Somerset Safeguarding Adults Board:
PRESS RELEASE
Review recommends improvements following death of Somerset resident

A series of recommendations have been made by the Somerset Safeguarding Adults Board (SSAB) following the death of a Somerset resident.

The recommendations are shared in a report published today (22nd July 2025) which documents the situation of Juliet (pseudonym), who had been living primarily at her partner's address for several years, but also had her own tenancy in Taunton, but she stayed in this property only intermittently. Partner agencies became concerned that Juliet was experiencing domestic abuse in the form of violence which often arose when she refused his demands for sexual intercourse. There was also concern that Juliet was experiencing coercion and control and it also appeared that she was being financially exploited.

Juliet had been dependent on alcohol for several years which appeared to be a factor in her self-neglect. At times, her alcohol dependency also appeared to be a barrier to Adult Social Care acknowledging that she may have care and support needs. In addition to alcohol dependence, Juliet experienced depression, was a heavy smoker, she was diagnosed with Chronic Obstructive Pulmonary Disease and was registered partially sighted in 1995.

The Police obtained a Domestic Violence Protection Order which prevented her partner from abusing Juliet for a time. However, Juliet tended to gravitate back to him and the risks which arose from her relationship with him, continued until her death.

The review made 12 recommendations, which highlight improvements that could be made in the way information is recorded and shared across the health and social care system, the report makes recommendations, including:

- That a Multi-Agency Risk Assessment Conference (MARAC) should consider the option of requesting a professionals meeting to be held in complex cases, particularly where a victim with complex needs is repeatedly being referred back to MARAC. When requesting a professionals meeting, the MARAC should identify a lead agency and preferably a co-ordinating worker.
- That Somerset NHS Foundation Trust ensures that the High Intensity User Group (HIUG) criteria are consistently applied and that the grounds for deciding that a person does not meet the criteria for HIUG comply with policy and are fully

documented. The Trust should conduct an audit of referrals to HIUG which are declined on the grounds that they do not meet the criteria.

- That NHS Somerset Integrated Care Board obtains assurance that GP practices provide regular dedicated time to discuss adult patients about whom there are safeguarding concerns, these are robustly recorded and that a register is kept to ensure ongoing monitoring of such cases.
- That Avon and Somerset Police provides a report to Somerset Safeguarding Adults Board setting out their efforts to improve the quality of rape investigations including consideration of the support provided to victims with protected characteristics and victims who appear alcohol dependent.
- That Somerset Safeguarding Adults Board reviews the options for the management of chronic dependent drinkers recommended by Safeguarding Vulnerable Dependant Drinkers England and Wales and considers which option(s) should be implemented across Somerset.
- That the Safer Somerset Partnership considers how best to increase professional awareness of the services which provide support to perpetrators of domestic abuse and how to refer or encourage self-referral to these services.
- That Somerset Adult Social Care should reinforce the requirement to check the records the service holds of any person who is the subject of a safeguarding referral, so that an informed decision can be made about whether the person appears to have care and support needs.
- That Somerset Safeguarding Adults Board write to NHS England to propose that they develop an e-learning module on the impact of acute and longitudinal alcohol use on mental capacity for delivery locally.

The learning from this review will be shared with the NHS Integrated Care Board (ICB), Somerset NHS Foundation Trust, South Western Ambulance Service, Housing Services and Associations, Somerset Council's Adult Social Care, Safer Somerset Partnership and the Police.

Professor Michael Preston-Shoot, Independent Chair of the SSAB said:

> "Juliet's sad story has highlighted that further work is required to share information across the Somerset organisations to safeguard those with care and support needs. I am pleased to see that the organisations involved were open to these improvements and lessons have been learned. Safeguarding Adult Reviews are fundamental to how agencies learn to improve their safeguarding practices for those who need their support. It is now incumbent on the Somerset Safeguarding Adult Board to ensure the recommendations from this review become common practice, so that those people in similar circumstances to Juliet can receive the help they need and deserve."

The Somerset Safeguarding Adults Board is made up of all the organisations which have a role in preventing the neglect and abuse of adults, including: Somerset Council, Somerset

NHS Integrated Care Board, Avon & Somerset Police, Somerset NHS Foundation Trust, Housing Associations, Care Providers, the Probation Service and Healthwatch Somerset.

For more information about the SSAB and a copy of the report visit www.ssab.safeguardingsomerset.org.uk

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Notes to editors