DSAB

Dorset Safeguarding Adults Board

Dorset Safeguarding Adults Board

Annual Report

2025-26

Safeguarding is everybody's business

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Dorset Safeguarding Adults Reviews (SARs) published 2025-2026 There were no Dorset SAB SARs published in 2025/ 2026. The Dorset Safeguarding Adults Board is currently working on 4 commissioned SARs, and if approved by the SAB within this current year, may be published in 2026-2027. All previous published SARs can be found on our website **Dorset SAB published SARs**	
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Foreword

I'm delighted to introduce the Dorset Safeguarding Adults Board (SAB) Annual Report 2025/2026.

Over the last year, we have continued to strengthen our commitment to safeguard adults with care and support needs from abuse, harm and neglect in Dorset.

Our Board meets jointly with the Bournemouth, Christchurch & Poole Safeguarding Adults Board and shares all its subgroups. This enables us to work efficiently with our statutory partners across the NHS and the Police and also with many other public, voluntary and community sector organisations.

It has been a busy and challenging year for many of our partners with increasing pressure across the system, but we have continued to work closely together to progress the priorities set out in our 2023-26 Strategic Plan to keep people safe. This has included:

- the launch of new independent SAB website enabling partner organisations and the public to access current safeguarding information and local learning
- sharing best practice and embedding learning through our annual multi-agency Safeguarding Adult Review (SAR) learning event
- hosting events with our partner housing providers and the voluntary and community sector to support them in building their networks and developing their understanding of safeguarding issues

In addition to assurance through Board meetings and subgroups, our partners completed an annual audit, providing assurance to the Board that safeguarding arrangements are effective, and that learning from Safeguarding Adult Reviews is being embedded in practice throughout their organisations.

This year, BCP Safeguarding Adults Board published 2 Safeguarding Adult Reviews (SARs) SAR Matthew, highlighting key learning points around mental capacity and executive function, trauma-informed care and risk management; and SAR Peter, highlighting the need for interagency collaboration and information sharing between healthcare providers, adult social care services, and other agencies to manage support for people with complex needs effectively. SAR Peter includes references to his management of diabetes, a theme that is being noted more frequently nationally. Although these are BCP SARs, the learning has been shared with agencies across both local authority areas.



I remain committed to ensuring that people's voices and their lived experience are reflected in our learning and approach to safeguarding with every Board meeting featuring a personal safeguarding story and every review focussed on the person and their choices.

Within this 2025/2026 reporting year we reflect on the achievements and progress against objectives set out in our strategic plan, in this Annual Report and look forward to working with partners on our new 2026/2029 3-year plan in the coming years.

I would like to thank our members and the Board support team for their continued commitment, leadership and hard work.



Siân Walker McAllister
Independent Chair
Dorset Safeguarding Adults Boards

The role of a Safeguarding Adults Board

A Safeguarding Adults Board (SAB) plays a crucial role in protecting adults with care and support needs who are at risk of abuse, harm and neglect by providing multi-agency strategic oversight of adult safeguarding.

A SAB oversees and seeks assurance on the effectiveness of the safeguarding work of its members and partner agencies which includes our statutory partners in the Local Authority, NHS, and Police as well as other public sector organisations, such as Prison & Probation, Fire & Rescue Service and importantly housing providers and the voluntary and community sector.

The SAB's functions and responsibilities are outlined in the Care Act 2014. Bournemouth, Christchurch and Poole Safeguarding Adults Board has three core duties:

- developing and publishing a **strategic plan** detailing how we will meet our objectives and how our partner agencies will contribute to delivering our strategic priorities
- publishing an **annual report** to report on progress against our strategic priorities and how effective we have been which includes what each partner has done to implement our strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action
- commissioning and publishing **Safeguarding Adult Reviews** (s.44 of the Care Act) when an adult in our area dies as a result of abuse, harm and neglect, whether it is known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult.

SABs must arrange a Safeguarding Adult Review if an adult in its area has not died but the SAB knows or suspects that the adult has suffered serious abuse or neglect and must ensure partners demonstrate how they work together so that lessons learned impact the future delivery of services to those with care and support needs.



Our partners

The Dorset and BCP Safeguarding Adults Boards are made up of senior representatives from the following agencies:

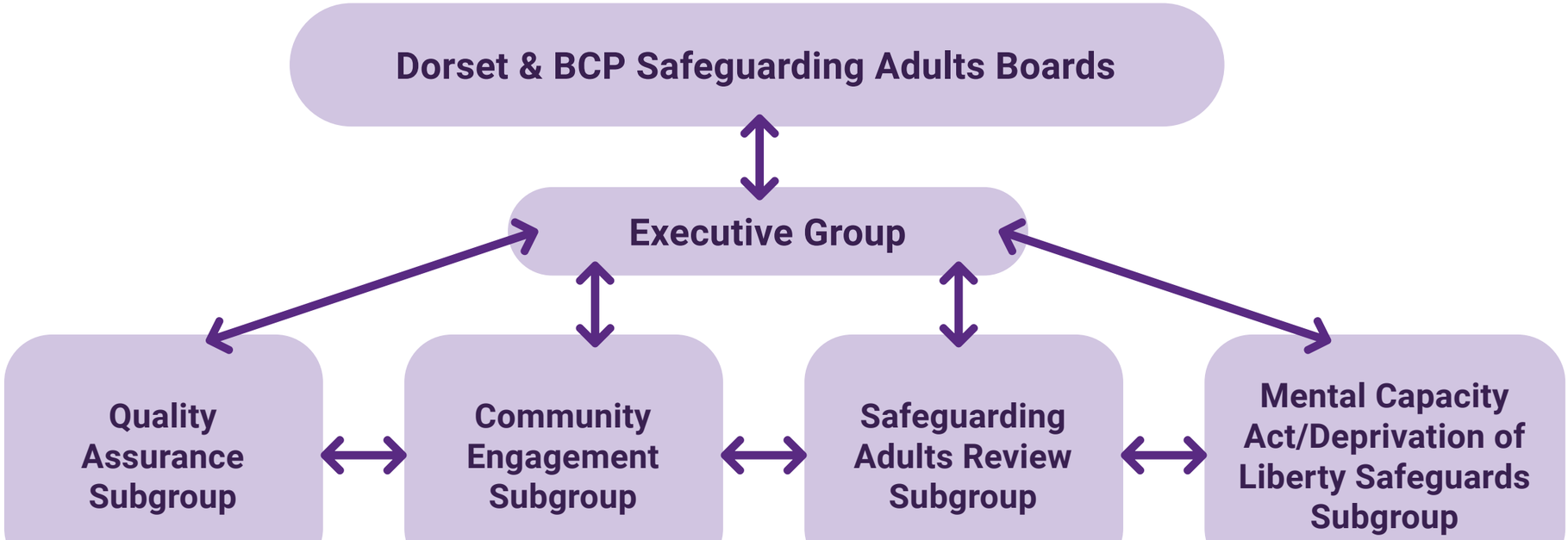
Our statutory partners:

Our board member organisations:

Local Authority representatives from Dorset and BCP Council include senior officers from Adult Social Care and Housing as well as Cabinet Members for Adult Social Care.

- **NHS Dorset HealthCare University** (NHS Foundation Trust)
- **NHS Dorset County Hospital** (NHS Foundation Trust)
- **NHS University Hospitals Dorset** (NHS Foundation Trust)
- **NHS South Western Ambulance Service** (NHS Foundation Trust)
- **NHS England**
- **Dorset & Wiltshire Fire and Rescue**
- **Volunteer Centre Dorset**
- **Probation Service**
- **CAN Community Action Network**
- **Department of for Work & Pensions**
- **HM Prison Service**
- **HMP Guys Marsh**
- **HMP Portland**
- **HMP The Verne**

Structure of the Dorset & BCP Safeguarding Adults Boards



Budget for 2025-26

Dorset & BCP SABs maintain a working budget to enable us to undertake our work, and the priorities identified in the strategy and business plan. Each year, contributions are received from statutory partners to support this work.

The Dorset & BCP SABs are grateful for the financial support of partners which enables us to carry out our work.

