff feel confident in dealing with complaints of this nature, and understand the separate offences of stalking and harassment.
    - To raise awareness of these issues by identifying champions for these issues across the police force similarly to that already undertaken by Devon and Cornwall Constabulary.
- NHS England
    - To consider nationally whether MARAC victims can be added to the exemptions for immediate referrals to and acceptance by mental health crisis teams instead of insisting upon a GP referral.

Further information

Read the full report

Learning from Children's Services

We encourage our readers to have a look at the latest newsletter to be issued by the Somerset Safeguarding Children Board.

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.

National News and Headlines

August 2018

- New guidance published by the Royal College of Nursing on behalf of Royal Colleges and professional bodies aims to improve the safeguarding of adults
- BBC: "Pension scam victims 'lost £91,000 each"
- Department of Health and Social Care has developed a short survey aimed at care workers to ascertain their motivations for working in the caring profession
- Ministry of Housing, Communities & Local Government launches rough sleeping strategy
- The Prince's Responsible Business Network launches a domestic abuse a toolkit for employers
- BBC Broadcasts documentary about a prosecution under the slavery Act (2015). Available on iPlayer until 14/09/2018

July 2018

- LGA launches social care "Green Paper"
- Unseen launches app to report modern slavery
- "Emerging Concerns Protocol" signed by eight health and social care regulators
- BBC: Dixons Carphone says data breach affected 10 million customers
- Government publishes Mental Capacity (Amendment) Bill
- Mental Capacity Law and Policy: "Supreme Court confirms that no need to go to court before treatment withdrawal where doctors and family agree"
- British Journal of Social Work publishes a special Issue: Elder Abuse & Social Work: Research, Theory and Practice
- New online form launched by Avon & Somerset Police to provide intelligence or information that you think they should be aware of if you believe a child or adult is vulnerable or being exploited
- HMICFRS published 'Understanding the difference: the initial police response to hate crime.
- CQC publishes "Beyond barriers: how older people move between health and care in England"

June 2018

- New learning disabilities improvement standards for NHS trusts published by NHS Improvement

- The Safer Somerset Partnership publishes the 12th edition of its Domestic Abuse Newsletter
- The Somerset Health and Wellbeing Board publishes its annual report
- Community Care: "Key advice on providing written evidence to the Court of Protection"
- CQC survey "shows some improvements in people's hospital experiences but highlights concerns around discharge and inequalities for those with mental health condition"
- The Telegraph: "Forty per cent rise in care home residents being evicted because of closures"
- New guidance on contingency planning published today by the Care Provider Alliance
- 39 Essex Chambers Mental Capacity Report – June 2018
- CQC publishes "Driving improvement: Case studies from nine adult social care services"

May 2018

- The Week "Nail salons used as a front for modern slavery"
- British Institute of Human Rights publishes Learning Disability & Autism Guide
- Birmingham Safeguarding Adults Board publishes Youtube Video: "Alan's Story Safeguarding from financial abuse"
- Chartered Institute for Building publishes "Construction and the Modern Slavery Act"
- Which?: "Stay clued up: eight biggest scams of 2018
- Care Provider Alliance, in collaboration with the Social Care Programme at NHS Digital, publishes "An Introduction to Cyber Security"
- Learning disability mortality review (LeDeR) interim report published
- Public Accounts Committee "Modern Slavery: co-ordinated action critical to helping victims"

April

- Healthwatch England publishes 2018 – 2023 strategy
- NICE publishes guidance on care and support of people growing older with learning disabilities
- Anti-Trafficking Review highlights the deficiencies of protection systems for survivors of human trafficking
- West Sussex Safeguarding Adults Board publishes Safeguarding Adults Review regarding the responses of agencies to 'unusual' injuries suffered by two people with learning difficulties living at a care home
- The Guardian: "More than 10% of women killed by a partner or ex-partner are aged 66 or over but they are the group least likely to leave their abuser and seek help"
- NHS England "Peter is living the life he chooses thanks to STOMP"
- Independent Inquiry into Child Sexual Abuse publishes Interim Report
- The Safer Somerset Partnership publishes the 5th edition of its newsletter
- National evaluation of the Troubled Families Programme 2015 to 2020: interim findings
- Independent: "Thousands of older people at risk of malnutrition and dehydration at inadequate care homes"

March

- CQC: "Wide variation uncovered in how NHS and local authorities work together when applying the Mental Health Act"
- NICE: "Care for people with learning disabilities should be close to home wherever possible"
- Useful factsheet produced by National FGM Centre
- Sentencing remarks published in R v Southern Health NHS Foundation Trust
- Bristol Safeguarding Adults Board publishes Mate Crime Thematic Review

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.

Social Care Institute for Excellence: e-learning

(please note that SCIE have recently begun charging for this content)

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

Other resources

- 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/

Get in touch

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

ssab@somerset.gov.uk

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