Annual Report 2025-2026

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1. Foreword

Producing an annual report is a statutory duty for a Safeguarding Adults Board and is an effective way of monitoring progress against a Board's strategic plan. The work highlighted in this annual report has taken place at a time of some turbulence, with changes in senior leadership and organisational arrangements for some partner agencies, increases in volume and complexity of adult safeguarding in a context of financial austerity the proposed national abolition of Healthwatch, the voice of service users and patients, and restructuring of ICBs. Nonetheless, this annual report provides evidence of how health, housing and social care statutory and third sector services have endeavoured to keep people safe from abuse/neglect.

Safeguarding Adults Reviews (SARs) continue to be a primary focus for the Board. The annual report provides details of the referrals received, the human stories that are being explored, and the outcomes and impact of completed and published reviews. The Board continues to prioritise evaluating the outcomes of SAR recommendations, holding for instance summits on homelessness, self-neglect and on organisational abuse to focus again on awareness, prevention of and responses to closed cultures.

The Board contributed to the local authority's preparation for CQC assessment, with a specific focus on the effectiveness of adult safeguarding. This has provided a further opportunity for reflection and review. CQC's report has been published (June 2026) and next year's annual report will detail how its findings have informed a refresh of the Board's strategic plan.

The Board's mandate includes seeking assurance from partners that local safeguarding arrangements are managed effectively. In addition to quarterly performance reports, a summary of which is included in this annual report, the Board has received assurance reports on mental health, out of authority placements, and suicide prevention. The Board has also focused on all-age exploitation, transitional safeguarding for care-experienced young people, the effectiveness of multi-agency risk management meetings, and hospital discharge.

A significant amount of work has been carried out by members of the SAB's sub-groups, details of which also appear in this report. We recognise that there is more work to do, to embed fully the lessons from safeguarding adults reviews and the findings from CQC assessment, to engage further with people with lived experience of safeguarding, to encourage an all-age approach to safeguarding, and to use data held by all partner agencies to inform the work of the Board. As always, we would welcome your feedback on this annual report and your feedback on how we can improve adult safeguarding to ensure that the people of Somerset live free from abuse and neglect.

Professor Michael Preston-Shoot, Independent Chair
Somerset Safeguarding Adults Board

2. Introduction

The Somerset Safeguarding Adults Board (SSAB or "the Board") is required under the Care Act 2014 to produce an annual report each year.

The report must set out what we have done during the last year to help and protect adults at risk of abuse and neglect in Somerset.

Our annual report tells you:

- The profile of adult safeguarding in 2025/26
- How we have done in delivering our objectives during the year.
- The findings and impact of any Safeguarding Adults Reviews we carried out.
- The contributions of our member organisations to adult safeguarding.
- Our priorities looking forward.

This report will be published along with a one-page summary on the SSAB website, www.ssab.safeguardingsomerset.org.uk, for all partners, interested stakeholders and members of the public to access.

As required by the Care Act, it will also be shared with the Chief Executive and Lead Member of the Local Authority, the Police and Crime Commissioner and the Chief Constable, the local Healthwatch organisation, and the Chair of the Council's Health and Wellbeing Board. A copy will also be shared with the Chief Officer of the Integrated Care Board.

It is expected that those organisations will consider the contents of the report alongside how they can improve their contributions to both safeguarding in their own organisations, networks and in partnership with the Board.

Safeguarding is everybody's business

What is adult safeguarding?

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, whilst at the Same time making sure that the adult's wellbeing is promoted.

The aims of adult safeguarding are to:

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- Stop abuse or neglect wherever possible.
- Safeguard adults in a way that supports them in making choices and having control about how they want to live.

Who is an adult at risk?

An adult at risk is someone who is over 18 years of age who, as a result of their care and support needs, may not be able to protect themselves from abuse, neglect or exploitation. Their care and support needs may be due to a mental, sensory or physical disability; age, frailty or illness; a learning disability; substance misuse; or an unpaid role as a formal/informal carer for a family member or friend.

The 6 Safeguarding Principles

The work of the SSAB is underpinned by six safeguarding principles, which apply to all sectors and settings including care and support services. The principles inform the ways we work with adults, and are: Empowerment, Prevention Proportionality, Protection, Partnership and Accountability. Read further information about the six safeguarding principles.

What is abuse?

Abuse is when someone treats an adult in a way that harms, hurts or exploits them. It can happen just once or many times; it can be done on purpose or by someone who may not realise they are doing it.

Abuse and neglect can include: Physical abuse, Domestic violence, Sexual abuse, Psychological abuse, Financial or material abuse, Discriminatory abuse, Organisational abuse, Neglect and acts of omission, Self-neglect, Modern slavery and Sexual exploitation. Read further information on the signs, symptoms and indicators of each type of abuse

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

3. The Board

The Somerset Safeguarding Adults Board (SSAB) is a statutory body responsible for protecting adults’ rights to live independent lives, free from abuse and neglect. The Board works collaboratively with partners to set the strategic direction for adult safeguarding in Somerset and seeks assurance from partners that they have appropriate and robust safeguarding arrangements in place.

This is about how we prevent abuse and respond when abuse does occur in line with the needs and wishes of the person experiencing harm.

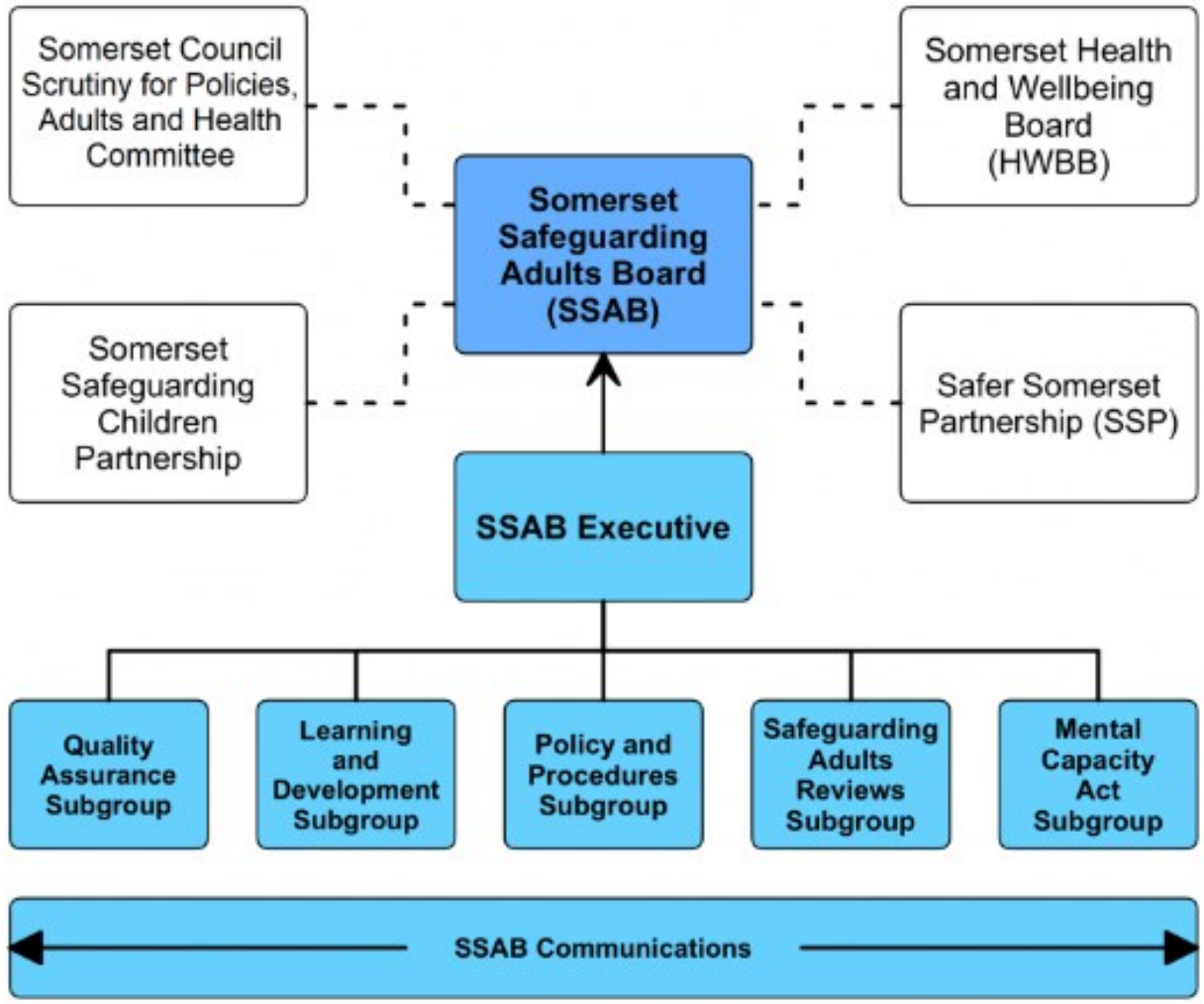
This applies to people aged 18 and over in the area who:

- have needs for care and support; *and*
- are experiencing, or at risk of, abuse or neglect; *and*
- (as a result of their care and support needs) are unable to protect themselves from either the risk of, or experience of, abuse or neglect.

The Board has a strategic role that is greater than the sum of the operational safeguarding duties of its core partners.

It oversees and leads adult safeguarding across the County and is interested in a range of matters contributing to the prevention of abuse and neglect.

Board structure as at 31/03/2025



There are strong synergies between the work of the SSAB and other key partnerships in the locality, including the statutory Safeguarding Children Partnership, Health and Wellbeing Board ('Somerset Board') and local Community Safety Partnership.

It is important the Board has effective links with these groups in order to maximise impact, minimise duplication and seek opportunities for efficiencies in taking forward work, and this is something we are keen to strengthen further.

To further strengthen collaboration and engagement opportunities across the local system, we have a Somerset Strategic Safeguarding Forum. This brings together the Chairs and Directors of the Somerset Safeguarding Adults Board, Safeguarding Children Partnership, Safer Somerset Partnership, Corporate Parenting and the Somerset Drugs and Alcohol Service. The forum enables us to address areas that

affect more than one board or partnership, working cohesively with one aim, to achieve better outcomes for local people.

We have seen the challenge of homelessness grow both in the County and nationally. To ensure that the Board's voice is heard and we can action learning from the human stories of people who experience homelessness, we have continued to be a member of the Homelessness Reduction Board. We have also reached out to our housing colleagues who are now under the Adult Social Care Directorate and have linked into homelessness teams to work together to address safeguarding and provide a focus on homelessness. We have completed a thematic review on homelessness and have hosted a summit to promote best practice to support those experiencing homelessness.