Where we receive our money from:

BCP Council	£70,000
Dorset Council	£70,000
NHS Dorset	£38,745
Dorset Police	£19,404
HM Prison & Probation Service	£1,500
Total	**£199,649**

Dorset Council Safeguarding Activity in 2025-2026

7,624

Total safeguarding concerns → received

Care Act s.42.1

1,141

Total safeguarding concerns → progressed

Care Act s.42.2

0

Total safeguarding concerns → progressed to other query

top four locations of abuse

49% own home

27% Care Home Residential

6% In the community

excluding community services

13% Care Home Nursing

concluded enquiries

Source of Risk

41% Service Provider

58% Known to individual

1% Unknown to individual

gender & age

15% of Safeguarding concerns **progressed** to a s.42 enquiry

Of those s.42 enquiries,

58% related to **females**

41% to **males** and **1%** **gender unknown**

73% of s.42 enquiries related to **people aged 65** and over

Outcome when risk identified

risk **removed** **20%**

risk **reduced** **73%**

risk **remains** **7%**

top four types of abuse

40% Neglect and Acts of Omission

15% Self Neglect

11% Physical Abuse

10% Domestic Abuse (including coercion)

Strategic Plan 2023-26

The work of the Boards is focused on delivering 4 strategic aims which are effective prevention, effective protection, effective learning and effective governance.

Preventative work in safeguarding	Seeking assurance on safeguarding practices	Assurance on delivery of 'Making Safeguarding Personal' (MSP)
Prevention Aim Continued development with partners of preventative work in safeguarding	**Accountability Aim** Continuing to seek assurance on safeguarding practice across system partners	**Partnership working Aim** Assurance on delivery of 'MSP' using a whole family approach
We will → Review learning from SARs from DBCPSAB & other Boards and revisit thematic learning from reviews to inform preventative work with adults with care and support needs. → Ensure we always take account of the experiences of people who use services or receive safeguarding interventions. → Seek assurance on an annual basis from partners that learning is embedded in the work of all frontline staff in all services in line with our Training & Development strategy. → Ensure that the Boards' subgroups are able to provide evidence of system learning and working to deliver preventative work. → Ensure there is good multi-agency working with a contextual safeguarding approach to preventative work with people who are homeless. → Improve use of data from all partners to enable us to identify trends which influence preventative work across all agencies.	**We will** → Continuously develop how we receive assurance as governance frameworks evolve across every statutory partner. → Ensure data is understood/ used to identify themes for every partner to progress in their safeguarding work; that information and learning is shared across the system. → Work in partnership across the safeguarding children and community safety partnerships to ensure that complexities of 'Transitional Safeguarding' are understood well. → Seek assurance on delivery of safe and person-centred practice in private mental health hospitals and for all placements of people outside our area. → Seek assurance that 'Think Family' practice across all agencies is embedded. → Continue to seek assurance on health & social care practice and provider care quality. → Seek assurance that the system is working to safeguard people via the new national policing initiative, 'Right Person, Right Care'.	**We will** → Seek assurance from all partners that Making Safeguarding Personal (MSP) is embedded throughout all agencies' safeguarding work. Seeking evidence that people have opportunity to express their outcomes at every stage in their safeguarding journey. → Involve people in the work we do – review how we communicate more widely with people and listen to and act upon the voices of those who have experienced safeguarding interventions. → Deliver our communication/ engagement strategy to the widest audience with the support of the voluntary and community sector through our Community Engagement Subgroup. → Ensure that the Quality Assurance subgroup continues to audit application of MSP and provides data which evidences that application of MSP is embedded.

Key achievements in 2025-2026

In our strategy we said...

Continued development with partners of preventative work in safeguarding

This is what we achieved…

- Shared learning and invited practitioner reflections through an annual SAR Learning Event with over 200 attendees.
- Continued partnership working with Probation & Prison Services to highlight safeguarding issues within prisons and as part of planning for prisoner release. At our meeting in January 2026, progress updates were shared as well as relevant national learning relevant e.g. SAR X (Norfolk SAB), which addressed the challenges of releasing an aging prisoner with history of sexual offending.
- Continued collaboration with the Housing sector through quarterly meetings and an annual in-person event to focus on safeguarding issues including cuckooing, anti-social behaviour and vulnerability.
- Continued strategic links with Higher & Further Education safeguarding leads to embed learning from Safeguarding Adult Reviews and discuss emerging safeguarding issues in their sector.
- Continued engagement with safeguarding leads and safeguarding practitioners from the Voluntary & Community sector. An in-person conference was held for the wider sector to increase understanding of safeguarding and the support available to volunteers and the public.
- Delivered a new independent SABs website to enable partner organisations and the public to access current safeguarding information and local learning.

  dbcpsafeguardingadults.org.uk

Continuing to seek assurance on safeguarding practice across system partners

This is what we achieved…

- Updated multi-agencies policies and procedures to share best practice with partners and support the implementation of recommendations from SARs (including; Safeguarding Adult Review (SAR) Policy; Multi-Agency Risk Management (MARM) Guidance; Safeguarding Policy, and the Boards' Training Strategy).
- Developed a Memorandum of Understanding (MOU) across local authorities and NHS partners to guide practitioners about the escalation process for adult patients in an Acute Hospital where there is disagreement as to whether a patient should be detained under the Deprivation of Liberty Safeguards or Mental Health Act.
- Produced and circulated a range of '7-Minute' Learning Reviews related to published SARs **SAR 'Matthew', SAR Peter, '7-Minute Learning on MAPPA** and sought assurance from partners that learning was cascaded to support change in practice.
- Continued connections with safeguarding children's partnerships and community safety partnerships to ensure common understanding and focus on shared risks and concerns as well as issues and ongoing reviews.
- Sought assurance that the system is working to safeguard people via the new national policing initiative, 'Right Care, Right Person' through presentations to our Board.

Assurance on delivery of 'Making Safeguarding Personal' (MSP) using a whole family approach

This is what we achieved…

- Local authorities shared data relating to their MSP practice at quarterly Quality Assurance subgroup meetings including how people involved in safeguarding interventions felt about the process and their desired outcomes.
- Partners reflected on their MSP practice in our annual audit questionnaire and detailed what they were doing to ensure every interaction takes a personalised approach.
- Continued focus on MSP through presentations from partners of personal safeguarding stories' at each Board Meeting.
- Engagement with families to gather insights about what the person was like to make the Safeguarding Adult Review personal.

Subgroup Chairs Reports 2025-2026

Safeguarding Adult Review (SAR) Subgroup

The Safeguarding Adult Review (SAR) subgroup met on 5 occasions throughout 2025-2026.

- During 2025-2026 the SAR subgroup provided the governance leading to the delivery and publication of two BCP Safeguarding Adult Reviews – SAR Peter & SAR Matthew.
- Reviewed 13 referrals during the year where 9 of these met the criteria for commissioning a SAR. 3 referrals were included in a Self-Neglect Thematic Review). A further 3 referrals were grouped into a thematic SAR to explore issues of women who have taken their own lives when their children had been removed due to child protection proceedings and 3 referrals were commissioned as individual SARs.

The SAR Policy was reviewed and approved in November 2025 to provide additional clarity for partners when making referrals.

Quality Assurance (QA) Subgroup

The Quality Assurance Subgroup met on 4 occasions during 2025-26.

- Considered and agreed a Safeguarding Supervision Framework to ensure that safeguarding supervision is offered to all colleagues in partner organisations which were then able to provide assurance that their staff are supported in this important work.
- Undertook Data analysis which showed low volumes of safeguarding advocacy uptake; then followed up working with the commissioned advocacy service which produced a short video for the SAB website
- The local authorities and a healthcare provider engaged in audit work on Making Safeguarding Personal, aligned with one of the key areas of focus in the Strategic Plan.
- Focussed on the care provider market and the challenges of international recruitment in the sector and how quality of care provision and safeguarding can be impacted.
- Regularly reviewed SAR Action Plans and tracked relevant recommendations Contributed to updated Multi-Agency
- Risk Management (MARM) guidance arising from recommendations within SAR Simon and SAR Edward.
- Continued to work with partners to encourage improved system-wide data recording, particularly in respect of protected characteristics which help evidence how actions and outcomes of safeguarding interventions impact our communities.

Mental Capacity Act/ Deprivation of Liberty Safeguards (MCA/ DoLS) Subgroup

The Mental Capacity Act & Deprivation of Liberty Safeguards (MCA & DoLS) Subgroup met on 4 occasions during 2025-26.

