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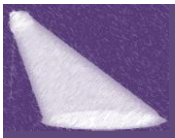

Spotlight on…

Sunderland Thematic SAR Homelessness

What Happened?

The Sunderland Safeguarding Adults Board reviewed the deaths of four men experiencing homelessness between December 2023 and March 2024. Each had complex needs, including:

- Mental and physical health issues
- Substance misuse
- Histories of trauma

Despite multiple interventions, engagement with services was inconsistent. Causes of death included suspected overdoses, chronic illness complications, and cardiac arrest.

What Did We Learn?

The review identified key challenges:

- Difficulty maintaining tenancies
- Lack of continuity in care
- Barriers to mental health and substance misuse support

Key takeaway: Services must work together to provide flexible, person-centred support and improve coordination across housing, health, and social care.

✅ **Key Messages for Frontline Staff**

- **Adopt a trauma-informed approach** – Understand how past trauma affects behaviour and engagement.
- **Be proactive with outreach** – Maintain contact with those who disengage.
- **Share information promptly** – Avoid gaps in care through timely communication.
- **Plan around the person** – Tailor interventions to individual needs and circumstances.
- **Escalate concerns early** – Use safeguarding pathways when risks increase.
- **Work together** – Coordinate across agencies for holistic support.

Sunderland-SAR-v5.pdf

In this issue:

Child sexual abuse: overcoming obstacles in practice

Content note: This article references child sexual abuse in a professional safeguarding context.

I recently attended a conference organised by Wandsworth Children's Services on Child Sexual Abuse (CSA). Alongside an excellent practice-focused presentation by Anna Glinski (Deputy Director, Centre of expertise on child sexual abuse), what stayed with me most powerfully was the *lived experience* shared by victims and survivors. Their accounts were honest about the long shadow abuse can cast—yet equally clear about the courage, determination and resilience it takes to rebuild a life after harm. Hearing those experiences, in the room and in their own words, was a profound reminder that safeguarding is not just a process: it is about people, dignity, and hope.

The session also began with a clear "health warning" for professionals: CSA is hard to think about and talk about, and it can affect each of us differently at different times. We were encouraged to be mindful of others' experiences, to be kind to ourselves personally and professionally, and to respect each other's learning journeys.

In the spirit of Family Safeguarding, the key takeaways below have an impact on Adults practice too, especially where there are children in the family or in lines of trauma-informed practice and Adverse Childhood Experiences.

Key takeaways for safeguarding practice

1) CSA is more prevalent than systems identify

A recurring theme was the gap between the scale of CSA and what services formally recognise. The presentation highlighted that *far more children are sexually abused than services identify*, underlining the importance of professional curiosity, confident enquiry, and not waiting for "perfect" evidence before acting protectively.

2) Context matters: CSA happens in many settings and relationships

CSA can occur within the family environment, through personal or "trusted" relationships outside the family, online interactions, through intermediaries, in groups and networks, or by unknown perpetrators. Understanding this range helps avoid overly narrow assumptions about where risk "usually" sits – and supports more accurate risk assessment and safety planning.

3) Vulnerability is often shaped by environment and adversity

The presentation highlighted how wider pressures and vulnerabilities can increase opportunity and risk. For example: children living with neglect were noted as *five times more likely* to be sexually abused; those in residential care *four times more likely*; and disabled children *at least twice as likely* to be targeted. It also highlighted increased risk where there is parental substance misuse, and the frequent overlap with other forms of abuse (including emotional abuse and domestic abuse).

4) Practice obstacles are real – and they can be addressed

Professionals can be held back by silence, ignorance and fear – especially fear of "getting it wrong" or not knowing what to say. The presentation reframed what helps: communication, knowledge, hope/courage. The message was clear: confidence grows through shared learning, supervision, and supportive multi-agency practice, not through avoiding the conversation.

5) Evidence is rarely "clear cut" – and safeguarding cannot wait for certainty

A key point was that we rarely reach a position of "absolute knowing". CSA may not come with straightforward disclosures, corroboration, or clear forensic evidence. This is exactly why safeguarding decisions should be grounded in *the whole picture* – signs, indicators, context, and risk – rather than relying solely on verbal statements.

6) "No further action" should not mean "no further support"

The presentation explained how a police/CPS "no further action" decision can unduly influence the wider system response – sometimes being misinterpreted as evidence that abuse did not happen. It recommended avoiding the term "no further action" in these contexts and instead using "no further police action at this time", alongside a multi-agency discussion at the conclusion of enquiries/investigations to consider ongoing risk and support, with clear recording and information-sharing.

7) We should talk directly (and safely) about CSA

A strong practice message was that practitioners **can and should talk directly** to children and families about concerns – taking account of disability, language and ethnicity, and ensuring confidence across the workforce (including foster carers). The principle translates strongly into adult safeguarding too: many adults we work with are living with the impacts of childhood trauma, and sensitive, trauma-informed enquiry can be a turning point in someone getting the right help.