Membership of the Board

Board members as of 31 March 2026:

Name	Organisation	Job Title
Michael Preston-Shoot		SSAB Independent Chair
Natalie Green		SSAB Business Manager
Lead Statutory Partners		
Lisa Simpson	Avon & Somerset Constabulary	Superintendent
Shelagh Meldrum Sarah Ashe	NHS Somerset Integrated Care Board	Director of Quality and Nursing Associate Director of Quality and Nursing
Mel Lock Emily Fulbrook Kirsty Larkins	Somerset Council	Director, Adult Social Services Service Director, Adult Social Care Operations Service Director, Housing General Fund
Partner Members		
Jane Spencer Bethany Brier-Jones	Abri Housing	Tenancy Support Services Manager Tenancy Sustainment Officer
Phil Boyce	Care Quality Commission	Inspection Manager
Sarah Hawker	Department for Work and Pensions	Advanced Customer Support Senior Leader, Avon, Somerset and Glo'cester
Tracey Pugh	Devon & Somerset Fire and Rescue Service	Safeguarding Officer

Helen Orford	Discovery	Managing Director
Becky Arrowsmith	Golden Lane Housing	Head of Housing
Kim Sadler	Healthwatch Somerset	Healthwatch Somerset Manager
Ashley Fussell	Probation Service	Senior Probation Officer
Louise Smailes	NHS Somerset Integrated Care Board	Interim Designated Nurse for Safeguarding Adults
Hilary Robinson	Registered Care Providers Association	Chief Executive
Cindy Furze	Rep. people who use services and the Voluntary Sector	Spark
Trudy Craig	Somerset Care Ltd	Head of Governance
Cllr Sarah Wakefield Vicky Chipchase Carolyn Smith	Somerset Council (Adult Social Care)	Lead Member – Adult Social Care Head of Quality, Performance and Assurance Principal Social Worker
Lucy Macready	Somerset Council (Community Safety)	Head of Community Safety
Simon Lewis	Somerset Council (Housing)	Head of Housing
Rachel Handley	Somerset Council (Public Health)	Consultant in Public Health
Wendy Dootson	Somerset NHS Foundation Trust	Director of Safeguarding
Angela Hill	South Western Ambulance Service NHS Foundation Trust	Safeguarding Specialist
Katy Buckle	Swan Advocacy	Head of Services

The Work of the Board

Much of the work of the Board takes place in the sub-groups, which are well represented by multi-agency partners. The chairs of the groups meet together quarterly and all of them provide reports to the Executive Group each quarter.

Safeguarding Adults Review (SAR) Sub-group

During 2025–2026, the Safeguarding Adults Review (SAR) Sub-group continued to support the Board in meeting its statutory responsibilities in relation to the commissioning and oversight of Safeguarding Adults Reviews. The subgroup considered referrals against the Care Act 2014 criteria, quality assured review processes and reports, and worked to ensure that where a statutory SAR was not required, learning reviews and other proportionate review activity could still be undertaken to identify and share important learning.

During the year, Somerset continued to experience a high level of SAR referrals, reflecting both the profile of the Board and increasing awareness across partner agencies of the purpose and value of review activity. The subgroup worked closely with other partnerships and boards to help determine the most appropriate review route in complex cases, including where other review processes might also apply. This supported proportionate decision-making and helped ensure that review activity remained focused on achieving meaningful learning and improvement.

Alongside its core casework, the subgroup also contributed to the development and refinement of local SAR processes during 2025–2026. This included reviewing how SARs are managed from referral through to publication, reflecting on how learning recommendations are formulated and implemented, and considering how best to strengthen independence, consistency and the effective dissemination of learning. The subgroup's work was closely linked to wider Board activity, with learning from reviews informing policy, procedures, development activity and strategic priorities.

Overall, the Safeguarding Adults Review Subgroup made a significant contribution to the Board's assurance and improvement framework during 2025–2026. Through its oversight of referrals, reviews, thematic learning and process development, it helped to ensure that cases were considered robustly, that learning was identified and shared effectively, and that the partnership continued to strengthen its response to complex safeguarding issues across Somerset.

Policy and Procedures Subgroup

During 2025–2026, the Policy and Procedures Subgroup continued to provide oversight and leadership in the review, development and maintenance of

safeguarding policy, procedures and practice guidance on behalf of the Somerset Safeguarding Adults Board. Its work supported the Board's strategic priority of ensuring that safeguarding professionals across Somerset have access to up-to-date, clear and effective guidance that reflects both statutory requirements and learning from practice.

Over the course of the year, the subgroup progressed a substantial programme of policy and guidance review. Key areas of focus included self-neglect, organisational abuse, legal literacy, professional curiosity, Multi-Agency Risk Management, engagement with adults who do not engage with services, disclosures of alleged non-recent abuse, and guidance to support access to hospital services. This work demonstrates the subgroup's broad contribution to strengthening safeguarding practice across a range of complex areas.

The subgroup also played an important role in embedding learning from Safeguarding Adults Reviews, thematic reviews and other quality assurance activity. In particular, it ensured that recommendations arising from review activity were translated into practical guidance, briefing materials and procedural updates that could support frontline practitioners and managers in their decision-making. This included strengthening escalation pathways, improving supporting tools such as flowcharts and quick-reference materials, and refining guidance so that it is accessible and usable in practice.

By March 2026, a number of guidance documents had either been reviewed and updated, agreed for publication, or were in the final stages of amendment following subgroup discussion. Alongside this, the subgroup identified the need for a more systematic and cyclical approach to reviewing documents held on the SSAB website, helping to ensure that published procedures remain current, relevant and aligned with emerging learning and local priorities. Overall, the work of the Policy and Procedures Subgroup in 2025–2026 made a significant contribution to the Board's assurance framework by supporting consistent, high-quality safeguarding practice and by helping to ensure that learning is effectively translated into policy and procedure.

Learning and Development Subgroup

During 2025–2026, the Learning and Development Subgroup continued to provide a multi-agency forum for identifying safeguarding adults learning needs, coordinating development opportunities, and ensuring that learning from safeguarding practice, audits and Safeguarding Adults Reviews was translated into practical development activity across Somerset. Its work supported the Board's priority of promoting

shared learning and strengthening workforce understanding of key safeguarding themes.

Over the course of the year, the subgroup maintained and progressed its workplan through meetings held across 2025, with continued activity planned into 2026. Its programme included oversight of learning recommendations arising from reviews, safeguarding adults conferences and summits, Safeguarding Adults Practice Updates, regional webinars, the Somerset Safeguarding Adults Network Forum, Section 42 training, website and newsletter content, and wider promotion of SSAB guidance.

The subgroup also played a key role in delivering and promoting learning linked to specific safeguarding themes and review findings. This included work to support dissemination of practice briefings, learning events, advocacy briefing materials, feedback from Section 42 training, awareness raising activity, easy read resources and thematic conferences. Throughout the year, the subgroup used its workplan to monitor progress against agreed learning actions and to respond collectively to emerging development needs.

A continued emphasis throughout the year was on ensuring that safeguarding guidance and learning materials were accessible, relevant and well promoted. Through its oversight of briefings, webinars, conferences, training development and practice updates, the Learning and Development Subgroup made an important contribution to the Board's assurance and improvement framework by helping to ensure that lessons from reviews and practice were embedded across partner agencies and translated into meaningful development opportunities for practitioners across Somerset.

Performance and Quality Assurance Subgroup

During 2025–2026, the Performance and Quality Assurance Subgroup continued to provide the Board with oversight of safeguarding performance, quality assurance and partnership intelligence. Its work focused on using data, information and audit activity to identify risks, trends and areas for improvement, and to support the Board in understanding how effectively safeguarding arrangements were operating across Somerset.

Throughout the year, the subgroup received and scrutinised quarterly performance and assurance reporting covering safeguarding activity, practice quality, complaints and escalation, Deprivation of Liberty Safeguards and mental capacity, advocacy, safeguarding and MCA training compliance, hate crime, care market quality and sustainability, and Safeguarding Adults Review activity. This provided a broad and structured overview of local safeguarding performance and emerging risks.

The subgroup also considered a range of assurance reports and service updates during the year, including work to strengthen the safeguarding triage process, improve data quality and recording, review referral pathways and feedback mechanisms, and refresh the subgroup's terms of reference and forward plan. Practice quality audit activity and the implementation of the Somerset Practice Quality Framework provided additional assurance, with reported improvements in audit findings and opportunities for further learning identified through regular scrutiny.

Overall, the Performance and Quality Assurance Subgroup made an important contribution to the Board's assurance framework by coordinating multi-agency quality assurance activity, strengthening the use of performance information, and ensuring that safeguarding risks, trends and areas requiring attention were regularly reviewed and escalated where needed. In doing so, it supported both accountability and improvement across the safeguarding partnership.

Mental Capacity Act Subgroup

During 2025–2026, the Mental Capacity Act Subgroup continued to support the Board by developing and monitoring guidance, best practice and assurance in relation to the Mental Capacity Act, associated legislation and local application. The subgroup brought together leads from partner organisations to promote consistent understanding of MCA responsibilities and to strengthen practice across Somerset.

Building on previous work to promote the application of MCA assessments and the role of executive functioning in safeguarding practice, the subgroup continued to support training, guidance and awareness activity during the year. This included maintaining a focus on the MCA Competency Framework, monitoring training compliance, and promoting learning through webinars and practice updates for both practitioners and care providers.

During 2025–2026, the subgroup also progressed qualitative audit activity, supported the development of the MCA Forum, and continued work on practice briefings linked to key safeguarding themes, including access to hospital services. This reflected the subgroup's ongoing role in identifying areas where further clarity, learning and system-wide consistency were needed, particularly in relation to complex practice issues where mental capacity, safeguarding and risk overlap.

Overall, the Mental Capacity Act Subgroup made an important contribution to the Board's strategic priority of promoting MCA understanding and application. Through its work on guidance, audit, forums, practice briefings and workforce development, it supported partner agencies to strengthen confidence and consistency in applying

the MCA in safeguarding contexts and helped ensure that this remained a visible and active area of Board oversight during 2025–2026.

4. Safeguarding Successes

Sam

DSFRS were called to Sam's (pseudonym) home frequently between 2023 and 2025 due to cooking related incidents whilst under the influence of alcohol. There were also concerns around poor housekeeping, unsafe smoking practices, burn marks on furniture, mental health issues and self neglect. DSFRS provided fire safety advice and fire retardant equipment to Sam and raised concerns to other agencies.

DSFRS made several referrals into Adult Safeguarding and Social Care during this time period, highlighting the risks to both Sam and his neighbours. Although initial referrals were not accepted, Section 42 enquiries were opened in 2024 and again in early 2025, and a social worker was allocated. DSFRS also shared information with the Housing Association and conducted several Home Fire Safety Visits jointly with the Housing Officer to reinforce fire safety messages.

The Housing Association, Abri, undertook their own safeguarding measures, including carrying out monthly PCFRA (Person Centred Fire Risk Assessments) and made consistent attempts to engage with Sam including allocating a Housing Support Partner.

There was positive collaborative working demonstrated between DSFRS, Abri and Adult Social Care (Adult Safeguarding).

In August 2025, a final Home Fire Safety Visit was conducted, where the technician carrying out the visit reported "(Sam) was in great spirits and had made good

progress to stay safe. (Sam) is not currently drinking alcohol. (Sam) had very few electricals and was charging safely and unplugging where needed. (Sam) uses the microwave and airfryer mostly and the kitchen was clear of clutter and a sign on the wall reminded him to use the microwave if he has had a drink. (Sam) understood how to stay safe and had recalled everything from (the Home Safety Technician's) previous visit. (He) is smoking safely and (there are) no signs of burn marks. (Fire retardant) throw provided on previous visit still in use. (Sam) was engaging and happy to have us visit today."

Mr Smith

Mr Smith was supported by the Safeguarding Team over a period of about 18 months. He had experienced physical, emotional and psychological abuse. He had also experienced financial abuse from people who had visited his home. This had a big impact on his confidence, his sense of safety and his trust in other people.

The social worker took time to build a trusting relationship with Mr Smith. They visited him regularly and did not rush him. At first, the visits helped Mr Smith to feel safer and to understand that he could choose what support he wanted. The social worker listened to him, asked what mattered to him, and helped him think about what would make life feel safer and better.

The social worker worked with Mr Smith to understand who was coming into his home and whether those relationships were safe. They helped him think about the difference between healthy friendships and relationships that could put him at risk. This included talking with him about who he trusted, who made him feel worried, and what he could do if he felt unsafe.

Practical support was also put in place. The social worker helped Mr Smith to access support with his money and to regain more control over his finances. They worked with other professionals when needed, shared information safely, and helped make sure that plans were in place to reduce the risk of further abuse. This included checking that Mr Smith knew who to contact if he was worried or if someone tried to take advantage of him again.