- Discussed the need for a Memorandum of Understanding (MoU) across local authorities and NHS partners to guide practitioners about the escalation process for adult patients in an acute hospital where there is disagreement as to whether a patient should be detained under the Deprivation of Liberty.
- Safeguards or Mental Health Act Undertook in-depth analysis of a thematic review of SARs in our region featuring mental capacity – partner agencies in Dorset and BCP reviewed the recommendations and provide assurance as to how they were being implemented.
- Reviewed SARs from other areas to consider whether the issues arising could happen in Dorset and BCP and what further preventative work would be of benefit locally.
- Reviewed local SARs to ensure that specific actions and learning relating to mental capacity are effectively tracked and learning implemented. Shared training resources from organisations in order to create a suite of learning materials to assist with understanding of executive functioning and fluctuating capacity.

Community Engagement Group (CEG)

A Safeguarding Adults Conference with the Voluntary & Community Sector (VCS) was held in November 2025 during National Safeguarding Adults week which was well-attended with 88 people from across the sector.

- Speakers included the SAB Independent Chair, professionals from the Dorset & BCP Adult Social Care Safeguarding teams and an informative session on dementia.
- The aim of the conference was to help engage the wider VCS better with the Safeguarding Adults Board, improve understanding and enable learning.
- The SAB website was promoted, along with resources available to the sector.

Partner assurance

This section highlights the achievements and progress of each of our partners, as described by them, to implement the SAB strategy in 2025-26 as well as the work they have done to embed learning from Safeguarding Adults Reviews, strengthen safeguarding practice and protect adults with care and support needs.

We asked all the Board partners a number of questions to provide the Board with assurance that they were delivering against our Strategic Plan. Questions were in relation to learning from SARs, which have taken place over the previous 3 years, delivering a strong preventative focus in practice and delivery of services appropriate to people's protected characteristics. Partners' responses follow.



Dorset Council Adult Social Care

Learning from SARs

Dorset Council embeds learning from SARs through a variety of formats including safeguarding webinars, 'National Adult Safeguarding Week' programme delivery, and supervision. Resources for learning developed by the SAB are cascaded across the organisation.

Mandatory annual updates for all Dorset Council staff complement the wider safeguarding training offer which aims to build staff confidence and knowledge of current practice; prevent harm occurring and support adults at risk.

Dorset Council has a passionate and committed workforce promoting a culture of learning, professional curiosity and innovation to drive forward improvements underpinned by a strengths-based approach to practice.

Key initiatives to support risk management, learning, practice and governance included:

- Safeguarding Practice Forum for practitioners
- High Risk Domestic Abuse (HRDA & HRDAP) meetings (4/week) attended by the Adult Safeguarding Service
- A self-neglect toolkit work on substance misuse guidance
- Risk enablement forum – supportive environment for frontline practitioners and managers to discuss individuals with complex and high-risk needs, with senior managers and subject experts
- Meetings e.g. Partnership Coordination Group and eSocial Care Provider intelligence sharing as well as local Multi-Disciplinary Team/ virtual ward meetings
- Community Events – working with Community Groups and Faith Groups
- Adverse incidents dashboard monitors data to identify changes or trends.

An external audit of our Safeguarding service was commissioned in 2023, producing an action plan and providing assurance going into the 2025 CQC inspection that our Safeguarding model meets a high standard.

The Quality Assurance Programme Lead and Manager maintain a strong connection with the Safeguarding Service in Dorset Council as well as attending SAB events.

Learning from Dorset SAB 'SAR Simon' (published 23/24)

Changes to our Out-of-Area contract monitoring processes have been implemented as a result of learning from SAR Simon to ensure that additional checks are in place and a robust handover process followed when people move across county or country boundaries. Dorset Council instigates a formal handover, with both the host and receiving authority having an obligation to complete details of commissioning arrangements, restrictions, quality concerns, financial viability, and recent safeguarding activity. If there are concerns about the setting's occupancy or CQC rating these are considered at an early stage and risks assessed, service quality is noted and investigated. Dorset Council maintains high quality records of steps taken during placement processes.

Learning from BCP SAR Edward (published by BCP SAB during 2024-25)

Practice and understanding in relation to self-neglect, hoarding and the exploitation of vulnerable adults is a continued focus for Dorset Council. Two new posts were developed in the safeguarding service to enable enhanced practice knowledge development and support to the wider service. Postholders liaise directly with NHS colleagues, housing providers, our

commissioned drug and alcohol support service (REACH) and Dorset Police to ensure that we respond to risk as a partnership. Both roles are operationally focused and lead on Section 42 enquires and support community workers to navigate often complex and challenging situations to support the person to achieve positive outcomes as a result of the safeguarding intervention.

Dorset Council Housing has also developed a cuckooing protocol with social housing landlords and there are a number of resources linked to cuckooing available to all staff.

Learning from BCP SAR Peter (published by BCP SAB during 2025-26)

Implemented learning by strengthening practice in several areas, including:

- Improved consistency of documentation – routine Quality Assurance audits of care plans, escalation, safeguarding referrals and capacity assessments
- Strong supervision and governance structures
- Clinical audit of essential care tasks, especially in care homes and supported living.

Evidence of a strong preventative focus

- Developing our organisational improvement approach highlighting reports focusing on areas of learning such as audit, SARs, adverse incidents, complaints, commissioning and Domestic Homicide Reviews (DHRs). These will be analysed to identify emerging themes and priority improvement areas to be monitored.
- Launched our Prevention, Early Intervention and Assessment Guidance to support adults in Dorset to live their best lives as independently and as well as possible by taking a proactive approach aiming to help avoid longer term support.
- A new Prevention and Early Intervention Team launched in October 2025, leading and working collaboratively across services to identify and respond to emerging need by taking a proactive approach to supporting individuals before challenges become crises; by supporting people to remain independent in the homes and communities they love; and by helping individuals stay connected to the relationships that matter most.

By working holistically and integrating technology-enabled care, equipment, digital inclusion, community assets, reablement, and strengths-based practice, we're building a model that supports independence and fosters resilience.

We launched our transitional safeguarding pathway in November 2024, working closely with Children's Services to create a clear pathway for young people to access safeguarding support if they are at risk of harm and avoid them being 'screened out' as their care and support need may not be immediately obvious. This approach complements the Birth to Settled Adulthood (B2SA) pathway.

The Safeguarding service continues to attend community events to raise awareness of safeguarding and how people can seek support.

Delivery of services appropriate to people's protected characteristics

Care and Support assessments consider a person's cultural identity, heritage and preferences. Checks are made to ensure that a person's individual needs and protected characteristics are captured in individual assessment and support plans.

- October 2025 – Corporate Director delivered vlog focusing on Black History Month and a round table discussion took place focused on Culturally Competent Practice.
- November 2025 – Adult Social Care Roadshow presentation focusing on cultural competency.
- We are reviewing recording mechanisms on Mosaic to ensure that we improve capture of EDI and protected characteristics to better understand our communities and identify gaps in accessing support to inform service design.
- Learning from complaints and adverse incidents also supports improvements in inclusive practice.
- A focused workstream ensures that individuals known to Multi Agency Public Protection Arrangements (MAPPA) who have a care and support need are supported positively and their protected characteristics are recorded.

Case study X:

A safeguarding concern was raised about an older adult's (X) lack of access to gas and electricity and associated risks of self-neglect. X was not engaging with health services, who were also unable to make contact. After several attempted visits, adult social care eventually made contact. 3 visits have now taken place, with X starting to open up about their financial situation; their significant debts to utility companies and their refusal to accept referrals to debt support services.

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X is secretive and anxious about possible repercussions and fear that many letters are scams, choosing not to pay energy providers resulting in urgent warning letters.

X's home is very cold in the winter and in a poor state of repair, causing them to use multiple blankets for warmth, battery operated lights, and a gas camping stove for cooking. X does not have a phone, limiting communication to letters or in-person visits and the back door does not lock, increasing safety concerns.

The team explored X's wishes, asking what makes them feel safe, and whether they want support with actions. The team worked with X to review water debt and with their permission, statements were requested. Home security was discussed and X agreed to consider a new locking back door, and a quote has been arranged. X has now provided permission for their recent financial statements to be reviewed to check benefit entitlement and potential income maximisation.

X has significant trust barriers and was reluctant/ fearful to engage with services. An increasingly positive relationship has been built enabling access to their home and sharing of financial information. Longer term engagement is important to prevent escalating concerns.

Dorset Police

Learning from SARs

The main development is the creation of Safeguarding Hubs within each of our two Local Policing Areas (LPAs). These are aligned with BCP and Dorset which means consistency in resourcing, allowing partnership working to improve.