Why the lived experience input mattered so much

The voices of victims and survivors cut through any tendency to over-professionalise the issue. Their experiences highlighted the importance of being believed, being asked the right questions, and being offered support that doesn't depend on a criminal justice outcome. Most of all, I was struck by their resilience – how people can and do move forward after profound harm, especially when services respond with compassion, consistency, and informed practice.

Useful resources to share with partners

- **Child Sexual Abuse Response Pathway** (an interactive resource guiding professionals from first concerns through safeguarding and criminal justice): http://www.csacentre.org.uk/response-pathway
- **Free eLearning (intra-familial CSA, ~90 minutes)**: www.csacentre.org.uk/training/elearning
- **Support Services Directory (England & Wales)**: https://www.csacentre.org.uk/get-support/
- **Stop It Now Helpline (free, confidential advice): 0808 1000 900**
- **Using supervision and team meetings to improve responses to CSA** (practice improvement guide): http://www.csacentre.org.uk/knowledge-in-practice/practice-improvement/

Renters' Rights Act – Key Changes and Safeguarding Implications

The **Renters' Rights Act** was passed in October 2025 and will come into effect on **1 May 2026**. Below is a summary of the key changes and their potential impact on safeguarding:

Key Changes

- **Phase 1 – Effective 1 May 2026**
  - Abolition of **Section 21 "no-fault" evictions**.
  - All tenancies become **open-ended assured periodic tenancies** (no fixed terms).
  - **Rent increases** limited to once per year with two months' notice.
  - Ban on **rental bidding wars** and limits on upfront rent (max one month).
  - Landlords **cannot discriminate** against tenants with children or those on benefits.
  - Tenants gain the **right to request pets**, with landlords required to respond fairly.
- **Phase 2 – Late 2026**
  - Launch of a **national Private Rented Sector database**.
  - Introduction of a **Private Landlord Ombudsman** for dispute resolution.
- **Phase 3 – Longer term (2030s)**
  - Extension of the **Decent Homes Standard** and implementation of **Awaab's Law** to the private sector.

Adults Safeguarding Implications

A. Shift in "visibility triggers": risk may present later and in crisis

Historically, Section 21 notices have often acted as a practical "alert" for services that a household is destabilising. With Section 21 removed, vulnerable adults may come to attention later via Section 8 possession routes, homelessness presentations, or repeated disrepair/arrears contacts.

There is increased likelihood of higher-acuity presentations (mental distress, self-neglect, exploitation, domestic abuse, substance misuse relapse) when cases do surface, potentially raising s42 enquiry demand and multi-agency meeting burden.

B. Potential safeguarding benefit: reduced fear of arbitrary eviction can support disclosure

Greater tenure security may reduce the "silencing effect" of sudden eviction threats and increase disclosures about:

- landlord harassment/illegal eviction attempts,
- unsafe conditions affecting health,
- exploitation occurring in or around the tenancy.

An early increase in contacts/referrals may reflect improved reporting, not necessarily increased incidence.

C. Grounds-based possession risks: vulnerability may be mislabelled as 'ASB' or 'breach'

Post-May 2026, landlords generally must rely on grounds for possession (rather than no-fault eviction). Commentary highlights significant reforms to the possession framework.

The Safeguarding risk comes with the fact that issues such as arrears, clutter/disrepair, or

neighbour complaints may be linked to:

- cognitive impairment/mental ill health,
- self-neglect/hoarding,
- financial abuse, coercion or exploitation.

We need consistent multi-agency practice so that "housing enforcement/possession" cases prompt safeguarding screening, MCA considerations, and MSP-aligned intervention where criteria are met.

D. Repairs/standards reforms: likely increase in disrepair reporting – clear triage needed

As tenants feel safer to raise disrepair, contacts may rise and should be routed appropriately. Longer-term PRS standards reforms (Decent Homes/Awaab's Law-style hazards) are intended to improve safety and health outcomes.

The multi-agency should prevent over-referral into safeguarding by being clear on "housing enforcement vs safeguarding" thresholds, while ensuring safeguarding is triggered when adults cannot protect themselves or where abuse/neglect/exploitation is indicated.

E. New system levers: PRS Database + Ombudsman create prevention/intelligence opportunities

Late-2026 reforms should increase transparency and strengthen targeting of poor practice and dispute resolution.

This would be an opportunity for intelligence-led prevention (repeat rogue landlords, patterns of harassment/unsafe properties affecting vulnerable adults) if lawful information sharing routes are agreed.

Launch of the updated London Multi-agency Procedures and Guidance

The London Multi-Agency Procedures and Guidance are intended to provide guidance for all workers who have responsibilities related to adult safeguarding. It sets out the principles, values and how organisations and individuals should be working together to respond to abuse or neglect of adults with care and support needs in London. Individual Safeguarding Adults Boards have agreed to and adopted this policy, practice guidance and procedures, including Richmond and Wandsworth SAB.