The social worker supported Mr Smith to move forward at his own pace. This included helping him settle into a new home, encouraging him to keep routines that supported his wellbeing, and helping him stay connected with his local community.

Mr Smith began eating and drinking well, focusing on his physical fitness, and thinking carefully about the people he spent time with.

Mr Smith often still chooses to spend time on his own. The social worker recognised this as part of his recovery and did not see it as a failure. Instead, they helped him think about safe choices, positive routines and ways to ask for help if he needed it. The work was person-centred and focused on what Mr Smith wanted his life to look like.

Over time, Mr Smith has grown in confidence. He is more able to recognise when a friendship feels safe and when it may not be healthy for him. He is more willing to talk to professionals and now seeks help when he needs it. He knows that his mental and emotional health is still fragile, but he also understands that healing takes time. The support from the social worker helped him regain control, make safer choices and build a more settled life.

Ms Jones

A safeguarding referral was received for Ms Jones because of concerns about self-neglect. Ms Jones is in her 70s. Her home had become very cluttered and hoarded, which made it difficult for her to move around safely and use some areas of her home. There were also concerns about fire safety, falls, hygiene and the impact on her health and wellbeing.

Ms Jones had received support before. This included support through a direct payment, micro-providers and the Home Safety Team. These services had tried to help, but progress had been difficult. The Safeguarding Team was told that Ms Jones "did not engage" and "did not make progress quickly enough." The social worker understood that this did not mean Ms Jones did not want help. It meant that the support needed to be offered in a different way.

The social worker took a relationship-based approach. They visited Ms Jones regularly, usually every week. They did not begin by asking her to clear her home quickly. Instead, they spent time getting to know her, listening to her story and understanding what was important to her. Some visits took place away from her home, in places where Ms Jones felt more comfortable. This helped reduce pressure and gave her space to talk.

The social worker explored Ms Jones' strengths, wishes and worries. They asked what she wanted to change and what felt too difficult. They also talked with her

about the risks in her home in a calm and respectful way. This included talking about fire safety, safe walking routes through the home, how she could access important rooms, and what support would help her feel more in control.

The social worker worked at Ms Jones' pace. They helped her begin to sort through her belongings gently and safely. This was not just a practical task. Many of the items had memories attached to them. The social worker gave Ms Jones time to talk about these memories, including positive memories and difficult experiences from her past. This helped the social worker understand how trauma and adverse childhood experiences had affected Ms Jones' mental health and her home environment.

The social worker also helped coordinate support from other people and services where this was needed. This could include practical help in the home, advice about home safety, support to reduce fire risk, and conversations with other professionals so that everyone understood the plan. Information was shared carefully and only when needed. The aim was to reduce risk while keeping Ms Jones involved in decisions about her own life.

Each small step was recognised and celebrated. This helped Ms Jones feel proud of what she had achieved. It also helped build her confidence. The social worker encouraged her to make choices, set small goals and notice the progress she was making. Over time, Ms Jones was able to identify a personal goal that mattered to her.

The outcome was significant for Ms Jones. She is now able to walk through her home and garden for the first time in years. This means her home is safer and easier to use. It has also helped improve her wellbeing and sense of control. The safeguarding work showed that progress with self-neglect can take time, and that people are more likely to accept support when they feel listened to, respected and not judged.

The Clutter Rating Scale and associated guidance, published on the Somerset Safeguarding Adults Board website, is used by the Safeguarding Service to identify the level of hoarding and inform actions. Please see an example from the Clutter Rating Scale below.

Clutter Image Rating (CIR) – BEDROOM

Please select the CIR which closely relates to the amount of clutter

1	2	3

4	5	6

7	8	9

5. Safeguarding in numbers

How much abuse and neglect was reported during 2025/2026?

Number of individuals involved in Safeguarding concerns

2024/25	2025/26
1,838	1517
Concerns	Concerns

The total number of safeguarding concerns received by Somerset in 2025/26 was 1517 – an decrease of 17.5% from 2024/25. Individuals can have more than 1 concern raised about them.

Safeguarding concerns received that required a statutory response in 2025/2026

2024/25	2025/26
712	415
Enquiries	Enquiries

Less safeguarding enquiries were carried out in Somerset during 2025/26

– 415, of which 405 were Section 42 enquiries and 10 other safeguarding enquiries.

However, Somerset continues to see a higher proportion of concerns going on to be accepted as an enquiry - the conversion rate in for 2025/26 is 30% compared to 39% in 2024/25.

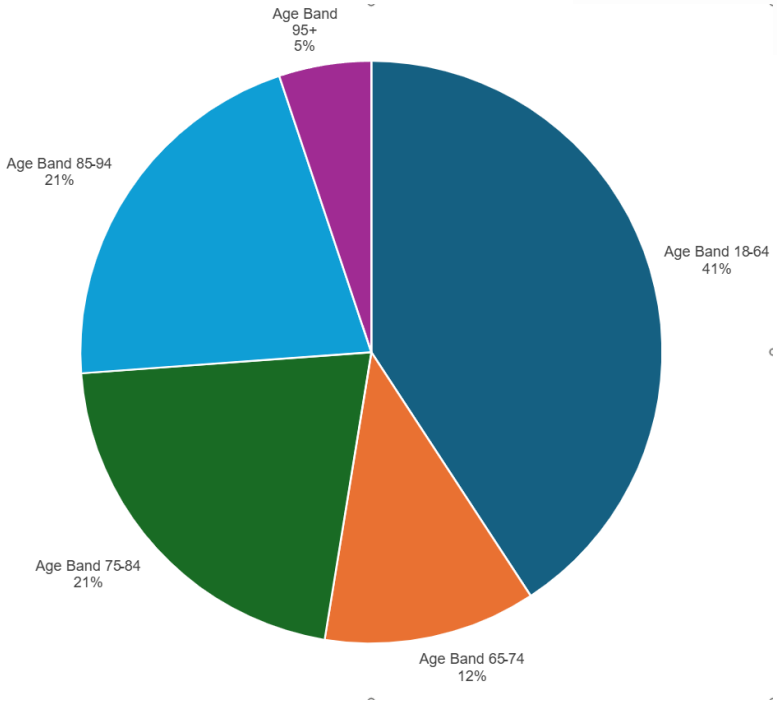
Who was at risk of abuse and neglect in 2025/2026?

The majority of individuals that required a statutory response were female:

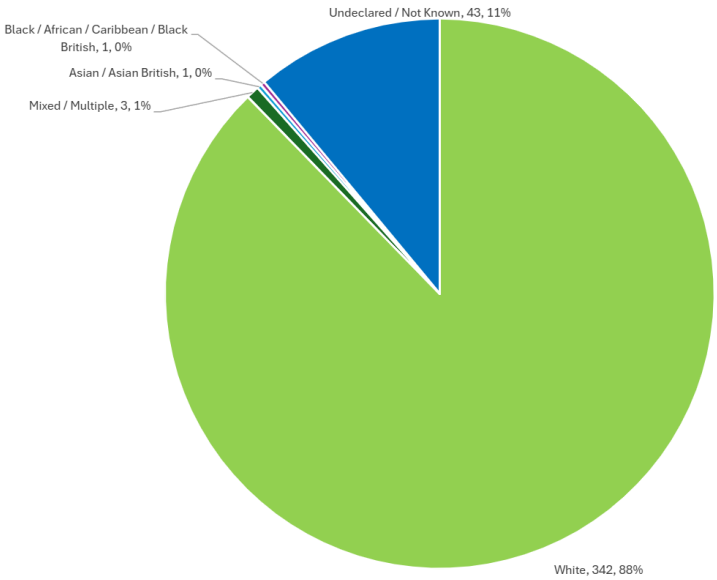
56% Female

44% Male

The majority of individuals where the concern resulted in a Section 42 safeguarding enquiry were aged 65 and over:

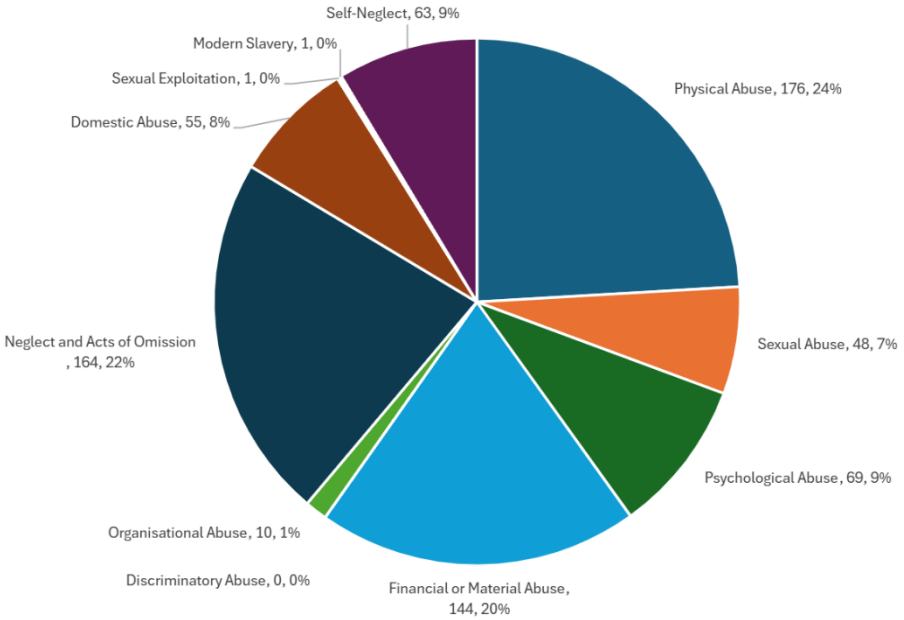


The majority of individuals where the concern resulted in an enquiry under Section 42 of the Care Act (2014) were from white ethnic backgrounds:

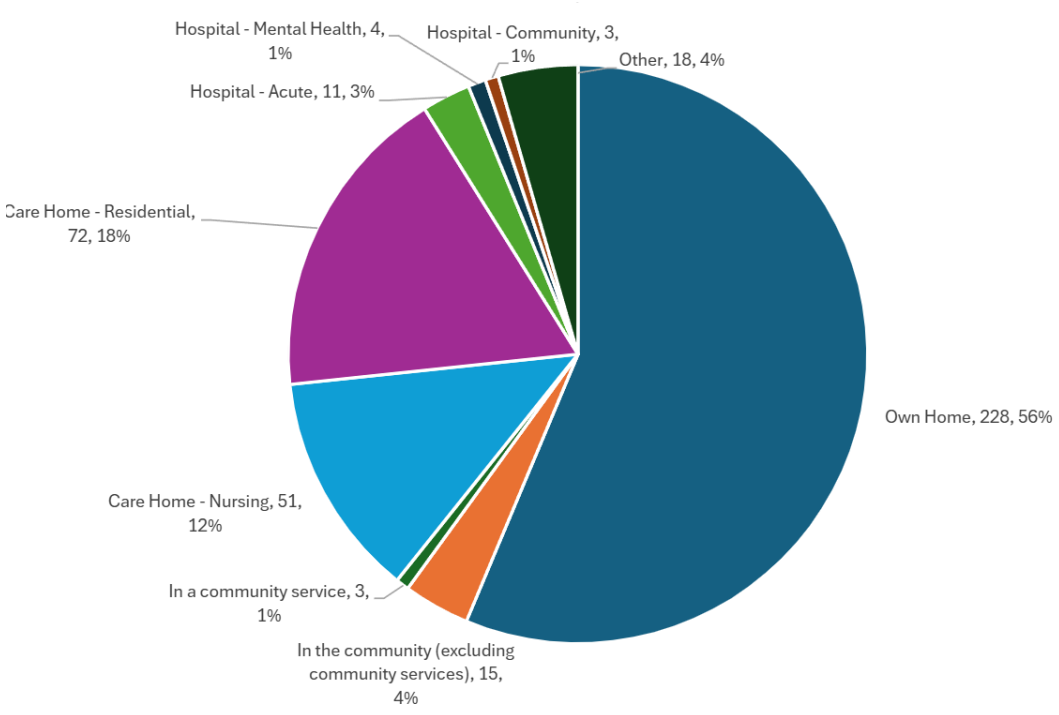


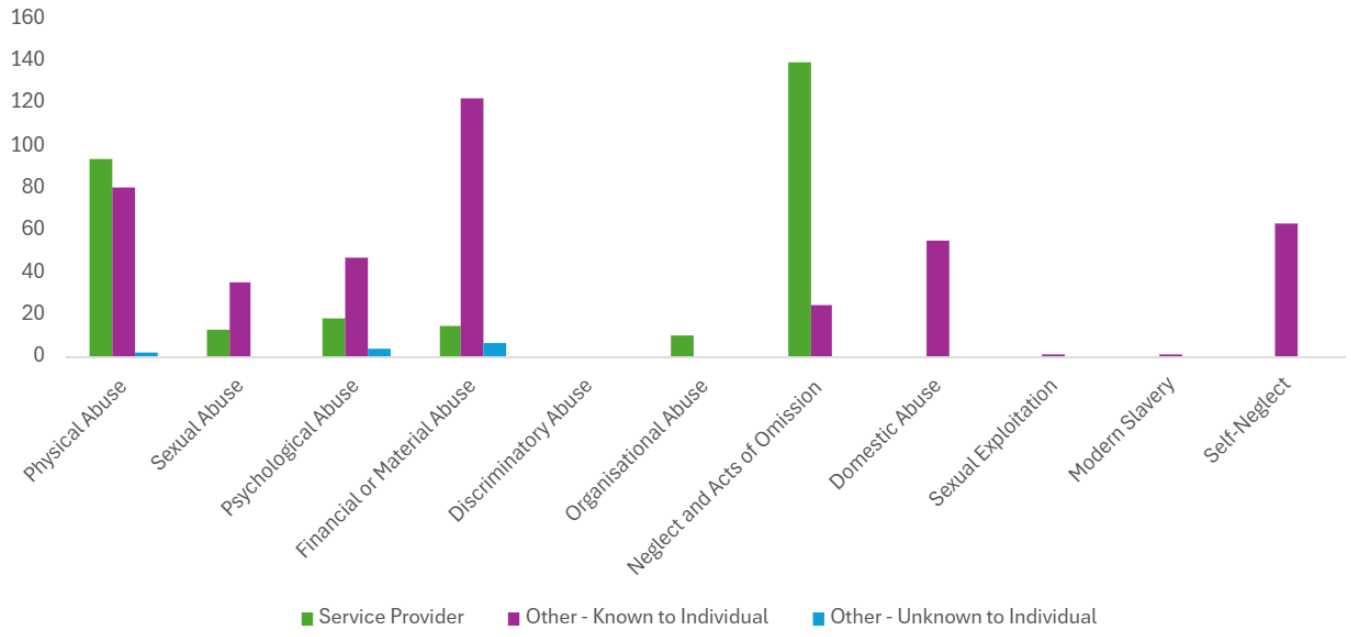
Type of abuse and source of risk

The most common risk type was Physical Abuse, which accounted for 24% of risks, followed by Neglect and Acts of Omission at 22% and Financial and Material Abuse at 20%



As has long been the case nationally, the most common location of risk remains the person's own home where 59% incidents took place and is an increase from last year (57%).





Mental Capacity

In all 128 cases where the adult at risk was assessed as lacking capacity to make decisions related to the safeguarding enquiry, 94% resulted in the individuals being supported by an advocate, family member or friend.

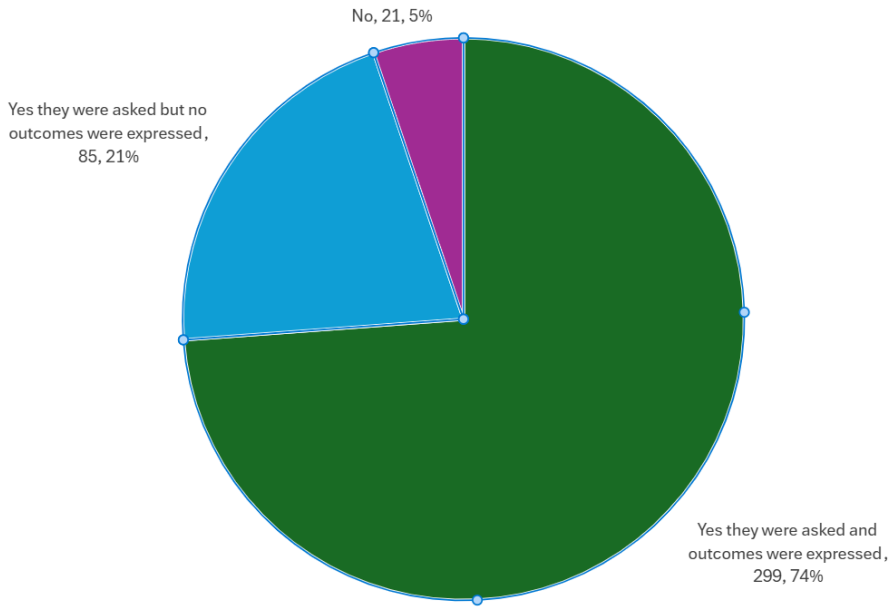
Making Safeguarding Personal

What does Making Safeguarding Personal mean?

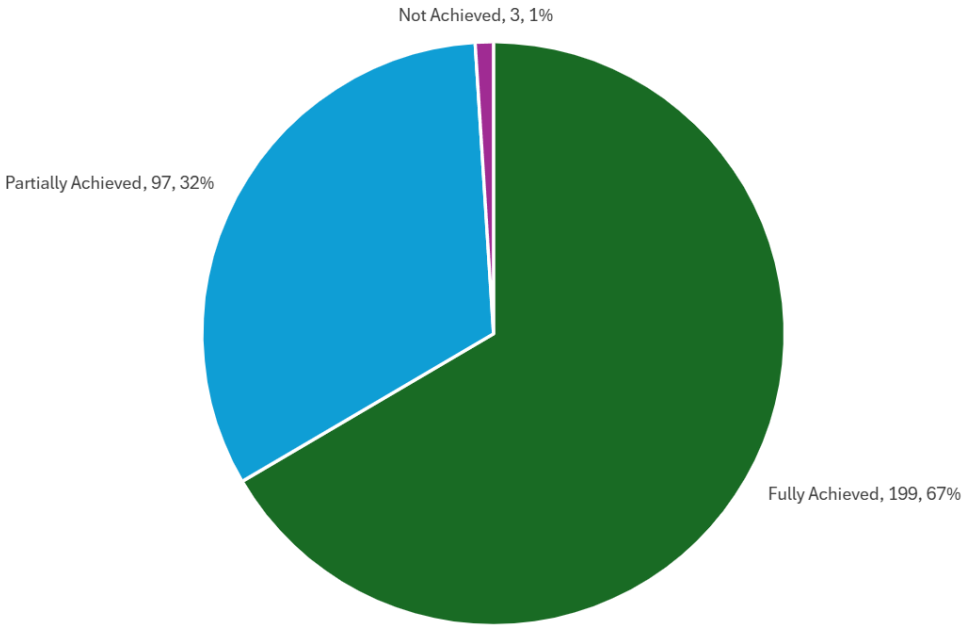
Making Safeguarding Personal (MSP) is about having conversations with people about how we all might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

It is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process. The extent to which local services continue to promote an MSP approach has been monitored by the SSAB via its organisational self-audits, designed to give assurance to the Board of local practice.

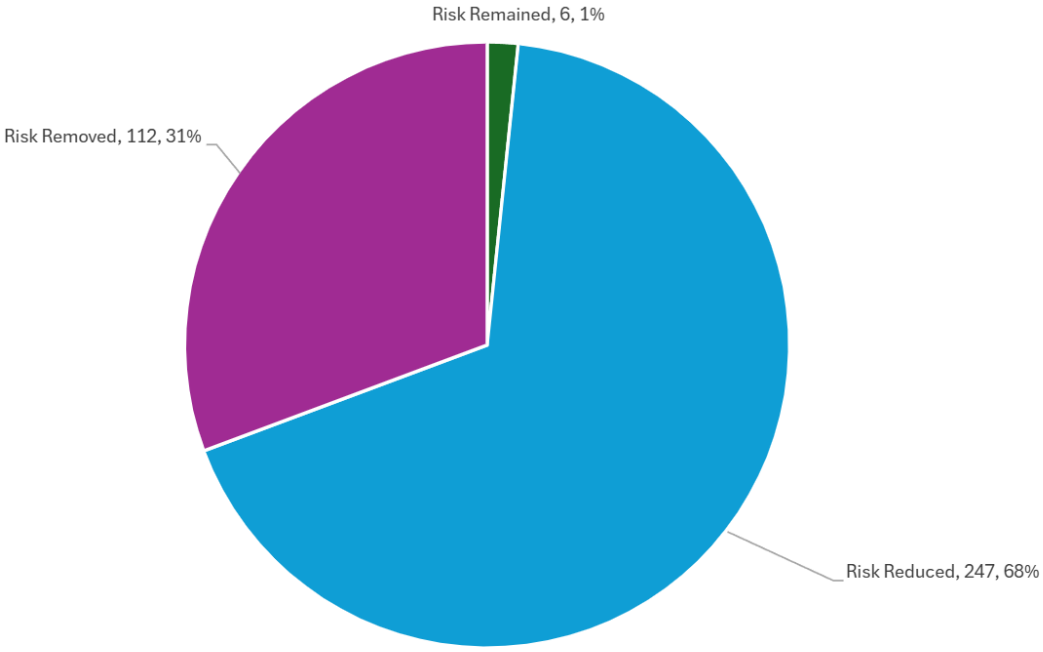
The majority of people, or their representative, were asked what their desired outcomes were.



In 97% of cases where desired outcomes were stated, these were fully or partially achieved



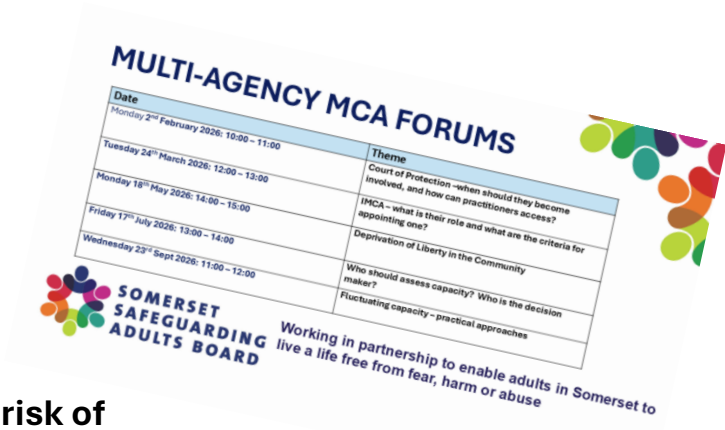
Outcomes of enquiries made under Section 42 of the Care Act (2014)



4. Communications

This page brings together key safeguarding adults learning and communication resources for practitioners. It highlights current practice updates, webinar opportunities, Mental Capacity Act (MCA) forums, and digital channels that support ongoing professional development and awareness raising across Somerset.

Safeguarding Adults Practice Updates



Safeguarding Adults Practice Updates are published to support understanding of adult safeguarding and the learning that emerges from safeguarding adult reviews. They are designed to help practitioners reflect on practice themes, strengthen decision-making, and apply learning to day-to-day work with adults who may be at risk of abuse or neglect.