Greater consistency of investigators, supervisors and heads of department has made it easier for partner agencies to know who to link in with, allowing better collaboration around investigations. This has enabled partners to know who to contact regarding more strategic issues and how to escalate any concerns.

Dorset Police has worked hard on the quality of the Public Protection Notices (PPNs) submitted by our staff. The Multi-agency Safeguarding Hub (MASH) will provide direct feedback to Officers when they identify any issues. Frequent systemic issues are highlighted and tackled through any necessary process, change and training. The MASH Detective Inspector also has a monthly meeting with local authority colleagues where PPNs are reviewed.

Within the MASH, we have a dedicated Adult Safeguarding Detective Sergeant. This gives consistency in approach and a point of expertise.

Multi-Agency Risk Management meeting (MARM) attendance is something that at times we have struggled with, particularly in the BCP command area. The benefits of having the officer in the case attend are well known but due to shift patterns and other demands, this has not always been possible. Plans are now in place to improve how MARM attendance is allocated.

Evidence of a strong preventative focus

Dorset Police has processes that aim to identify vulnerabilities at points of contact with us. For example, risk assessments within the Force Command Centre will ask a number of questions and if the caller is identified as vulnerable, it can help determine how we respond.

Throughout the year, Dorset Police has run communication campaigns around particular themes. For example, there has been considerable work around Violence Against Women and Girls (VAWG), an area where sadly, we know that perpetrators will often target those with vulnerabilities.

One of Dorset Police's priorities is a pledge to put victims first, to prevent and reduce victimisation and to meet an individual's needs.

Delivery of services appropriate to people's protected characteristics

Officers and staff should always consider Equality, Diversity, Inclusion (EDI) and receive training.

1. The Paedophile Online Investigation Team (POLIT) has dealt with individuals who are neurodivergent and have offended without properly understanding their behaviour. Opportunities to support and educate the individual have been taken rather than a criminal justice route.

2. Within Multi-agency Public Protection Arrangements (MAPPA), EDI is considered when dealing with every case – ensuring that the risk management plans put in place take account of any protected characteristics.

3. An example of considering the protected characteristics of victims was in a Honour-Based Abuse (HBA) case. A domestic Grievous Bodily Harm (GBH) between uncles and father or son (victim). Domestic Abuse Act (DAA) support given to the victim and his family and then discussed through Multi-Agency Risk Assessment Conference (MARAC).

   This resulted in the family being moved to Southampton whilst the three suspects were charged with GBH. This case required cultural understanding due to the complexities of the criminal aspect of the family business, the shame it would bring to some family members, and ultimately the victim's refusal to deal drugs in line with the family business being the apparent reason for the sustained attack from family members.

NHS Dorset

NHS Dorset

Learning from SARs

NHS Dorset Integrated Care Board (ICB) fully recognises the importance of Safeguarding Adults Reviews (SARs) under Section 44 of the Care Act 2014. Learning from SARs is a core component of our safeguarding governance, and we remain committed to ensuring that learning is embedded across commissioning, quality assurance, and frontline practice.

Over the last three years, learning from SARs including Aziza, Matthew, Billy, Peter, Edward, and Simon has directly informed several developments within NHS Dorset. These have strengthened practice in key areas such as self-neglect, trauma-informed care, mental capacity, domestic abuse, and multi-agency working.

Strengthened self-neglect and complex risk practice (Linked to SARs: Aziza, Billy, Peter, Edward, Simon)

Learning from SARs has highlighted the need for consistent and coordinated responses to self-neglect and chronic risk. NHS Dorset has implemented:

- The Boards' MARM (Multi-Agency Risk Management) approach and improved guidance for practitioners, which included specific training sessions on MARM and is incorporated into Adult Safeguarding update training (level 3).
- Increased oversight of high-risk cases through the NHS Dorset Safeguarding Team, including case consultation and supervision for All Age Continuing Care (AACC) practitioners.
- A self-neglect dashboard to identify themes, emerging risks, and patterns requiring system attention has been developed and now incorporated in the Health Inequalities Dashboard on the Dorset Insights and Intelligence Service (DiiS).
- An audit into the MARM process completed with recommendations shared.

These changes have improved shared understanding, promoted earlier intervention, and strengthened multi-agency coordination.

Stronger trauma-Informed and person-centred approaches (Linked to SARs: Aziza, Matthew, Edward)

Learning highlighted the importance of engaging individuals with compassion, understanding and a trauma-informed approach. In response, NHS Dorset has incorporated trauma-informed principles into Level 3 safeguarding training to strengthen practitioner confidence and promote more person-centred practice.

Focus on domestic abuse, coercive control, and exploitation (Linked to SARs: Aziza, Edward)

Domestic abuse and exploitation remain key risks identified in SARs. NHS Dorset has responded by:

- Delivering specialist domestic abuse training to NHS Dorset staff, including coercive control awareness.
- Ensuring NHS providers incorporate domestic abuse pathways into staff training and clinical policies.

These actions have improved practitioner awareness and response to complex domestic abuse dynamics.

Evidence of a strong preventative focus

NHS Dorset ICB maintains a strong preventative safeguarding focus through system-wide collaboration, community engagement, and proactive initiatives designed to reduce harm before it occurs. Prevention is embedded across commissioning, quality assurance, training, and partnership work. Below is evidence demonstrating this commitment.

NHS Dorset works closely with partners and local communities to promote early identification of risk and support wellbeing. Evidence includes:

- Active participation in the Dorset & BCP Safeguarding Adults Board (SAB) Strategy, ensuring a shared, system-wide approach to early help and early intervention.
- Named GPs and Designated Professionals advising and supporting primary care to identify early indicators of self-neglect, domestic abuse, mental health decline and health inequalities.

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This reinforces that prevention is led across the system – not only within specialist safeguarding teams. Health inequalities programmes focused on prevention (e.g. targeted vaccination programmes, enhanced access to mental health care, and outreach to marginalised groups).

Delivery of service appropriate to people's protected characteristics

NHS Dorset ICB is committed to delivering safeguarding practice that actively considers and responds to people's protected characteristics under the Equality Act 2010. Our approach ensures that safeguarding interventions are personalised, rights-based, and inclusive, with reasonable adjustments made to meet diverse needs.

Staff are trained to recognise how characteristics such as disability, age, race, sex, gender identity, religion, and sexual orientation may influence risk, engagement, accessibility, and the person's experience of safeguarding.

We embed these considerations through:

- Trauma-informed and culturally competent practice.
- Mental Capacity Act–compliant decision-making and advocacy referrals.
- Accessible communication and reasonable adjustments.
- Outcome-focused approaches aligned with Making Safeguarding Personal (MSP).
- Multi-agency working to address inequalities and barriers to access.

NHS
Dorset HealthCare University
NHS Foundation Trust

Dorset HealthCare

Learning from SARs

Over the last three years, all but one published Safeguarding Adult Reviews (SARs) have involved Dorset HealthCare (DHC) services. DHC employs over 7,000 staff across mental health, learning disabilities, children and families, community services and community hospitals. Learning from SARs is actively shared and embedded into practice.

The Safeguarding team leads the dissemination and implementation of SAR recommendations, working closely with operational colleagues. In the past year, the team has aligned with the Patient Safety Team under the Patient Safety Incident Response Framework (PSIRF), strengthening the Trust-wide learning and response framework.

Governance and Learning Structures

DHC has monthly learning & review groups which include Integrated Care Services, Mental Health, Learning Disabilities, and Children & Young Families which take a "Think Family" approach.

There is a bi-monthly DHC Safeguarding Group that oversees progress of SAR actions, and shares learning from the SAB (e.g. 7-minute briefings). This is supported by DHC Communications for wider dissemination.

Training: Core safeguarding levels 1 & 2 are being reviewed. Staff are offered bespoke SAR-related sessions and staff feedback on the impact of learning and is collected through training evaluations.

Embedding learning and assurance: The Safeguarding team collaborates with operational colleagues to audit practice once learning has had time to embed. The Clinical Audit & Effectiveness team supports ongoing audits and quality improvement.

DHC's Safeguarding workplan includes regular auditing aligned to SAB priorities and key learning themes from statutory reviews which include:

SAR Peter: Key learning and actions have been implemented including rolling out a Mental Capacity Act (MCA)

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leaflet across DHC, implementing recommendations in psychiatric liaison services and encouraging practitioners to take stronger consideration of social circumstances and caring responsibilities. This is evidenced through training feedback, completed MCA assessments, hospital discharge planning records and carers assessments documentation.

