Sunderland Safeguarding Adults Board Newsletter

Sunderland Safeguarding Adults Board **is a multi-agency partnership providing strategic leadership for adult safeguarding across the City of Sunderland to promote the welfare of adults at risk of abuse and neglect, and is responsible for ensuring the effectiveness of what partner agencies do to support this. Follow us on X (formerly Twitter): @SunderlandSAB**

Issue 22 | Summer 2025

This issue at a glance:

- Learning from SSAB's recently published Safeguarding Adults Reviews
- Safeguarding Learning Week 2025: Themes
- Multi-Agency Safeguarding Hub (MASH): A Good Practice Case Example from Northumbria Police
- Focus on: Cuckooing (also known as 'home takeover' or 'home invasion')
- Useful Resources

Who Should Read this Newsletter?

Everyone with an interest in safeguarding adults, enabling them to live their lives free from abuse and neglect, to access and receive appropriate care. We hope this newsletter is a useful resource for you to receive information regarding safeguarding adults, keeping you up-to-date, sharing good practice and important information. Please feel free to share this newsletter across your organisation.

Learning from SSAB's Recently Published Safeguarding Adult Reviews (SARs)

SSAB has published several Safeguarding Adult Reviews (SARs) in the period January - August 2025:

- Thematic SAR: Human Stories featuring Homelessness (covering 4 cases)
- 'Alex' SAR
- 'James' SAR

Thematic SAR: Human Stories featuring Homelessness

Background

This was a themed Discretionary SAR to look at the deaths of 4 homeless people who were all clients of the Sunderland Council's Housing Options Team.

Between 23 December 2023 and 8 March 2024, 4 clients of Sunderland Council's Housing Options Team (Homelessness Service) sadly died. Two were found in their (temporary) accommodation, 1 died in hospital and 1 on the streets of Stockton (out of area). Two took overdoses, the person in hospital died of complications from COPD and the 4th, in Stockton, with cardiac arrest and possible overdose. The cases are referred to as 'R', 'A', 'S' and 'T' in the report.

In every case, the person had a long history of homelessness, involvement with the Housing Options Team and had complex support needs involving poor mental health, poor physical health and substance misuse.

Key Lines of Enquiry

- Homelessness issues and their impact on physical and mental health
- Complex mental health & some physical health issues where substance misuse is also a factor
- Challenges associated with engaging with homeless individuals

- The systems and approach in place in Sunderland to support homeless people who also may have a range of complex physical and mental health issues and substance misuse/addiction issues alongside their homeless presentation.
- The culture and knowledge in place in Sunderland to support homeless people who also may have a range of complex issues as described above – this would include:
    - understanding of issues such as the effects of substance misuse and/or mental health issues on executive functioning and decision making, and whether any additional support or training for staff is needed in this area.
    - the extent to which practitioners have a trauma-informed approach to their practice, and whether any additional support or training for staff is needed in this area.
- The actions that were taken by all agencies involved with the 4 individuals who died. Whether different outcomes for the individuals could potentially have been achieved if services had responded or been configured in a different way.
- The learning that all agencies who support homeless people can take from these 4 cases, on a no-blame basis, to support better outcomes from other individuals who need these services in the future

Prior learning from the Alan SAR (published 2021), where similar themes were seen, was also taken into account.

Observations & Findings by the SAR Author

- All four men had longstanding mental health, physical health and substance misuse.
- Reported benefits of co-location, evidence of referrals, joint visiting and multi-disciplinary discussions. Doubts about availability of wrap-around support and outreach. Some evidence of "revolving doors". Evidence of efforts to engage, meet needs and minimize risks. Too much reliance on signposting.
- Documentary evidence explicitly refers to multi-disciplinary and multi-agency meetings only in one case (S). The MASH (Multi-Agency Safeguarding Hub) did discuss one case (A). There is evidence across all four cases of liaison and information-sharing between some services.
- CARM (Complex Adults Risk Management) experienced as useful but some concerns about confidence in activating CARM and uncertainty about the interface with section 42. Not all services represented at MASH.
- Some services submitted adult at risk notifications but some of the documentary evidence records “no safeguarding concerns.” Some agency submissions record

missed opportunities to refer adult safeguarding concerns. Only evidence in one case of a section 42 enquiry (S).

- Similar finding in SAR Alan. Is capacity used in decision-making about section 42 referrals? How is self-neglect seen in this context?
- Adult Social Care (ASC) had no contact in one case (R). There seems to be evidence in three cases of care and support assessments. T was deemed not to have eligible needs. S appears to have declined a care package. A participated in a telephone assessment, but no service was provided.
- Reported difficulties in securing ASC involvement; reliance on housing. Some evidence that making safeguarding personal is not embedded
- Relationship breakdowns, bereavements and adverse childhood experiences were evident (for example, A and T).
- Is practice sufficiently attuned to social isolation, loss of relationships and impact of trauma?
- Documentary evidence records assumptions and/or assessments of capacity and in each case the person was recorded as having capacity. Yet there is also evidence of not carrying out stated intentions. In several cases there is evidence of concerns regarding brain injury.
- There were assumptions of capacity and expressed uncertainty about how to include executive functioning in assessments.