Safeguarding Adults Week

Safeguarding Adults Week 2025 took place from 17 to 21 November 2025 and provided an opportunity for organisations to work together to raise awareness of safeguarding issues, promote partnership learning, and share resources that strengthen prevention, empowerment, and person-centred safeguarding practice. The overarching theme for 2025 was Prevention: Act Before Abuse, with daily themes including *Change the Conversation*, *Prevention in Practice*, *Creating Empowering Environments*, *Trust Your Instincts*, and *Celebrate Safer Cultures*.

MCA Forums

The SSAB runs bi-monthly multi-agency MCA forums via Teams in 2026. These one-hour sessions include a short-themed presentation followed by discussion, giving practitioners space to explore challenges in applying the Mental Capacity Act, share anonymised cases, and build practical confidence through peer learning and multi-agency discussion.

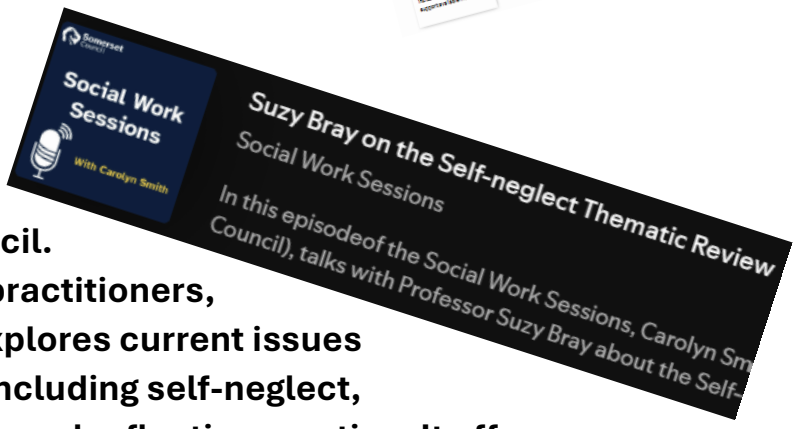
SSAB Website

The Somerset Safeguarding Adults Board website is a central source of information for professionals and the public. It provides access to guidance, training and resource pages, webinar recordings, safeguarding adults reviews, newsletters, events, and practical tools that support effective safeguarding practice across the partnership.

SSAB Twitter/X

The SSAB Twitter/X presence supports timely communication by sharing campaign messages, learning opportunities, event promotion, and safeguarding awareness content. It can be a useful channel for practitioners who want quick updates on current themes, public messaging, and new resources linked to adult safeguarding practice.

Social Work Sessions Podcasts



Social Work Sessions is a podcast hosted by the Principal Social Worker for Adult Social Care in Somerset Council. Through conversations with front-line practitioners, leaders and academics, the podcast explores current issues in adult social care and safeguarding, including self-neglect, safeguarding adults reviews, wellbeing, and reflective practice. It offers an accessible way for staff to engage with learning outside formal training sessions.

Social Work Sessions | Podcast on Spotify

5. Themed Summits

Three important safeguarding themes were explored in summit discussions: self-neglect, homelessness, and organisational abuse. Although each theme has distinct features, they are closely connected through issues of vulnerability, risk, dignity, rights, and the need for coordinated multi-agency responses. The document outlines what each theme means, why it matters, common indicators, and practical considerations for effective safeguarding practice in a UK context.

Self-Neglect

The Self-Neglect Summit agenda is designed as a focused morning of learning, reflection, and practical discussion. It opens with an introduction from Professor Suzy Braye and is framed by learning from the recent thematic Safeguarding Adults Review on self-neglect. The programme includes an opportunity for questions, a dedicated session on hoarding, and breakout discussions exploring challenges, barriers, and potential solutions in different contexts, including care homes, people self-neglecting at home, homelessness, and issues of capacity and executive function. The summit then draws together feedback from the breakout groups before closing with guidance on the self-neglect toolkit, MARM, resolving professional differences, and a final question-and-answer session.

Self-neglect refers to a wide range of behaviour in which a person fails to care for their personal hygiene, health, or surroundings to the extent that it places their wellbeing or safety at risk. In safeguarding practice, self-neglect may include poor nutrition, inadequate hydration, refusal of essential care, unsafe living conditions, untreated medical needs, or hoarding behaviours. Since the Care Act 2014 guidance, self-neglect has been recognised as a safeguarding concern in England, helping practitioners respond more consistently to situations where adults are unable or unwilling to protect themselves from serious harm.

- Neglect of personal care, hygiene, nutrition, or medical treatment
- Unsafe or unsanitary home conditions, including severe clutter or hoarding
- Repeated refusal of support despite escalating risk
- Difficulty managing finances, medication, or everyday living tasks
- Social isolation, trauma, cognitive impairment, addiction, or deteriorating physical or mental health

Practice with self-neglect requires a careful balance between respect for autonomy and the duty to prevent serious harm. Effective responses are usually person-centred, trauma-informed, persistent, and relationship-based. Practitioners should remain professionally curious, assess mental capacity where appropriate, record engagement attempts clearly, and work collaboratively across services such as health, housing, social care, and voluntary organisations. Building trust over time is often essential, especially where the person has had negative experiences of services or feels judged.

Homelessness

The Homelessness Summit agenda is structured around learning, lived experience, service mapping, and action planning. It begins with welcome remarks and a review of best practice, followed by a session on what a homelessness review identified. The programme then moves into the voices of people with lived experience, including contributions from Step Together and YMCA, before using an interactive scenario discussion to explore practical responses. Later sessions focus on the range of services available across prevention, outreach, crisis support, assessment, stabilisation, recovery, and independence, with input from housing, rough sleeping, health, and partnership services. The day concludes with reflection on strengths and gaps, identification of actions, and closing remarks to support future development.

Homelessness is broader than rough sleeping and includes a range of situations where a person lacks safe, secure, and stable accommodation. This may include people living in hostels, temporary accommodation, refuges, bed and breakfast accommodation, sofa surfing, or staying in places not designed for habitation. Homelessness is a safeguarding issue because it is often associated with significant health inequalities, trauma, exploitation, substance use, poor mental health, and barriers to accessing support. Research and practice guidance increasingly emphasise that people experiencing homelessness can face overlapping risks, including self-neglect, multiple disadvantage, and exclusion from mainstream services.

- Increased risk of physical ill-health, untreated conditions, and early mortality
- Greater exposure to violence, exploitation, abuse, and victimisation
- High levels of trauma, stigma, and mistrust of statutory services
- Frequent overlap with self-neglect, substance misuse, mental ill-health, or cognitive impairment

- Challenges in accessing benefits, healthcare, housing pathways, and coordinated support

Good safeguarding practice with homelessness depends on partnership working, flexibility, and sustained engagement. Services should avoid interpreting non-engagement as lack of need. Instead, responses should recognise the impact of trauma, poverty, adverse life experiences, and systemic barriers. A coordinated approach may involve adult social care, housing teams, homelessness services, mental health support, substance misuse services, primary care, hospitals, and community organisations. Where there is risk of abuse or neglect and care and support needs are present, a safeguarding concern should be considered alongside housing duties and wider support planning.

Organisational Abuse

The Organisational Abuse Summit agenda focuses on best practice, regulation, learning from case examples, and system improvement. It opens with welcome remarks and an overview of best practice, followed by a session on the role of the Care Quality Commission. The agenda then creates space for questions before examining what was learned from Mendip House, Hillview, and Somerset Court, including what enabled change and what barriers affected implementation. In the later part of the programme, speakers cover provider concerns and Section 42 pathways, quality assurance of care providers, and the police role when organisational abuse is identified. The summit closes with identification of actions and final reflections, emphasising accountability and continuous improvement across services.

Organisational abuse refers to neglect, poor care, mistreatment, or harmful practice that occurs within a care setting, service, or institution. It may take place in hospitals, care homes, supported living services, day services, or other organisations responsible for providing support. Organisational abuse is often not a single incident but a pattern of poor practice that affects more than one person. It can include rigid routines, unsafe staffing levels, poor leadership, disrespectful or degrading treatment, failure to meet care needs, neglect of basic rights, inadequate responses to concerns, and cultures that normalise harm or silence staff and people using services.

- Repeated complaints, incidents, or safeguarding concerns within the Same service
- Poor standards of care, unsafe practices, or unmet health and personal care needs

- Institutional routines that ignore individual choice, dignity, or cultural needs
- Weak leadership, poor staff supervision, and failure to learn from incidents
- A closed culture where whistleblowing is discouraged and concerns are minimised

Responding to organisational abuse requires prompt information sharing, effective oversight, and decisive leadership. Practitioners should look beyond isolated incidents and consider whether patterns suggest wider service failure. This may involve safeguarding enquiries, quality monitoring, regulatory involvement, commissioning action, and listening carefully to the experiences of people who use the service and their families. A strong safeguarding culture is one in which concerns are raised early, practice is transparent, staff are supported and supervised, and continuous improvement is expected.

Shared Themes Across the Three Summits

Across self-neglect, homelessness, and organisational abuse, several shared themes emerge. First, safeguarding is most effective when it is person-centred and grounded in dignity, rights, and the individual's voice. Second, complex risk rarely sits within one agency alone, so multi-agency working, clear escalation, and shared accountability are essential. Third, trauma, stigma, exclusion, and poor experiences of services can reduce trust and make engagement harder, which means practitioners need persistence, empathy, and professional curiosity. Finally, prevention matters: early identification of risk, strong leadership, reflective supervision, and learning from safeguarding reviews can all improve outcomes and reduce repeated harm.

Conclusion

The three summit themes highlight the importance of responsive, coordinated, and compassionate safeguarding practice. Whether the concern relates to a person who is self-neglecting, someone experiencing homelessness, or a pattern of poor care within an organisation, the focus should remain on safety, wellbeing, human rights, and meaningful outcomes. Organisations can strengthen their response by improving multi-agency pathways, investing in training and supervision, using trauma-informed approaches, listening to lived experience, and ensuring that safeguarding is embedded as everybody's responsibility.

6. Safeguarding Adults Reviews

All safeguarding is complex, challenging work but this is never more so than when an individual dies or is seriously harmed through abuse or neglect. The impact on families, carers and the professionals involved should not be under-estimated and is never taken lightly by any organisation or professional.

A vital role of the Board is to seek assurance on the effectiveness of local safeguarding activity and to ensure practice continually improves. It is required to commission Safeguarding Adults Reviews (SARs) to identify whether lessons can be learnt about the effectiveness of multi-agency working to safeguard adults at risk.

The Care Act 2014 states that a Safeguarding Adults Review (SAR) must be arranged by the Safeguarding Adults Board when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and when there is concern that partner agencies could have worked more effectively to protect the adult. A SAR must also be arranged if an adult has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

SARs are demanding pieces of work and are dependent on the openness and reflection of agencies involved to identify what worked well and what could have been better.

The SSAB has a multi-agency SAR sub-group whose role it is to ensure statutory requirements are met in relation to reviews, and the quality assurance of review reports. The sub-group has been chaired by the Chair of the Somerset Safeguarding Adults Board to address the increase in the number of SAR referrals, those progressing to SARs and the reoccurring themes.

Where a case meets the criteria, and it is not possible to demonstrate the necessary degree of independence from within the partnership, the Sub-group will oversee the appointment of an independent, external Chair and/or Review Author. Where independence can be demonstrated from within the partnership, for example where the review can be chaired by a senior representative from a partnership agency with no involvement in the case, the Board has developed a local review process which is similar to that used by some other Boards.

Ten Safeguarding Adults Reviews concluded during 2025/26 including a thematic review of three cases. These are summarised below. A further sixteen reviews are at different stages, and are being progressed by the Board's SAR Sub-group. Within the ongoing reviews, we have a thematic review focusing on substance use, which also considers mental capacity, self-neglect andengagement and how this is addressed by agencies and we are reviewing a further self-neglect thematic review reflecting on learning from the first.