SAR Edward: Key learning and actions have been implemented including updating DHC MARM guidance (2025) reflecting SAB updates, updating SAB documents shared on intranet, embedding trauma-informed practice in partnership with Dorset Mental Health Forum (DMHF), rolling out of a Mental Health Training Programme led by lived experience and trauma specialists. This is evidenced through training attendance and feedback, and a MARM audit is planned for 2026/27.

SAR Simon: Key learning and actions have been implemented including improving transition planning between services and geographical areas, sharing care/support plans between placing and host authorities, learning for MCA, greater involvement of family/friends and post-Mental Health Act (MHA) assessment planning using multi-agency approaches.

This is evidenced through training attendance and feedback, MCA assessment audits, contingency planning recorded in patient electronic records and Approved Mental Health Professional (AMHP) reports.

SAR Billy: Key learning and actions have been implemented including improved risk assessment and management planning, greater use of MARM, engaging with people who decline services, MCA assessments with attention to executive functioning and strengthening the family/social network approach.

This is evidenced through team audits of risk assessment, management planning, and wellbeing plans and MARM audits and use of family network form in electronic record are planned for 2026/27 and 2027/28.

SAR Aziza: Key learning and actions have been implemented sharing risk assessments and crisis plans with all agencies, confirming communication preferences, greater use of advocacy, financial support for students, information sharing with family and greater use of MARM meetings.

This is evidenced through policy and guidance review, team audits of risk assessment, management planning, and wellbeing plans and MARM audits and use of family network form in electronic record are planned for 2026/27 and 2027/28.

Evidence of a strong preventative focus

DHC evidences a strong preventative focus through training compliance, recording of advice given on safeguarding advice line, supervision arrangements and documentation as well as team engagement across DHC in multi-agency forums to plan service delivery, with input from people who use those services.

DHC is a partner and engages in all multi agency work for adult safeguarding, children's safeguarding, Community Safety Partnership, Health & Wellbeing Boards; Prevent and Multi Agency Public Protection Arrangements (MAPPA).

Delivery of services appropriate to people's protected characteristics

Equality Impact Assessments (EIA) completed for all policies and procedures across all services - including all safeguarding policies and procedures.

1. Equality, diversity and inclusion work with set standards and adherence to legislation in recruitment processes.

2. Act in response to complaints; whistleblowing (Freedom to Speak up Guardians); allegations against staff if having a safeguarding element.

3. Have a good network and inclusion of people with lived experience in Trust-wide business.

Dorset County Hospital NHS Foundation Trust

Learning from SARs

In response to learning from recent SARs including 'Aziza', 'Billy', and 'Simon', Dorset County Hospital (DCH) has implemented significant changes in policy, training, and clinical practice to strengthen safeguarding and patient care.

Key achievements include:

- Enhanced communication policy: Clear processes for patient and carer communication preferences, including consent for email and alternative methods.
- Return to face-to-face care: Majority of appointments are now in person, with robust guidance for virtual consultations and adoption of the NHS Patient-Initiated Follow-Up (PIFU) programme.
- Learning Disability & Autism work plan: Addressing diagnostic overshadowing through practitioner-led initiatives, pain management, and reasonable adjustments.
- Mental Capacity Act training: Targeted and supplementary training for staff to ensure compliance with MCA principles, including consideration of 'unwise' decisions.
- Embedding key themes: Application of MCA, 'Think Family' approach, domestic abuse awareness, and recognition of executive dysfunction in care planning.

DCH remains committed to continuous improvement, aligning local practice with national programmes while addressing safeguarding priorities.

Evidence of a strong preventative focus

Safeguarding is supported through DCH's Safeguarding Quality Improvement Plan, which prioritises prevention and community involvement and is overseen through quarterly board-level safeguarding reports. Mandatory safeguarding policies and training for all staff and volunteers' emphasis early identification and prevention.

DCH works in partnership with the Safeguarding Adults Board and Safeguarding Children's Partnership, and delivers targeted community awareness activity within DCH departments, such as domestic abuse and neglect prevention campaigns. Preventative practice is embedded through early identification tools for issues such as domestic abuse and self-neglect, proactive discharge planning with safeguarding considerations, and the support of Safeguarding Leads and Named Professionals. Safeguarding data and trends, including frequent attenders and adults at risk, are monitored to inform action.

A strong safeguarding culture is promoted through high training compliance, visible safeguarding messaging across DCH, onsite support from the safeguarding team, and shared learning from safeguarding reviews via newsletters and training.

Delivery of services appropriate to people's protected characteristics

DCH recognises that the NHS has a core role to play in reducing health inequalities by improving access to services and tailoring services around the needs of the local population in an inclusive way.

DCH is committed to delivering on its statutory obligations under the Equality Act (2010) and uses data intelligently to assess for any disproportionate safety risk to patients from across the range of protected characteristics. Our updated incident management system will allow for the details of patients to be directly drawn from the healthcare record, and incidents can be analysed with protected characteristics to give insight into any inequalities.

Within our patient safety response toolkit, we directly address any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we consider inequalities, and this is built into our documentation and governance processes.

Engagement of patients, families and staff following a patient safety incident is critical to any review of patient safety incidents and their response. We ensure that we use available tools such as Easy Read, translation and interpretation services and other methods (as appropriate) to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

University Hospitals Dorset
NHS Foundation Trust

University Hospitals Dorset NHS Foundation Trust (UHD)

Learning from SARs

There has been significant transformation in adult safeguarding at UHD over the last 3 years.

Level 3 safeguarding training has been introduced to all appropriate staff, previously only L1 and L3 training was offered. Importantly, all Safeguarding L3 training includes a face-to-face element where specific cases involving UHD and learning from local SARs is included. UHD align to the Intercollegiate document for training purposes, as well as the Essential Core Skills Framework and Oliver McGowan training has been introduced.

Our Mental Capacity Act (MCA) policy and supporting information has been updated to include Executive Functioning when considering a person's mental capacity. This is included within our Safeguarding Training. Our MCA training is being reviewed. UHD engage with partners and subgroups including the MCA subgroup.

UHD was pivotal in producing a Memorandum Of Understanding (MOU) for ensuring a person lacking capacity is protected (Article 5 Human rights Act) where there is professional disagreement between whether the MCA (and DOLS) or MHA are best applied to support the person remaining in an acute hospital.

Understanding of exploitation including cuckooing is strengthened within training and we have started seeing an upward trend on referrals regarding exploitation.

The Specialist Learning Disability and Autism (LD&A) practitioners (which includes MCA) provision at UHD has doubled and been banded at a higher grade to create more visibility of specialist staff as well as more development of all working for UHD.

An audit and subsequent review of UHD referral forms now specifically includes capture of the person's wishes as part of the Making Safeguarding Personal agenda. The updated referral form is shared with our GP colleagues as well as Adult Social Care. The updated referral prompts staff to consider that when a crime has potentially been committed contact with the police should be made.

The safeguarding team has strengthened our lines of communication at UHD with the student team (who support student nurses and midwives, amongst other roles) The student team work closely with Bournemouth University to support students.

We have engaged with our discharge team at UHD specifically around hoarding and forging close links with Fire & Rescue services. Our discharge team now make referrals direct to the team to ensure patients are supported home safely. UHD staff have attended SAR learning events.

MARMs are now regularly called by UHD where there are ongoing or emerging concerns about an adult at risk to ensure information is shared across partners in a safe and proportionate manner.

Specialist Domestic Abuse Advocates have delivered regular training events to increase staff awareness of stalking, coercion and control and identify people who may previously have been 'hidden' from services, such as older people. Within the training they discuss a trauma aware approach, staff can access trauma aware supporting videos via the staff intranet.

Delivery of services appropriate to people's protected characteristics

Dedicated teams to support patients including patient experience and LD&A practitioners. We have produced story boards to support patients with their hospital journey.

We invited a family to share their loved one's story at Senior Nurse and 'Grand Round' meetings (medical staff), staff signed pledges. Our patient experience team support with patient stories which are shared for Board and for ward staff to learn from.

A UHD consultant has been working with Bournemouth University to produce a Health ability passport to ensure patients' needs can be captured pre-admission/ attendance and they can be better supported.

Charity support helps provide sensory boxes and tools to support patients in hospital.

DORSET & WILTSHIRE
FIRE AND RESCUE

Dorset & Wiltshire Fire and Rescue Service

Learning from SARs

When local SARs are published, they are made accessible via our Learning Hub, ensuring that all staff have the opportunity to review the findings and learning points.