The 2025 policy refresh builds on a decade of Care Act 2014 implementation, integrating best practices and learning.

- It reinforces the legal frameworks – enhances key Care Act sections and laws like Equality Act 2010, GDPR (Information sharing agreements), and Human Rights Act. Strengthens safeguarding standards, as well as duty of candour/whistleblowing.
- The core of the guidance is unchanged – the six safeguarding principles, wellbeing principle, Making Safeguarding Personal, partnership working, risk management, defensible decision-making & duty of candour are all retained.
- New Practice Themes – Cultural competency & humility; Victim-blaming language guidance; Homelessness & inclusion; Online harms & exploitation; Use of AI in safeguarding.
- Procedural Changes – Historic allegations guidance; Deceased adult concerns flowchart; PiPoT framework strengthened; Target timescales & closure summary record: Safeguarding stages changed with 3 points of decision-making (Concern→ Enquiry→ Plan) and Closure is now considered at any stage, with ongoing emphasis on monitoring and review.
- Provider Oversight – Organisational abuse lens now called Provider Support Process; system signals & escalation routes to ICB/NHSE.

Training and resources

Alcohol Change UK has published new **national guidance to help local areas improve housing and support for people with alcohol dependency and complex needs**. Two new guidance documents are now available online:

- The Blue Light Approach: Improving accommodation options for people with alcohol dependency and complex needs. Part One: Main report and information guides. This report is **aimed at commissioners, housing leads and service managers**. It provides a clear framework for change and an Improvement Plan Audit Tool to help partnerships understand local need, identify gaps, and plan a more effective housing system.
- The Blue Light Approach: Improving accommodation options for people with alcohol dependency and complex needs. Part Two: The law, benefits, and national guidance. This companion guide is written **for frontline practitioners**. It explains how housing law and the welfare benefits system can support people who are alcohol dependent to access and keep accommodation. It includes practical case studies and guidance on challenging unfair decisions.

NEW practitioner guidance on digital vulnerability **Supporting Older Victims of Technology Facilitated Domestic Abuse** – written by Dewis Choice, Dyfed-Powys Police and Parental Education Growth Support (a pioneering lived-experience social enterprise working alongside parents, carers and guardians impacted by child-to-parent abuse, including abuse from adult children). The toolkit draws on police data, victim insights and real-life case studies to show how perpetrators misuse everyday technologies to monitor, control, exploit and intimidate older victims. The guide provides well-researched insights into technology-enabled abuse and offers practical prevention tips. The Practitioner Quick Action Response outlines steps to prevent mobile stalking, secure bank accounts, and lock smart devices. Notable sections cover coercive control disguised as help and explain the legal framework, helping practitioners recognise crime, inform victims, and promote safety.

Romance Fraud Awareness Video Campaign – the Metropolitan Police, in collaboration with West Midlands Regional Organised Crime Unit and the City of London Police, launched a national awareness campaign to tackle romance fraud; a crime where victims are deceived into fake relationships and socially engineered to hand over money or personal information. The new video series features victim accounts and crime prevention advice on identifying the signs of fraud before it causes emotional and financial harm. For more information, visit https://www.actionfraud.police.uk/romance-fraud

Diana's Story – after losing her husband, Diana sought companionship on a pen-pal site, where she formed a connection that turned out to be based on deception.

Nazaha's Story – looking to rebuild her life after an abusive marriage, Nazaha met someone on a marriage app whose intentions were not genuine.

Get me to hospital – Social Care Institute for Excellence (SCIE) developed guidance in relation to people lacking capacity who were refusing conveyance to hospital: when and how to use the Mental Capacity Act to convey a person to hospital for physical health treatment

Update from SAB Executive

The SAB Executive met in October and reviewed the Risk Log and sub-group reports, as well as partner updates. Key issues discussed included Inappropriate use of A&E for MH patients in acute crisis and agreeing to adopt the London Multi-agency Procedures and Guidance.

Quality and Improvement Sub-group

The Quality and Improvement Sub-group met in December 2025. It discussed the launch of the updated London Multi-agency Procedures and Guidance, the Quality Assurance Framework and Safeguarding Adults Partnership Assessment Tool (SAPAT) and updated its Terms of Reference.

Safeguarding Adult Review (SAR) Sub-group

The SAR Sub-group met in November and December 2025. One new referral was received and discussed by the SAR Sub-group for Wandsworth but the sub-group felt that more information was needed around cause of death before deciding on whether it met the mandatory criteria for a SAR.

You can access via the website the Published reports and 7-minute briefings for all SARs.

Richmond and Wandsworth Community Forums

The Richmond Community Forum met in December 2025. The group discussed scams data and the launch of the updated London Multi-agency Procedures and Guidance.

The Wandsworth Community Forum met in October 2025 and had a presentation about the Safeguarding in Sport support provided by London Sport, discussed the business plan actions and updated from partners.