We continue to receive regular referrals for the SAR Sub-group's attention, who consider the themes that are being presented and how we can address these proactively. The continued presentation of self-neglect and mental capacity themes has led the Board to focus on these areas, but homelessness, substance use has also become consistant themes, so we are working with our partners to promote multi-agency working, particularly to achieve engagement.

'David' Safeguarding Adults Review

Background

The individual, referred to as David, was a man with mild learning disabilities, epilepsy and physical health needs affecting his mobility. He lived at home with his family, who were closely involved in his care and support. David had a range of interests, including a strong engagement with computers and the internet, which formed an important part of his daily life.

David had not experienced epileptic seizures for many years and, following consultation with him and his family, a decision was made to gradually reduce and discontinue his anti-epileptic medication in line with national STOMP principles.

In the period prior to his death, David experienced increasing distress. He became worried and upset, engaged in self-injurious behaviours and expressed thoughts of dying. His family sought support from health and social care services during this time. Clinical opinion did not associate his presentation with medication withdrawal or with a first episode of psychosis.

David subsequently sustained serious injuries at home. The Coroner concluded that these injuries had been inflicted deliberately with the intention of ending his life. He remained in hospital for a number of months before his death.

Findings and areas for learning and improvement

The review identified a number of important areas for learning across partner agencies in relation to supporting people with learning disabilities who self-injure or experience emotional distress.

A central finding relates to the need to better understand the lived experience of individuals with learning disabilities who self-injure. Evidence referenced within the review highlights limited research in this area, particularly in capturing individuals' own explanations for their behaviour. Themes identified include attempts to relieve overwhelming emotions, responses to trauma or loss, and challenges in articulating emotional distress.

The importance of Making Safeguarding Personal is reinforced throughout the case. Safeguarding responses must be person-led and outcomes-focused, ensuring that individuals are fully involved in decisions about their care and support. This includes enabling meaningful conversations about risk and desired outcomes, and ensuring that advocacy is considered to support understanding and engagement.

The review highlights the need for improved care coordination and communication between services. Agencies must work together to develop a shared and comprehensive understanding of an individual's needs, including the use of bio-psychosocial approaches where appropriate. Clear coordination of care across services is essential, particularly where individuals present with complex needs and risk.

There is also learning in relation to professional responses to risk and escalation. Where concerns are identified, there should be timely consideration of safeguarding processes, including referrals or the convening of multi-agency risk management meetings (MARM), based on an informed assessment of risk.

Finally, the case emphasises the importance of adopting a 'Think Family' approach. The needs of family members, particularly where they act as carers, must be recognised and responded to as part of the safeguarding response. This includes assessing risks to both the individual and their family, and ensuring that support is tailored appropriately to the circumstances.

Recommendations where further assurance is being sought or the recommendation has been completed or implemented:

	Summary of Recommendation
1	With due regard to protecting the confidentiality of David and his family's identity in any publicly accessible training, design and deliver training to review the learning from the circumstances of David's care and support.
2	Taking the learning from this review, undertake a brief review of the independent advocacy services available to adults with learning disabilities who live in their parental home, to ensure that a) these are available and accessible, and b) that staff in health and social care services for adults with learning disabilities are clear about their duties to offer independent advocacy support and integrate the advocacy contribution into planning for care.
3	Taking the learning from this review, and any other relevant recent Learning Disabilities reviews, undertake a brief review of the care coordination policies for adults with learning disabilities in both Adult Social Care and the Trust to determine whether these address the need for clarity on case management and case coordination leadership.
4	Undertake a rapid review of the mainstream and psychological therapy pathways available to adults with mild learning disabilities and their families who experience self-injury behaviours and make recommendations to commissioners about future service developments.
5	Taking the learning from this review, undertake a rapid review of the home treatment support options available to families where an adult with learning disabilities is injuring themselves repeatedly in their home environment and make recommendations to commissioners about future service developments.
6	Taking the learning from this review, undertake a rapid review of the governance arrangements that support joint working between the NHS and the Council's Learning Disability services. This should consider whether there are clear mechanisms for escalating concerns when agencies are not responding to requests for involvement. Any action plan follows the review should be agreed and monitored by the MHLDA Delivery Cell.

‘Juliet’ Safeguarding Adults Review

Background

Juliet (a pseudonym) was a 63-year-old woman who died in Taunton in August 2022 at the home of her partner. She had a long history of alcohol dependency, self-neglect and poor physical health, alongside experiences of domestic abuse across a number of relationships over many years.

Concerns from partner agencies centred on her relationship with her partner, where there were repeated reports of physical violence, coercive and controlling behaviour, financial exploitation and sexual assault. Despite these risks, Juliet often returned to live with her partner, describing him at times as providing care and support, reflecting the complexity of the relationship.

Juliet also maintained a tenancy in Taunton, although she spent limited time there due to poor living conditions and the pull of returning to her partner’s address. Agencies worked to improve the condition of her home and support her to live independently; however, these efforts were not sustained.

During the period covered by the review (August 2020 to August 2022), there was extensive involvement from multiple agencies, including police, health services, adult social care and housing. She was frequently in contact with emergency services, particularly ambulance and hospital services, often in the context of intoxication, injury, or disclosures of abuse.

A Safeguarding Adults Review was commissioned by Somerset Safeguarding Adults Board to examine the effectiveness of multi-agency working, risk management and safeguarding responses in the context of self-neglect and domestic abuse.

Findings and Areas for Learning and Improvement

Multi-agency Working and Coordination

The review found that while there were periods of effective multi-agency collaboration, including an initial professionals meeting and MARAC involvement, this approach was not consistently sustained. After early intensive intervention, agency involvement became more reactive, characterised by responses to incidents rather than coordinated, proactive planning.

There was limited use of multi-agency forums to manage ongoing complexity. Opportunities to convene additional professionals meetings, escalate to MARM

processes, or maintain coordinated oversight were not fully utilised, particularly as risks escalated later in the case.

Understanding of Risk and Complexity

The review identified that professionals did not consistently recognise or respond to the intersecting nature of risks, particularly the combined impact of domestic abuse, alcohol dependency and self-neglect. Risk assessments often considered issues in isolation rather than as interconnected factors influencing Juliet's vulnerability.

There were gaps in the depth of risk analysis, particularly within MARAC processes, where the complexity of Juliet's circumstances, including sexual abuse, coercion and financial exploitation, was not always fully explored or reflected in action planning.

Engagement, Voice and Lived Experience

Professionals found it difficult to develop a consistent and in-depth understanding of Juliet's needs and lived experience. Her engagement with services was inconsistent, often influenced by alcohol use, and she had limited continuity of professional relationships due to frequent contact with emergency services.

Although there were examples of relational practice leading to improved engagement, these were not sustained. As a result, opportunities to better understand the underlying drivers of her self-neglect and her relationship dynamics were limited.

Application of Safeguarding and Legal Frameworks

There were inconsistencies in the application of safeguarding processes and legal frameworks. In particular, opportunities to initiate safeguarding enquiries at an earlier stage were missed, and decisions regarding care and support eligibility were not always informed by a full understanding of risk.

There was also evidence that existing information was not always reviewed when new safeguarding concerns were raised, leading to repeated decisions that did not fully reflect the cumulative risk profile.

Responding to Domestic and Sexual Abuse

The review highlighted gaps in responses to domestic and sexual abuse. While incidents were frequently reported or disclosed, the response did not consistently

include consideration of specialist support services such as Independent Sexual Violence Advisors (ISVAs) or referral pathways to appropriate services.

There were also challenges in progressing criminal justice responses, particularly where Juliet did not wish to support prosecution, and limited evidence of alternative safeguarding approaches to manage ongoing risk. [somersetsa...Juliet.pdf]

Consideration of Self-Neglect

Self-neglect was recognised as a significant risk factor; however, it was not always managed alongside other forms of abuse. When Juliet was living independently, her self-neglect risks were more clearly identified, but these risks appeared to receive less attention when she was living with her partner. [somersetsa...Juliet.pdf]

Interventions aimed at reducing self-neglect, such as improving her home environment, were not always supported by sustained care planning or sufficient ongoing support.

Mental Capacity and Decision-Making

Professionals generally assessed Juliet as having capacity to make decisions, including decisions to return to her partner. However, there was limited exploration of how alcohol dependency, coercion and control may have impacted her ability to make safe decisions or exercise autonomy. [somersetsa...Juliet.pdf]

There was also limited assessment of her capacity specifically in relation to managing risk within her relationship, including the potential influence of abuse and dependency.

Service Provision and Gaps in Support

The review identified gaps in available services and support pathways. This included limited access to refuge provision suitable for individuals with alcohol dependency, and missed opportunities to refer to services such as falls prevention or specialist domestic abuse support.

There was also limited focus on engaging with the perpetrator or addressing abusive behaviour through available intervention programmes.

Recommendations where further assurance is being sought or the recommendation has been completed or implemented:

	Summary of Recommendation
1	That 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.
2	Where cases are being repeatedly referred back to MARAC, the MARAC chair should consider whether or not this may be an indication that they system is not working for the victim and request that a professionals meeting is held.
3	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.
4	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.
5	That the providers of the range of falls prevention and support services in Somerset complete a 7-minute briefing on the services they offer and how to access them and that this 7-minute briefing is promoted on the Somerset Safeguarding Adults Board website.
6	That Avon and Somerset Police provide 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.
7	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.
8	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.
9	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.
10	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.
11	That Avon and Somerset Police and partner agencies adopt the following approach in relation to Domestic Violence Protection Orders (DVPO): Immediate Safety: The police's objective during the night is to ensure the immediate safety of the Domestic Violence Protection (DP) individual. Follow-Up Process: Early the next morning, information sharing with agencies involved with the DP, and activation of the Multi-Agency Risk Assessment Conference (MARAC) for consideration of actions or a S42 referral. If there it is deemed not to be a MARAC case, a MARM should be arranged. Lead Agency and Key Worker: In cases of complexity and repetitive patterns, there should be a consideration for a lead agency and a key worker to coordinate efforts.
12	That Somerset Safeguarding Adults Board and the Safer Somerset Partnership arrange a joint learning event to disseminate the learning from SAR Juliet and DHR Henrietta.

Homelessness Thematic Review

Background

This thematic Safeguarding Adults Review examined the experiences of adults who were homeless or at risk of homelessness and who had multiple and complex needs, including self-neglect, substance misuse, physical and mental ill health, and exposure to abuse and exploitation. The review drew on a range of cases to identify common themes in practice and system response.

The individuals included within the review often experienced significant social exclusion, limited engagement with services, and repeated contact with emergency

and crisis services rather than sustained support. Their circumstances were frequently characterised by unstable housing, poor health, and vulnerability to harm, including exploitation, violence and neglect.

The review was commissioned to understand how effectively agencies worked together to safeguard adults within this cohort, with a particular focus on multi-agency coordination, engagement, risk management and access to appropriate services. It also sought to identify learning to improve responses to people experiencing homelessness within the safeguarding system.

Findings and areas for learning and improvement

Understanding of Complexity and Multiple Disadvantage

The review identified that individuals experiencing homelessness often presented with multiple, overlapping needs, including substance misuse, mental health issues and self-neglect. However, services did not always demonstrate a shared or comprehensive understanding of this complexity. [somersetsa...Juliet.pdf]

There was evidence that needs were sometimes considered in isolation, rather than recognising the cumulative and interacting nature of risks, which limited the effectiveness of interventions and the development of holistic care planning.

Engagement and Person-Centred Practice

Engagement with individuals experiencing homelessness was consistently identified as a challenge. Many individuals had sporadic or crisis-driven contact with services, and traditional service models were not always effective in sustaining engagement.