Looking back at the Safeguarding Adult Reviews (SARs) published over the last three years, we have reviewed the recommendations from recent SARs to identify any implications for Fire and Rescue Service (FRS) practice.

Overall, many of the recommendations were not directly applicable to FRS operational responsibilities. However, where relevant, the following changes or developments in practice have been identified:

SAR Billy

A recommendation referred to welfare calls being directed to the Police. These calls are now more commonly directed to the Ambulance Service, with FRS providing support where entry is required.

SAR Edward

Practice developments have been implemented in response to learning relating to cuckooing:

- Cuckooing has been incorporated into safeguarding training. This has been reinforced through awareness campaigns and posters displayed at stations and offices.
- Training has been completed with 'Escapeline' to strengthen awareness of County Lines and cuckooing.
- Guidance has been updated following the launch of the SaferBCP 'cuckooing referral form', and the form has been used in practice following a recent incident.

SAR Matthew

- The referral form has recently been reviewed and updated to improve clarity and effectiveness.
- A continued issue regarding limited feedback from partner agencies has been noted. Where feedback is received, this is shared with the original referrer and/or watch to support organisational learning.

Evidence of a strong preventative focus

FRS demonstrates a strong preventative focus through its data-led targeting of vulnerability, robust safeguarding governance, and active participation in multi-agency partnerships. Prevention is embedded in strategic planning, operational delivery, and performance management. Staff are trained and empowered to identify and report safeguarding concerns.

Our Community Safety Plan 2024-2028 outlines a four-year strategic framework focused on saving lives, reducing risk through prevention and protection, and improving service delivery. It is designed to ensure resources are in the right place, with the right skills, to meet community risks.

Delivery of services appropriate to people's protected characteristics

Fire does not discriminate and nor do we.

- We dynamically monitor development and compliance with the Equality Act and Public Sector Equality Duty by staying abreast of legislative changes such as the Worker Protection Act, Supreme Court ruling on biological sex, Employment Rights Act – accounting for protected characteristics.
- Our Community Safety Plan is informed by widespread public consultation – during consultation, we approach various community groups to reflect as many voices as possible. This and our strategic assessment of risk informs our strategies and plans – so that the identified needs of people consider their protected characteristics.
- We complete People Impact Assessments for procedures and significant changes – ensuring that changes and decisions are assessed for impact on people who share characteristics and that any negative impacts are reduced, removed or justified with a legitimate aim.
- Staff Networks – members offer support for each other, but concerns are also heard and considered for organisational improvement at our Culture Development Committee. These drive changes such as better accessibility for neurodivergent staff, better support for new parents etc.

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The needs of our staff and our service users are considered throughout various functions and processes such as:

- Translation services for written and verbal communication e.g. Home Fire Safety (HFS) visits, hot strikes (fire safety checks carried out in the surrounding area following a fire), business safety checks, legal proceedings for people who don't have English as their first language (mostly supporting people from different ethnic backgrounds), HFS materials are translated into 26 languages. To assist Afghan resettled families, we created comprehensive translated videos in Dari and Pashto along with children's booklets.
- Customs and expectations at community events e.g. targeted safety campaigns, religious celebrations (mostly supporting people based on their race and Religion/Belief). Following the summer riots in 2024 we increased our outreach to faith groups to provide public reassurance and encourage better communication.
- Reasonable adjustments or other accommodations at recruitment, interview, have a go days etc. for disability, race, religion/belief
- Safeguarding Team were part of a Personal Safety Workshop, considering protected characteristics that might make people more vulnerable to violence such as women, disabled people, LGBT+.

NHS
South Western Ambulance Service
NHS Foundation Trust

South Western Ambulance Service NHS Foundation Trust (SWAST)

Learning from SARs

Themes identified from SARs for SWAST include:

- **Professional curiosity** – We recognised there was a need to develop the professional curiosity of our workforce, primarily because internal documentation did not evidence this. Action was taken to include professional curiosity in the mandated level 3 safeguarding training, in respect of applying professional curiosity (what are you seeing, hearing, smelling; the context of the situation; what is not being said or is missing; who else may be in the property, at risk etc.) and in documenting what has been observed.

The revised safeguarding forms include prompts to encourage sharing holistic information.

- **Sharing of information** – SWAST safeguarding team has reviewed how we share information, aligned with the review of our safeguarding forms. Operational staff can share information with GPs via the electronic Patient Care Record (ePCR), however safeguarding referrals are not shared routinely with GPs. Safeguarding forms encourage staff to contact police if there is a concern.
- **Mental Capacity** – Mental capacity does not sit in the safeguarding portfolio but learning from SARs is shared across the organisation and the Trust's position on the application of the Mental Capacity Act is being reviewed. National guidance is available to paramedics in relation to how to apply the Mental Capacity Act in pre-hospital urgent care on the 'Joint Royal Colleges Ambulance Liaison Committee' and this is reflected in the new SWAST MCA policy. Mental capacity is included in safeguarding training with topics such as executive function, impact of coercion and fluctuating capacity. SWAST is in the process of identifying a Mental Capacity Lead.

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- **MARM (Flags and Care plans)** – The safeguarding team has increased in capacity, appointing a safeguarding specialist for each county. Referrals to the fire service are made using our electronic safeguarding referrals. Where a person at risk is conveyed to a hospital the safeguarding referral can be shared to support decisions around safe discharge planning within the SWAST footprint. This enables specialists to participate in MARM meetings, and to raise concerns or facilitate a MARM meeting as required.

Evidence of a strong preventative focus

Our operational crews highlight concerns which amount to care and welfare, but do not reach safeguarding thresholds and share these with our social care colleagues. Work is underway to refine crews' understanding of safeguarding versus care and welfare and our new safeguarding referral forms support this process.

Delivery of services appropriate to people's protected characteristics

SWAST appointed a 'Learning Disability and Vulnerability Lead' in November 2024 who has co-developed the Trust learning disability strategy and is in the process of developing dementia-friendly resources.

SWAST has developed a new Quality, Equality Impact Assessment policy and Panel to ensure any service development and policies are duly considering those with protected characteristics.

SWAST has created a mental health team, which works with colleagues in partner organisations across our footprint to provide urgent mental health response in a specialist mental health vehicle.

Probation Service

Learning from SARs

Over the past 18 months, Dorset Probation has implemented significant changes to embedding learning from SARs (Aziza, Matthew, Billy, Peter, Edward, Simon) into everyday practice. A key focus has been strengthening professional curiosity and risk management which has also been prompted from learning from MAPPA Serious Case Reviews (SCRs) and internal Serious Case Reviews. Reflective Supervision Panels were introduced for complex safeguarding cases, enabling staff to challenge assumptions and improve decision-making. Enhanced use of practitioner dashboards has supported timely safeguarding checks and risk reviews, with compliance improving from 44% to 48% in the past three months. These measures directly address SAR findings on missed warning signs and inadequate oversight.

Multi-agency collaboration has also been prioritised. South West Probation established a dedicated safeguarding hub with direct access to Dorset Police systems, allowing real-time information sharing and better coordination with social care and the MASH. It is hoped that the hub will gain access to other systems where safeguarding information is stored. The Safeguarding Families Together project embedded probation service officers within multi-disciplinary teams to address domestic abuse and whole-family safeguarding needs in a non-statutory context, reflecting SAR learning on holistic interventions. Additionally, annual SAR learning events and practice development days have reinforced joint working and continuous improvement across partner agencies.

Workforce development and targeted support for vulnerable cohorts have been central to change. Mandatory adult safeguarding training is in place for all Probation staff, complemented by trauma-informed practice sessions and SEEDS2 leadership programmes for managers promoting reflective practice. Specialist training on autism and ADHD in women was commissioned locally and supports SAR insights into missed vulnerabilities. Policy improvements include mandatory gatekeeping of all Pre-Sentence Reports,

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raising compliance to 81%, and the Probation Reset initiative to prioritise engagement at critical sentence points.

Gender-specific strategies, such as women-only reporting times and wellbeing activities, and a dedicated pod for 18-25-year-olds with trauma-informed approaches, demonstrate Dorset Probation's commitment to embedding SAR learning and improving safeguarding outcomes.

Impact statement: These changes have strengthened safeguarding practice, improved risk management, and enhanced multi-agency collaboration, ensuring that vulnerable individuals receive timely, person-centred support. For service users, this means safer transitions, better engagement, and access to tailored interventions. For staff, the improvements have fostered a culture of professional curiosity, reflective practice, and wellbeing, equipping teams with the tools and confidence to manage complex cases effectively and reduce the likelihood of serious harm.