Thematic Review Recommendations

There were 8 recommendations for SSAB, covering:

- SSAB oversight of developments of the homeless service
- Interface of CARM, MASH and Section 42 Safeguarding Enquiry processes/meetings
- Meetings of stakeholders (commissioners and providers)
- Continuation of work on transitional safeguarding
- Scrutiny of referrals under Section 42 and subsequent decision-making
- Work on mental capacity assessments (executive functioning)
- Auditing the outcomes of SAR Alan and this thematic review
- Sharing the report regionally.

'Alex' Safeguarding Adult Review

Background

- 'Alex' is a pseudonym
- 39 year old white British man
- Learning disability, autism, epilepsy, anxiety, emotionally unstable personality disorder
- Behaviour that challenged
- Lived in residential care. Around 39 placements during his life
- Continuing Healthcare funded
- Subject to Deprivation of Liberty Safeguards (DoLS)

Terms of Reference/Key Lines of Enquiry

- Scope was from January 2020, encompassing Alex's move into residential care in Sunderland, to December 2022 when Alex moved on from the residential care placement into an emergency placement.
- Transition
- Advocacy
- Deprivation of Liberty Safeguards
- Multi-Agency working
- Organisational issues
- COVID-19
- Cross-boundary working
- Communication & information sharing
- Support for staff working with people with complex and challenging needs

Key Findings by the SAR Author

- Alex moved to residential care in Sunderland in February 2020, one month before the COVID-19 lockdown commenced
- There was a transition plan in place but the move took place quickly
- He had around 39 placements during his life
- Alex was subject to a DoLS. Some deprivations were unauthorised.
- Alex had a paid RPR. There was insufficient contact with him and a lack of reporting to the Supervisory Body.

- There were a number of agencies and professionals involved

Lessons Learnt

- Transitions
- Trauma-informed practice
- Multi-agency working
- Deprivation of Liberty Safeguards
- Advocacy
- Safeguarding
- Working with complex and challenging needs

Recommendations by the SAR Author

- Agencies to emphasise the importance of face to face contact with clients and to promote this as the default.
- Agencies to consider that, if a situation arose again similar to the COVID-19 pandemic, a system like a RAG rating is used for assessing the need for face to face client contact, whereby Red indicates that face-to face contact is essential
- There should also be consideration of multi-agency agreement as to how to proceed for each case
- Commissioners of advocacy services to seek assurances that advocacy services have robust caseload management systems and supervision procedures in place
- SSAB to produce a 7 minute briefing on the topic of trauma informed practice
- Agencies to review 'DoLS awareness' amongst staff and the DoLS training offer within their organisations (as appropriate to the organisations role in respect of DoLS) and report findings to the SSAB
- Learning from SAR 'Alex' to be shared via the next SSAB Safeguarding Adults Week.

Recommendations/Actions identified by involved Agencies

Cumbria, Northumberland and Tyne & Wear Mental Health NHS Foundation Trust

- A transfer of care protocol with guidelines to support safe and effective transfer of care from one team/pathway/service to another was developed and is established within the service
- Learning from SAR 'Alex' to be shared Trust wide

GP

- The safeguarding team to be involved in the wider Multi-Disciplinary Team review across Sunderland and South Tyneside Integrated Care Board (ICB) to ensure complex care and learning from this case is shared
- Any learning and recommendations from this case to be shared with practices more widely through the use of training and discussion
- For any learning and recommendations to be shared on GP team net (website)
- To share any learning from the case with the complex care team within the ICB and head of Primary Care if appropriate

Adult Social Care

- Ensure where multiple Safeguarding alerts are made, case is escalated, so that the Head of Service is aware of complex safeguarding situations, irrespective of funding authority.

'James' Safeguarding Adult Review

Background

- 'James' is a pseudonym
- 50 year old white British man
- Learning disability and autism. Deep venous thrombosis, 10 year cardiac risk, obesity, high cholesterol
- Prescribed medication for mental and physical health
- Moved from Priory Group in the Borough of Redcar and Cleveland to Swanton Care, Sunderland
- Jointly funded by health (Tees Valley) and social care (Redcar and Cleveland)

Terms of Reference/Key Lines of Enquiry

- This SAR used the 'SAR in Rapid Time' methodology, to look at the systems learning from the case
- Scope was from 1st July 2021 to 12th December 2021. Scope timeframe included the transition period from the Priory Group to Swanton Care to the date of his death.
- Transition (6th July - 1st August 2021)
- Moving in day (2nd August 2021)
- Discrepancies in prescribed medication (6th August 2021)