The review highlighted the need for flexible, persistent and relationship-based approaches that prioritise trust-building and recognise the impact of trauma. A lack of consistent, trusted professional relationships reduced opportunities to understand individuals' lived experiences and respond effectively.

Multi-Agency Working and Coordination

Whilst there were examples of effective partnership working, the review found that multi-agency coordination was not consistently applied. In many cases, involvement from multiple agencies did not translate into a coherent or coordinated response.

There was limited use of structured multi-agency forums to manage complexity, and opportunities for shared planning and risk management were sometimes missed. This resulted in fragmented responses and an over-reliance on reactive, single-agency interventions.

Risk Assessment and Safeguarding Responses

Risk was often recognised but not always effectively managed. The review identified that safeguarding responses were sometimes delayed or not fully utilised, particularly in relation to self-neglect and chronic vulnerability.

There was also a tendency to accept high levels of risk as 'chronic' or 'lifestyle-related', which may have contributed to reduced professional curiosity and lower levels of escalation. This reflects the need for a stronger safeguarding approach to individuals experiencing ongoing harm linked to homelessness.

Access to Services and System Barriers

The review highlighted barriers in accessing appropriate services, particularly for individuals with the most complex needs. This included challenges in accessing accommodation, mental health services, substance misuse support and primary healthcare.

Service thresholds, eligibility criteria and limited availability of tailored provision contributed to gaps in support. Individuals were often required to engage with multiple services separately, which created additional barriers and reduced the likelihood of sustained engagement.

Information Sharing and Continuity of Support

Information sharing between agencies was variable, and the absence of consistent lead professionals or coordinated oversight contributed to fragmented care. Individuals frequently came into contact with different professionals, limiting continuity and reducing opportunities for relationship-based working.

The review identified a need for clearer accountability and coordination, particularly where individuals were known to multiple services over extended periods.

System Response to Self-Neglect

Self-neglect was a common feature across cases but was not always addressed through a coordinated safeguarding framework. Responses were often focused on immediate presenting issues rather than underlying causes or long-term risk.

Recommendations where further assurance is being sought or the recommendation has been completed or implemented:

	Summary of Recommendation
1	Somerset SAB to seek assurance from the Council's Adult Social Care and Housing Depts about the availability and take up of legal literacy training

	available to frontline social workers and housing officers. Importantly assurance should be sought into how key terms, such as 'capacity' and 'vulnerability' are understood in law and local practice and how discretionary powers under the Care Act 2014 and Housing Act 1996/Homelessness Reduction Act 2017 should be used creatively to reduce and prevent the risk of abuse and neglect facing neurodivergent adults, those with mental health issues and those living with the effects of drug and alcohol dependency. This may also include sharing existing resources, including those created by MHCLG as part of the autumn 2024 webinar series.
2	Review of the current self-neglect practice guidance and training offer for frontline practitioners and clinicians across the system, to ensure it adequately considers self-neglect in younger adults with complex and overlapping needs. Once reviewed, it is recommended that a practice briefing note, on the discrete issues around self-neglect and homelessness[58], is developed and disseminated widely, emphasising good practice and clarifying expectations around mental capacity assessments and decisions.
3	Somerset SAB to consider convening a meeting or event dedicated to how family, friends and partners are involved and supported when agencies are working with adults with mental health and substance use related care and support needs. This should include insights from lived experience, learning from the counties One Team and a reflective discussions about current practice within Adults Social Care and NHS.
4	Adult Social Care to conduct a review of data and practice about safeguarding concerns raised about people experiencing homelessness. The review should consider; -how the triaging process that occurs at Customer Services filters concerns about homelessness and the impact this has, potentially exploring the implementation of a 'trusted referrer' model that would enable concerns raised by designated teams or individuals to bypass the triaging process -how homelessness related concerns about recorded, monitored and quality assured. -how concerns raised by or on the suggestion of multi-agency forums and meetings, such as the Creative Solutions Panel, are prioritised and responded to. -a review of actions taken following receipt of safeguarding concerns about people experiencing homelessness training available to Customer Services

	staff about rough sleeping and homelessness related risks and safeguarding concerns.
5	ASC to work with their named Rough Sleeping Initiatives Advisor at MHCLG the potential for resourcing a dedicated Homelessness Social Work role in the county.
6	Somerset Council's Housing and Social Care Depts, HM Prison and Probation Service and Somerset Integrated Care Board to work together to establish a 'Transitions Panel' to prevent homelessness and the escalation of need for highly vulnerable people leaving prison, hospitals or supported housing/hostel pathways. This may be a discrete panel or an additional responsibility of an existing multi-agency meeting, such as Creative Solutions, dependent on resourcing and capacity.
7	Somerset SAB to recirculate the local MARM protocol, seeking assurance from key partners and local commissioners that the protocol has been promoted widely and it's use and outcomes recorded on local systems. Importantly, that MARM is a mechanism for responding to concerns that do not meet sec 42 thresholds, and not a replacement for formal safeguarding activity, should be restated.
8	Adult Social Care, Somerset ICB and Somerset Foundation Trust to work together to develop a briefing or practice guide that clearly sets out roles and responsibilities around assessing mental capacity when considering self-neglect and homelessness (see Recommendation 2) and provide clarity on how to assess fluctuating capacity and executive functioning as well as resolving professional differences about mental capacity decisions. Somerset SAB to seek assurance that the briefing has been circulated widely, especially with frontline practitioners and voluntary sector agencies. This recommendation should be considered, and where useful amalgamated, with similar recommendations made by the Thematic SAR on Self-Neglect.
9	Somerset Integrated Care Board to provide a written brief about the implementation of the NHS England Inclusion Health Framework. This should include plans to establish a named Inclusion Health Lead on the Safeguarding Adults Board (SAB) and a service map of current inclusion health provision in the county.
10	Somerset SAB Independent Chair to reach out to local Prison Governors to request a meeting to discuss HMPPS input in adult safeguarding arrangements, operationally and strategically, specifically related to

	discharge planning for highly vulnerable adults. This discussion might be linked to activity in Recommendation 6.
11	To monitor implementation of the recommendations in the Joint Ministerial Letter of May 2024, Somerset SAB to make homelessness a strategic priority in the Board's next annual plan. Priorities for action should include how learning from this review has been implemented, and an update from the Council about homelessness governance, including but not limited to the activities of the Homelessness Reduction Board.
12	Somerset SAB to request a presentation from the counties Public Health Team on the implementation of the 2024-29 Suicide Prevention Strategy[60] in relation to the support available to high-risk groups such as those experiencing homelessness, living with addiction and neurodivergent adults and how this is connected to activity in relation to Recommendation 9.

'Learning Disability' Local Learning Review

Background

A Multi-Agency Round Table Learning Event was convened to reflect on the learning arising from a Safeguarding Adults Review involving an adult with a learning disability who experienced significant distress and self-injurious behaviour.

The event brought together practitioners from across partner agencies to consider how services responded to increasing distress, self-injury and risk, and to identify learning to strengthen multi-agency practice.

The individual at the centre of the learning had a history of physical health needs and learning disability and was supported within a family environment. In the period leading up to the incident, there was evidence of increasing distress, emotional difficulty and self-injurious behaviour, alongside engagement with a range of health and social care services.

Findings and areas for learning and improvement

Understanding Emotional Distress and Self-Injury

The learning event highlighted the need for improved recognition and understanding of distress in people with learning disabilities. Practitioners reflected that self-injury may be linked to a range of underlying factors, including difficulty expressing emotions, trauma, anxiety and loss.

There was recognition that services do not always fully understand how individuals experience and communicate distress, which can limit the effectiveness of responses and delay appropriate support.

Person-Centred Practice and Voice of the Individual

A key area for learning relates to the importance of ensuring that the person's voice remains central within safeguarding and care responses. Practitioners reflected on the need to move beyond service-led approaches and focus on what matters to the individual.

The importance of Making Safeguarding Personal was emphasised, including enabling meaningful involvement in decision-making and ensuring that individuals understand and are able to express their wishes.

Care Coordination and Multi-Agency Working

The event identified the need for stronger coordination across services when supporting individuals with complex and overlapping needs. While multiple agencies were involved, there was not always a shared understanding of the individual's situation or a clearly coordinated plan.

Practitioners highlighted the importance of developing a holistic understanding of need, including physical, psychological and social factors, and ensuring that care is actively coordinated rather than delivered in parallel.

Professional Curiosity and Holistic Assessment

Learning from the event emphasised the need for greater professional curiosity in understanding behaviour and risk. This includes considering the wider context of an individual's life and developing comprehensive bio-psychosocial assessments where appropriate.

There was recognition that without this depth of understanding, services may respond to presenting behaviours rather than underlying need.

Risk Recognition and Escalation

The learning event highlighted the importance of timely recognition and escalation of risk. Practitioners reflected on the need to consider safeguarding responses, including formal processes or multi-agency risk management arrangements, where there are indicators of increasing harm.

There was a need to ensure that risk is actively reviewed and revisited, particularly where circumstances change or deteriorate.

Role of Family and Support Networks

The importance of adopting a "Think Family" approach was emphasised throughout the discussion. Families were identified as key partners in understanding the individual and supporting their wellbeing.

Practitioners highlighted the need to consider the impact of risk on family members and to ensure that support is offered to them alongside the individual.

Communication Between Services

The event identified that effective communication between services is essential to developing a shared understanding of risk and need. Where communication is limited or fragmented, there is a risk that key information is not brought together to inform decision-making.

Strengthening information sharing and ensuring clear communication pathways across agencies were identified as priorities for improvement.

Recommendations where further assurance is being sought or the recommendation has been completed or implemented:

'Family H' Safeguarding Adults Review

Background

This Safeguarding Adults Review concerns Ruby (a pseudonym), an 83-year-old woman with significant physical and mental health needs. She had a history of multiple hospital admissions, including for heart failure, hyponatraemia and diabetic ketoacidosis, and required support with medication management, including insulin administration. Concerns had also been raised about her cognitive function, including short-term memory difficulties.

Ruby lived at home and received care from a combination of informal family support and a micro-provider, although the extent and consistency of this support were unclear. Her son, Grant, had recently returned to live with her, and concerns were raised about his behaviour, including allegations of neglect, controlling behaviour and failure to meet her care needs. Reports indicated that Ruby may have been restricted to her bedroom and had limited access to food and drink.

Safeguarding concerns were raised shortly before Ruby's death in July 2024 following an incident involving her son. A referral was made to Adult Social Care, alongside a police welfare check after Ruby failed to attend a GP appointment. Given

the complexity of her needs and repeated hospital admissions in the preceding months, the review sought to consider whether opportunities to intervene and provide appropriate support had been missed.

The review was undertaken as a Local Learning Review over the period January to October 2024, with the aim of identifying learning to strengthen safeguarding practice and multi-agency working.

Findings and areas for learning and improvement

Medication Management and Health Oversight

The review identified issues relating to medication management, particularly around communication at hospital discharge. Ruby misinterpreted instructions regarding her warfarin medication, believing it had been discontinued when it should have been continued. This highlighted the importance of clear and accessible communication with patients, particularly those with cognitive impairment.

There were also concerns about medication compliance more broadly, which contributed to her deteriorating physical health. Although safeguards such as routine INR monitoring were in place within primary care, gaps in follow-up systems, particularly during staff absence, identified the need for more robust contingency arrangements.

Cognition, Mental Capacity and Communication

Concerns regarding Ruby's cognitive decline were recognised by some professionals; however, these were not consistently documented or communicated across services. Hospital discharge summaries did not routinely include information about cognition or mental capacity, limiting the ability of community services to fully understand her needs.

Although proactive steps were taken in primary care, including referral to a memory clinic, the absence of a consistent multi-agency understanding of her cognitive needs impacted care planning and risk management. The review emphasised the need for clearer recording and communication of cognitive assessments and capacity considerations.