Evidence of a strong preventative focus

We are active partners in the Pan-Dorset Reducing Reoffending Strategy, which prioritises early intervention, holistic support, and restorative approaches. This includes working not only with individuals on probation but also with their families and local communities to reduce risk and prevent harm. For example, our involvement in Safeguarding Families Together places probation officers within multi-disciplinary teams alongside social care, health, and domestic abuse specialists, ensuring whole-family safeguarding and early help for those at risk of harm.

Probation practitioners support community resolutions and Outcome 22 interventions, helping to steer individuals away from formal criminal justice processes and towards constructive support. These efforts are complemented by our engagement in Community Safety Partnerships, where we collaborate on campaigns like 'Just Don't' to challenge harmful behaviours and raise awareness of safeguarding responsibilities across the wider community.

Delivery of services appropriate to people's protected characteristics

Overview

Dorset Probation recognises the challenges of engaging individuals with complex needs or those who find it difficult to access mainstream services. Over the past three years, we have implemented a range of measures to equip staff with the skills, resources, and multi-agency support required to manage these cases effectively.

Training and professional development

All practitioners receive mandatory safeguarding and trauma-informed practice training, alongside specialist development on neurodiversity, mental health, and substance misuse. Recent training on autism and ADHD in women has helped staff tailor interventions for those who struggle with traditional service models. The Management Oversight and Quality Assurance Framework ensures reflective supervision and coaching, enabling staff to explore barriers to engagement and adopt person-centred approaches.

Specialist support and multi-agency collaboration

Dorset Probation utilises Complex Case Support Panels, bringing together senior probation officers, psychologists, and multi-agency partners to provide guidance and formulate bespoke plans. Specialist services such as the Offender Personality Disorder (OPD) Pathway and Pathways Enhanced Resettlement Service (PERS) provide structured interventions and emotional support for individuals with entrenched behavioural issues. Staff benefit from consultation and formulation processes, improving confidence and competence in managing these cases.

Gender-responsive practice and Women's Strategy

The Women's Pod offers a dedicated space for women under supervision, with tailored interventions and wellbeing activities that reduce barriers to engagement. Staff receive specialist training in trauma-informed practice and motivational interviewing. Dorset also participates in pre-release panels for women at HMP Eastwood Park, ensuring sentence planning and resettlement support are coordinated before release. Partnerships with local women's centres and specialist agencies provide wraparound support for women with multiple needs, including substance misuse, mental health, and domestic abuse. Gender-specific reporting times, wellbeing activities, and peer support groups further demonstrate our commitment to reducing barriers and supporting family stability.

Practical adaptations

Dedicated pods for the 18–25 cohort and co-location with partner agencies, including mental health and housing services, ensure staff can quickly link individuals to specialist support. For those with neurodivergent needs, probation practitioners use easy-read licence conditions and adapted communication techniques to improve understanding and compliance.

HMP The Verne

Learning from SARs

Within the HMP Prison Service (HMPSS) resettlement is a significant focus and we work with partner agencies for prisoners who are highlighted as high risk when due for release. We collaborate with multi-agency partners to manage these individuals, ensuring they have the appropriate support available to them.

Whilst in prison those highlighted as a risk upon release are supported via Assessment, Care in Custody Teams (ACCTs) and/or Challenge, Support & Intervention Plan (CSIPs) alongside mental health and resettlement referrals. These teams liaise with outside agencies, identifying and putting in place essential support for when the person is released with the aim of helping the person live a crime-free life.

Evidence of a strong preventative focus

We can evidence a strong preventative approach to safeguarding by demonstrating that safeguarding is embedded into everyday practice, informed by early identification of risk, and delivered through collaborative working with internal departments and external community partners. Safeguarding is clearly understood as everyone's responsibility, not solely the role of specialist teams.

Delivery of services appropriate to people's protected characteristics

The delivery of our services actively considers and responds to individuals' protected characteristics as defined under the Equality Act 2010. Safeguarding interventions are risk-assessed on an individual basis, with adjustments made to ensure prisoners are treated fairly, safely, and with dignity. Staff work collaboratively with Health, Safer Custody, Equality teams, and external partners to ensure vulnerabilities linked to disability, age, mental health, ethnicity, religion, or other protected characteristics are identified and addressed.

Equality monitoring, multidisciplinary decision-making, and reasonable adjustments are embedded within daily operational practice to reduce the risk of discrimination and harm.

1. Age and vulnerability – support for older prisoners

An older prisoner presented with mobility issues and increased vulnerability following a change to their regime, raising safeguarding concerns around isolation and access to essential services. Reasonable adjustments were made to work allocation and daily movement to accommodate mobility needs. Wing staff increased welfare checks and coordinated with safer custody and healthcare to monitor wellbeing. The prisoner was supported to access age-appropriate activities and peer support, reducing social isolation.

The intervention reduced the risk of neglect, falls, and deterioration in physical and emotional wellbeing, ensuring the service remained accessible and safe.

A safeguarding concern arose involving a prisoner whose religious beliefs impacted engagement with staff and healthcare, particularly during periods of religious observance.

Staff liaised with Chaplaincy and Equality representatives to better understand religious requirements. Safeguarding meetings and welfare checks were arranged to avoid key religious observance times where possible. Dietary, regime, and appointment flexibility were applied to prevent disengagement or escalation of distress. Respecting religious and cultural needs, improved cooperation, reduced tension, and ensured safeguarding concerns were addressed without discrimination.

Disability and mental health – adjustments to disciplinary and regime processes

A prisoner with a recognised mental health condition and cognitive impairment was involved in a safeguarding concern linked to behavioural incidents on the wing.

Healthcare and Mental Health teams were consulted before any action was taken. Communication methods were adapted, including simplified explanations, additional time, and staff support to ensure the prisoner fully understood proceedings.

Where sanctions were considered, the prisoner's mental health condition was explicitly documented, and alternative management options were used in place of punishments that could exacerbate distress.

This approach prevented disproportionate outcomes, ensured procedural fairness, and reduced the risk of further deterioration in mental health, while still addressing risk and behaviour.

HMP Portland

Learning from SARs

HMP Portland remains committed to learning from local and national Safeguarding Adult Reviews (SARs) and incorporating relevant learning into practice. Particular focus is given to improving awareness and understanding of issues that can affect vulnerable adults, including exploitation, coercion, county lines activity, self-neglect, mental health deterioration and barriers to accessing support. The prison recognises the importance of effective multi-agency working, information sharing and early intervention in safeguarding vulnerable adults.

Evidence of a strong preventative focus

HMP Portland demonstrates a strong preventative approach to safeguarding through robust identification, management and review processes designed to identify vulnerabilities early and reduce the risk of harm.

- All new receptions are screened twice within the first 24 hours of arrival to identify safeguarding concerns, vulnerabilities, support needs and risks relating to self-harm, bullying, disability, first-time custody and other factors.
- The prison's online change of circumstances forms provide an additional route for staff to raise concerns, automatically notifying the Safety Team and relevant departments.
- Safeguarding concerns can be raised through the Prison Family Support Line, safeguarding referral forms and Challenge, Support, and Intervention Plan referrals, ensuring concerns can be identified from multiple sources.
- The weekly Safety Intervention Meeting provides multi-disciplinary oversight of the establishment's most vulnerable and complex prisoners, with referrals accepted from any member of staff.
- The Inter-Departmental Risk Management Meeting (IRMM) brings together Offender Management, Security, Residential, Psychology, Healthcare, Substance Misuse and Safer Custody teams to review MAPPA-eligible prisoners and other complex public protection cases, enabling coordinated risk management and safeguarding planning.

Delivery of services appropriate to people's protected characteristics

HMP Portland delivers safeguarding services that recognise and respond to the diverse needs of prisoners protected under the Equality Act 2010. Safeguarding interventions are individually assessed and adjusted where necessary to ensure prisoners can access support fairly, safely and with dignity.

- All safeguarding referrals are considered alongside individual vulnerabilities, including age, disability, mental health, protected characteristics and social care needs.
- Where prisoners have mobility, physical health or social care needs, established referral pathways exist with local authority social care teams to secure assessments, specialist equipment and appropriate support.
- Residential units have designated Safety and Equalities Representatives who provide peer support, help identify concerns and assist prisoners who may require additional practical support.
- The Samaritans Listener Scheme operates 24/7, providing confidential peer support for vulnerable prisoners.
- Healthcare, Safer Custody, Equality and Residential teams work collaboratively to ensure reasonable adjustments are implemented where required and that support plans reflect individual needs.

