From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this practice briefing. It shares learning from the Safeguarding Adults Review concerning Raymond and supports multi-agency reflection and improvement.

The briefing focuses on financial exploitation, timely escalation, trauma and grief, suitable accommodation, and cognitive functioning and mental capacity.

Please discuss the learning with your team and consider what needs to change in your own practice and across your professional network.

This document includes a feedback sheet to capture how the learning has been used.

What is a Safeguarding Adults Review?

Safeguarding Adults Boards must arrange a review where an adult with care and support needs dies, or experiences serious abuse or neglect, and there is concern that partner agencies could have worked more effectively together.

Reviews identify what agencies and practitioners can learn and how that learning should improve future practice.

Raymond

The SAR was undertaken using the SSAB Local Learning Review and the key messages contained in this briefing reflect the learning to emerge from this.

How you can make a difference

Learn to recognise:

- persistent financial exploitation, physical abuse and self-neglect as interconnected safeguarding concerns;
- how trauma, grief, frailty, substance dependency and cognitive impairment can affect engagement and behaviour;
- when delays, disagreement or fragmented plans require prompt senior escalation;
- the need for decision-specific, time-specific and collaborative mental capacity assessment; and
- accommodation as an essential part of risk management, not a separate issue.

Consider: What will I change in my practice, and what support, supervision or escalation do I need?

Key features of Raymond's case

Raymond was living in interim bed-and-breakfast accommodation. He was remembered as a warm, caring and humorous man—a "gentle giant" and an informal father figure within the local street community.

Raymond lived with chronic pain, frailty, memory and cognitive difficulties, long-standing alcohol and drug dependency, and suspected cardiac problems. He experienced seizures, overdoses and blackouts, and had difficulty managing personal care, nutrition and his living environment.

He repeatedly sought help and wanted support. However, intoxication, memory difficulties, distress and deteriorating health affected his ability to engage consistently. He was also vulnerable to financial and physical abuse, including theft, coercion and assaults.

Key considerations for practice arising from the review

1. Financial abuse, exploitation and self-neglect

Act on patterns, not only isolated incidents. Repeated theft, coercion, assault, unusual withdrawals, giving away money to keep the peace, or marked changes in behaviour may indicate escalating exploitation. Shame, fear of being labelled a "snitch", intoxication or poor recall can make disclosure difficult.

- Build a chronology across agencies so cumulative harm is visible.
- Explore the adult's wishes, strengths and desired outcomes; do not allow their voice to disappear from safeguarding discussions.
- Consider financial abuse alongside physical abuse, self-neglect, frailty and cognitive impairment.
- Use creative, proportionate risk reduction rather than assuming that refusal to report an incident ends safeguarding activity.

Reflect: Are we seeing the full pattern of harm, and have we asked the person what safety means to them?

2. Timely action, escalation and professional differences

Do not let process delay protection. Where risk is escalating, agencies should agree a lead professional, a shared plan, named actions and review dates. If assessment, funding or accommodation decisions are delayed, record and actively mitigate the additional risk.

- Escalate stalled action and unresolved disagreement promptly.
- Use the Resolving Professional Differences process; commissioned and voluntary organisations can also raise concerns.
- Record decision rationales, direct contact with the adult and contingency plans clearly.
- Maintain professional curiosity when a request is declined or a pathway reaches an impasse.

Reflect: If nothing changes after repeated concerns, who has authority to unblock the plan?

3. Trauma-informed practice, grief and behaviour

Ask what has happened to the person, not simply what is wrong. Bereavement, rejection, homelessness, exploitation, pain and insecure accommodation may intensify

distress. Aggression, withdrawal, hostility, agitation or missed contact can be expressions of trauma, grief, fear or cognitive difficulty.

- Identify anniversaries, losses and circumstances that trigger distress or increased substance use.
- Prioritise trust, consistency, psychological safety and long-term relational support.
- Adapt engagement to the person's routines and persist when contact is difficult.
- Use supervision and multi-agency reflection to avoid punitive or stigmatising responses.

Reflect: How might grief, identity, stigma and previous trauma be shaping the person's behaviour and choices?

4. Accommodation and safe support

Accommodation is part of safeguarding and risk management. A placement may prevent rough sleeping yet remain unsafe because of exposure to exploitation, poor accessibility, substance use, isolation, inadequate facilities or insufficient support.

- Assess whether accommodation meets physical health, care, communication and safety needs.
- Bring housing, adult social care, health, substance use and support providers together early.
- When only unsuitable interim accommodation is available, agree additional support, monitoring, risk mitigation and review.
- Advocate and escalate when historic information, stigma or process blocks a viable housing option.

Reflect: Does the placement actively reduce risk, or merely provide a roof?

5. Cognitive functioning and mental capacity

The presumption of capacity must not become a reason for non-intervention. Capacity is decision-specific and time-specific. Consider intoxication, withdrawal, memory loss, possible brain injury, executive functioning, trauma, pain and fluctuating presentation.

- Assess the person's ability to understand, retain, use or weigh information and communicate the decision.
- Consider whether the person can put a decision into effect in everyday life.
- Seek information from practitioners who know the person well, including voluntary and commissioned services.
- Use concise communication, repetition, accessible information and active checks of understanding.
- Record the evidence, adjustments, rationale and arrangements for review.

Reflect: Have we distinguished an unwise decision from an inability to make or implement the relevant decision?

Further information

- Somerset Safeguarding Adults Board
- Resolving professional differences
- Multi-Agency Risk Management guidance
- Care and Support Statutory Guidance
- Mental Capacity Act information

Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Organisation	
Date	
This briefing was cascaded to: (e.g. all district nurses; duty social workers etc.)	
This briefing was used in: (e.g. supervision with X number of staff; team meeting; development event etc.)	
Action taken as a result of the learning:	

Other feedback / discussion points