Mobility, Deterioration and Pressure Care

Ruby experienced a decline in mobility and developed pressure wounds, which were not consistently monitored or managed. While services were involved, there was limited evidence of coordinated oversight of her skin integrity and mobility needs.

Her increasing dependence and reduced mobility were not clearly documented as a trigger for reassessment of care needs. The review identified this as a missed opportunity to intervene and provide additional support.

Hospital Discharge and Care Planning

The review found gaps in discharge planning and coordination between hospital and community services. There was no clear evidence of a Section 9 Care Act assessment being completed, and key information, including the outcomes of occupational therapy assessments, was not consistently shared with primary care or other involved professionals.

Additionally, mental capacity considerations were not routinely included in discharge summaries, limiting continuity of care and the ability to make informed decisions about support needs following discharge.

Role of the Carer and Family Dynamics

Ruby's son was a central figure in her care; however, concerns were raised about his ability to meet her needs and his own health and wellbeing. There was a lack of clarity regarding his circumstances, including whether his behaviour was linked to alcohol use or underlying health issues.

The review highlighted that a carer's assessment was not undertaken, representing a missed opportunity to better understand his needs and capacity to provide care. The complexity of the caring relationship, including elements of potential control and dependency, required greater professional exploration.

Safeguarding Practice and Referral Processes

The review identified the need for greater clarity in safeguarding practice, particularly in distinguishing between safeguarding concerns and requests for care and support. In this case, there was a delay in escalation and follow-up, with reliance placed on informal checks by family members.

There was also limited feedback to referrers regarding actions taken, which reduced visibility of safeguarding responses and may have impacted ongoing risk management.

Multi-Agency Working and Coordination

Although multiple agencies were involved, the review found that services were often working in isolation, with limited evidence of coordinated multi-agency planning. There were missed opportunities to convene multi-agency meetings to bring together information and manage risk collaboratively.

The review highlighted the potential role of Multi-Agency Risk Management (MARM) processes as a proactive approach to managing complex cases and emphasised the importance of coordinated, shared responses to individuals with multiple and increasing needs.

Recommendations where further assurance is being sought or the recommendation has been completed or implemented:

	Summary of Recommendation
1	Integrated Care Board (ICB) should request assurance that all medical practices have a process to review patients who don't attend appointments.
2	Somerset NHS Foundation Trust (FT) consider including reference to mental capacity in their discharge summary to assist primary care.
3	Somerset NHS FT are to ensure that discharge summaries include information on cognitive or memory issues and should include information on mental capacity assessments to support primary care.
4	When home visits are being made, a holistic approach should be taken to review the health and well-being of patients.
5	The SSAB should promote across organisations that referrals need to be clear about whether they are making a safeguarding referral or a request for care and support. Adult Social Care should provide feedback to referrers, including GPs, on the outcome and actions taken following a safeguarding referral.
6	The SSAB should continue to promote the use of the MARM across all organisations and how it can be used at the Same time as a S42.

7	Adult Social Care and the Health System ensure that carers are offered assessments to ensure they are able to provide the necessary support.

7. Our Priorities for 2026-2028

The Board recognises more can be achieved by working together in partnership and has identified five strategic objectives for its strategic plan for 2025-2028 based on learning, intelligence and feedback. The plan will be updated annually:

1: Community Engagement
Desired outcomes: • **Strong engagement with local people and those who use our services to inform our decision making.** • **Safeguarding policies and procedures that are co-produced with people with lived experience.** • **Robust working links in our local communities to raise awareness of and confidence in adult safeguarding.**
What will demonstrate success: • **People with lived experience are empowered to give the thoughts and how they feel about their experience** • **There is a citizen-led safeguarding input in place to provide input into the Board's ways of working and effective safeguarding practice** • **Positive feedback from user groups on 'MARM' and how this works effectively within their environment.** • **Documents and guidance will be available in Easyread and a range of languages representative of our community**
2: Homelessness
Desired outcomes: • **Address the unique safeguarding needs of individuals experiencing through street homelessness, rough sleeping, temporary accommodation, sofa surfing.** • **Raise awareness of the dangers of rough sleeping and increase agencies understanding of their responsibility to refer safeguarding concerns.** • **Create an environment and culture in which practitioners are confident in escalating cases through an agreed pathway.**
What will demonstrate success:

- **Detailed objectives and timelines will be formulated after the thematic review and once the new structure of the local authority's housing department is clearer.**

3: Domestic Abuse and Exploitation

Desired outcomes:

- **All organisations understand what constitutes domestic abuse and exploitation, particularly focusing on older adults and all-age exploitation.**
- **Training professionals, particularly in hospitals and GP surgeries, to recognize signs of domestic abuse in older adults and ask the right questions to identify potential abuse**
- **Have an overarching partnership which aligns our approach to transitional safeguarding, including exploitation, county lines and substance misuse within an all-age exploitation strategy.**

What will demonstrate success:

- **Will be able to identify areas where there are levels of domestic abuse and exploitation being recorded across Somerset organisations.**
- **Provide the Board an understanding of the support available to people with learning disabilities and autism.**
- **A strategy will be agreed which addresses exploitation at any age and is adopted by all services and organisations.**
- **The Board has assurance that practitioners have an understanding of the domestic abuse and exploitation toolset.**

4: Transitional Safeguarding

Desired outcomes:

- **Recognise that the needs of young people do not change or stop when they reach 18.**
- **Consider all types of transitional safeguarding throughout life and the pathways to support them.**

What will demonstrate success:

- **Have a suite of documented pathways for transitions for those who may require safeguarding.**

- **Practitioners understand the importance of transitional safeguarding and how to support this.**

5: Promotion of MCA and its use

Desired outcomes:

- **Practitioners understand and are supported in how to apply the MCA.**
- **Practitioners understand their duties and responsibilities in regard to initiating an assessment of capacity.**
- **Practitioners understand their duties and responsibilities in regard to Best Interests.**
- **Create an environment and culture in which practitioners are confident in applying the Mental Capacity Act.**

What will demonstrate success:

- **Online training about mental capacity and self-neglect was delivered for care provider organisations in April 2024 - recording available on SSAB website.**
- **MCA Audit completed with an action plan in place.**
- **Clear set of practice recommendations made for improvements individually and generally. Incorporated into formal and informal training.**

8. Board Budget

An agreement remains in place to split the costs of any Safeguarding Adult Review equally between Avon & Somerset Constabulary, Somerset NHS Integrated Care Board and Somerset Council separately to the Board's core funding.

SOURCE OF FUNDS		CONTRIBUTIONS £	%
SOMERSET COUNCIL	- SAB MANAGER & CHAIR	54,967	43.5%
	- SAFEGUARDING ADULTS REVIEWS	12,687	10.0%
AVON & SOMERSET POLICE	- SAB MANAGER	23,402	18.5%
	- SAFEGUARDING ADULTS REVIEWS	12,687	10.0%
SOMERSET NHS ICB	- SAB MANAGER	10,000	7.9%
	- SAFEGUARDING ADULTS REVIEWS	12,687	10.0%
TOTAL CONTRIBUTIONS		**126,430**	100.0%
APPLICATION OF FUNDS		**EXPENDITURE £**	**%**
PAY			
SAFEGUARDING BOARD MANAGER		67,654	54.6%
INDEPENDENT CHAIR		16,499	13.3%
NON PAY			
SAFEGUARDING ADULTS REVIEWS		38,153	30.8%
ROOM HIRE		443	0.4%
TRAINING		990	0.8%
BT CHARGES/MOBILE CHARGES		96	0.1%
TOTAL EXPENDITURE		**123,835**	100.0%
ANNUAL OVERSPEND / (UNDERSPEND)		-2,595	

11. Our Work During 2025/26

The SSAB identified the following four objectives within its Strategic Plan for 2025-2028:

1. **Community Engagement**
2. **Homelessness**
3. **Domestic Abuse and Exploitation**
4. **Transitional Safeguarding and Exploitation**
5. **Promotion of MCA and its use**

During 2025/26 the Board's work continued to carry out its statutory duties, whilst moving forward, proactively raising awareness of the Somerset Safeguarding Adults Board, promoting learning and gaining assurance across its organisations in Somerset.

Priority Area 1: Community Engagement

What SSAB said it would do	What the SSAB did
Hear the voices of people with lived experience	• The Local Authority established a Working Together Board to support greater co-production opportunities to whom the SSAB has reached out, linking with other services who hear the voices of those with lived experience.
Increase and explore different ways to work with citizens of Somerset to improve our policies, systems and processes by understanding what matters to them.	A new role has been created within Adult Social Care which will engage with communities to achieve coproduction. It is currently being evaluated and will be ready for recruitment in the near future.

What SSAB said it would do	What the SSAB did
Provide accessible publications and guidance	• There is now accessible public facing leaflets available on the SSAB website. The annual report and strategic will be made Easyread and published.

Priority Area 2: Homelessness

What SSAB said it would do	What the SSAB did
Detailed objectives and timelines will be formulated after the thematic review and once the new structure of the local authority's housing department is clearer.	• The SSAB hosted a Homelessness Summit, which highlighted the services that were open to those experiencing homelessness. • The SSAB is represented on the Homelessness Reduction Board nd has Housing representaton on the SSAB Board.

Priority Area 3: Domestic Abuse and Exploitation

What SSAB said it would do	What the SSAB did

Collate data across organisations to understand the extent of domestic abuse for those who may need safeguarding, with a focus on domestic abuse of older people	• **Regional SABs have been working with the Police to identify data to understand where there are reports of domestic abuse and analyse this against information held by other agencies.**
Ensure there is a comprehensive approach to addressing the needs of people with learning disabilities and autism.	• **This is an ongoing area of work. The SSAB is planning a learning event to consider how Somerset supports those with a learning disability or autism. This will be one of a series of learning events that will take place in the Autumn.**
Young adults at risk may not be covered by Care Act duties; Commit to working in partnership to develop approaches to reducing risk of exploitation for all adults.	• **There is now an All-Age Exploitation Strategy from which an action plan will be drafted. Agencies for both children and adults attend the All-Age Strategic Exploitation Group and will be responsible for overseeing the action plan, once it is drafted.**

Working with Safer Somerset Partnership, develop effective interventions for practitioners to use to address domestic abuse or exploitation.	• **This will be included in the All-Age Exploitation Action Plan.**

Priority Area 4: Transitional Safeguarding

What SSAB said it would do	What the SSAB did
Adopt an approach to safeguarding that considers all types of transitions, building on best practice and learning from organisations across Somerset.	• **The Adult Social Care Preparing for Adulthood Service now has protocols for these transitions. Assurance reports are provided to the Board to provide an update on children's to adults' transitions.The Preparing for Adulthood Service works with young people who have a Learning Disability, Physical Disabilities and Health Conditions.** • **If a young person has a significant Mental Health Need the referral would come through the Preparing for Adulthood Team, however this would then be allocated to the MHSC Team to complete the Care Act Assessment.**
Promote the transitions' pathways across Somerset.	• **Before the pathway can be promoted, a system audit, across children's and adults will be undertaken to provide assurance of the pathways.**

Priority Area 5: Promotion of MCA and its use

What SSAB said it would do	What the SSAB did
Ensure practitioners understand how capacity, best interests, and the Court of Protection apply in the context of self-neglect.	• The SSAB conducted webinars to promote how MCA could be used to support those who self-neglect. The webinars are available on the SSAB website.
Ensuring that executive functioning is considered within the parameters of the MCA.	• The SSAB have been offering MCA Forum bi-monthly with a topic to introduce the session and a discussion period for practitioners to bring their cases for advice.

SOMERSET SAFEGUARDING ADULTS BOARD

www.somersetsafeguardingadults.org.uk
0300 123 2224
adults@somerset.gov.uk