Multi-Agency Working and Community Safeguarding

Effective safeguarding at HMP Portland is supported through strong partnership working and information sharing both within the prison and with external agencies such as Probation, Police, Local Authorities, Dorset Combined Partnership Board (DCPB), Healthcare providers, Housing Services, Social Care Teams and Community Outreach organisations.

Prior to release, identified vulnerabilities, safeguarding concerns and support needs are communicated to relevant agencies to support continuity of care, effective risk management and safer outcomes within the community. This collaborative approach assists in identifying and protecting vulnerable adults, reducing the risk of serious harm to self or others, and ensuring safeguarding responsibilities continue beyond the prison gate.

HMP Guys Marsh

Learning from SARs

Having reviewed the SARs over the last 3 years, none of them had custodial elements and so no areas of change in practice could be identified, however, we will as a prison look to raise awareness around 'Cuckooing' and 'County Lines' as these do affect us.

Evidence of a strong preventative focus

Safeguarding concerns are raised through our well-attended weekly Safety Intervention Meeting so that all departments are aware.

Healthcare also liaises with all relevant departments when concerns are raised.

Delivery of services appropriate to people's protected characteristics

There are quarterly prisoner forums held for each protected characteristic.

- Weekly cell cleans have been implemented for Mr. M who was not able to do this activity for himself due to his age and mobility. This is supported by staff and training bio cleaner prisoners.
- Before lock down, young adults are given extra gym time to support them through the period of lock up later in the day.
- Mr. A wanted to work in the kitchen and uses a wheelchair so reasonable adjustments are being made to support him in working in that area.

Board attendance

We would like to thank our Partners for continued commitment to attending our Board meetings.

	June 2025	Sept 2025	Dec 2025	March 2026 Dev. event	March 2026
BCP Council	✔	✔	✔	✔	✔
Dorset Council	✔	✔	✔	✔	✔
Dorset Police	✔	✔	✔	✔	✔
NHS Dorset	✔	✔	✔	✔	✔
Dorset HealthCare	✔	✔	✔	✔	✔
University Hospital Dorset	✘	✔	✔	✔	✔
Dorset County Hospital	✔	✔	✔	✔	✔
Dorset & Wiltshire Fire Service	✔	✘	✔	✔	✔
SW Ambulance Service	✔	✔	✘	✔	✔
Prisons & Probation	✔	✔	✔	✔	✔
VCS	✘	✔	✔	✔	✔

Story of difference

Albert's Personal Safeguarding Story

'Albert' is a 57-year-old white British man who has significant health needs, a cognitive impairment and history of substance misuse.

A safeguarding concern was received from a pharmacy and REACH (Drug and Alcohol Service) raising concerns of financial abuse and coercive controlling behaviour by a 'live in carer'.

A Section 42.2 enquiry was initiated.

Albert initially appeared fearful, withdrawn, and unable to speak freely. The carer was reported to be controlling finances, access to his home, and communication with others.

An Enquiry Planning Meeting (EPM) was held with multi-agency partners. Albert did not wish to attend the meeting, but his views and wishes were shared by the safeguarding practitioner.

His expressed outcomes were for the Police and housing to visit his home as he was scared.

Information shared indicated that Albert may be cuckooed and the Police were to lead an investigation with Dorset ASC & Housing to support.

The Police and Housing visited Albert and identified further risks, including;

- Criminal exploitation (cannabis farm, weapons and large sums of money)
- Confirmed Cuckooing of home

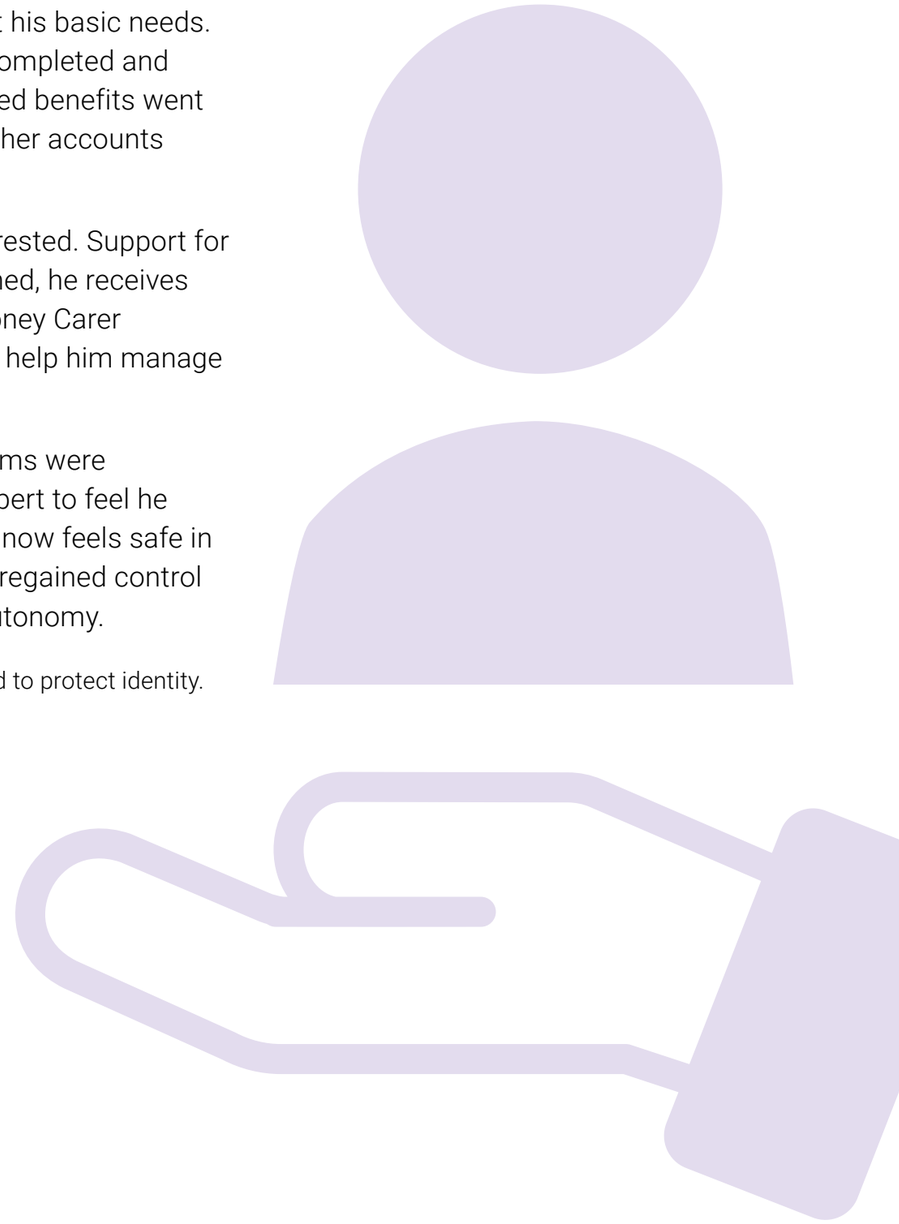
The Police and Housing took immediate action, the 'live in carer' was evicted, their belongings removed from the Property. locks were changed, key safe installed and a mobile phone was provided to Albert.

Albert disclosed to safeguarding he had no access to money and was scared to ask for support to meet his basic needs. A benefits check was completed and liaison with DWP ensured benefits went directly to Albert and other accounts were terminated.

The perpetrator was arrested. Support for Albert was commissioned, he receives 2 visits per day, and Money Carer Foundation engaged to help him manage his finances safely.

Essential household items were purchased to enable Albert to feel he had his home back. He now feels safe in his own home and has regained control restoring dignity and autonomy.

*Names have been changed to protect identity.



Safeguarding Adults

Safeguarding adults is about protecting the rights of people with care and support needs to live in safety, free from abuse, harm and neglect.

If you are concerned about a person who is over the age of 18 years, who has care and support needs, and you feel they are being abused or at risk of abuse from another person, you should seek help for them.

To report a safeguarding concern in the Dorset Council area contact 01305 221016

During evenings and weekends, call 01305 858250

Thank you for reading our Dorset Safeguarding Adults Board Annual Report 2025-2026

If you would like to get in touch, please do so by the following contact details:

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DSAB
Dorset Safeguarding Adults Board

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