- Registration with new surgery and transfer of patient records (11th August - 8th September 2021)
- Medication noted as 'no longer needed' and 'discontinued' (6th - 20th September 2021)

Systems Findings

- Supporting people when moving and responsibilities during transitions
- Moving GP surgery and transfer of medical records for complex/vulnerable patients
- Seeking clarification on prescribed medication
- Verifying medication changes
- Understanding the purpose of medications, side effects and consequences of missed doses and overdose

Recommendations by the SAR Author

1. There should be guidance for the different professionals around transition planning for when a person moves from one placement to another. Any guidance should be specific to the role each professional/agency plays in the transition process.
2. The above guidance should include the process for transferring information about an individual who is moving from one local authority area to another.
3. Transition plans must include plans for ongoing health support and medication, with assurances of continuity and sufficient supplies of medication whilst transferring GPs, and providing a contingency in the event of delays acquiring medication from the new practice/pharmacy.
4. Transitions plans should be multi-disciplinary with clarity around the roles, responsibilities and expectations of the professionals supporting the individual.
5. Social care accommodation providers to ensure that individuals who have moved to their provision are registered with a new GP on the day they move (or on next working day) to minimise the risk of interruptions to the continuity of healthcare provision.
6. Patient summaries should always include a list of prescribed medication and should reflect the ‘state of play’ from the day before registration ended.
7. GP surgeries should be notified in advance when a vulnerable patient with complex needs will be moving to their practice, and to be encouraged to engage in the transition process.

8. GP surgeries to consider gathering information in relation to vulnerabilities at point of registration.
9. Professionals should have a clear understanding of the roles of psychiatry and general practice, and that the GP is the prescriber of medication.
10. The lead partner/commissioner should be clear with everyone involved about how to escalate concerns, and who to contact to seek resolution to issues with prescribing. Social care accommodation providers should seek further clarity from the lead partner/commissioner about this when issues arise.
11. Psychiatrists should be explicit in correspondence to patients and other professionals that the list of medications included in any correspondence may not reflect the full list of medication prescribed.
12. Psychiatrists should be aware of all medication prescribed by using the GNCR (including that for physical health) in case of contraindications.
13. Social care providers must verify any apparent changes to medication through formal written communication from the prescriber.
14. GP practices to consider a system for alerting GPs when repeat medication for vulnerable patients is not ordered or collected.
15. Raise the profile of Electronic Repeat Dispensing amongst social care accommodation providers
16. Social care accommodation providers to consider the use of Electronic Repeat Dispensing.
17. Consideration to be given to proxy access to medical records for learning disability care homes.
18. Care providers should ensure that each client's care plan contains a list of prescribed medications which details what the medication is prescribed for, the effects of a missed dose, reduction or increase in dose or sudden cessation, the side effects of medication and when to seek medical assistance.
19. For the ICB to consider the totality of the recommendations made by this review, share with the Learning Disability GP lead and Safeguarding GP lead to consider the findings and recommendations, and report on how the learning and recommendations will be implemented/communicated out through primary care.

Safeguarding Learning Week 2025: Themes

SSAB is once again collaborating with Sunderland Safeguarding Children Partnership (SSCP) to deliver Safeguarding Learning Week, a timetable of events aimed at professionals, on a range of safeguarding themes. Events will include webinars, briefings and learning opportunities - all of which are free to attend. This year the week takes place from 17th - 21st November.

Events will be able to be booked via our Safeguarding Training and Events Booking System - see our 'Save the Date' flyer below for more details. Safeguarding Learning Week is a time for organisations to come together to raise awareness of important safeguarding issues. Working in partnership allows us to share our knowledge of safeguarding, learn from others and ultimately create safer cultures. If your organisation would like to deliver a virtual or in-person session during Safeguarding Learning Week that you're happy to open up to multi-agency staff to attend, then please let us know your plans by emailing **strategic.safeguarding@sunderland.gov.uk**.

The theme each year takes a lead from the national Ann Craft Trust, a charitable organisation which promotes safeguarding in sport and beyond. The overall theme for 2025 is '**Prevention: Acting Against Abuse**'. It's important to learn the right lessons when things go wrong. But it is much better to ***prevent*** abuse from occurring in the first place than it is to respond to instances of harm, abuse, neglect, and isolation. Ann Craft Trust is encouraging people to take a closer look at their approach to prevention. They want individuals and organisations to ensure that prevention is embedded in their policies and procedures.

"There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in".

– Desmond Tutu

Daily themes are also used throughout the week as a focus for learning activities. The Ann Craft Trust daily themes for 2025 are:

- Monday: Change the Conversation - proactive intervention; good practice to create safer environments that actively work to prevent abuse.
- Tuesday: Prevention in Practice - considering the role of good governance in shifting behaviours towards safer cultures.
- Wednesday: Creating Empowering Environments - how empathy, understanding, co-production, and positive risk taking can help create trauma informed approaches.
- Thursday: Trust Your Instincts - develop supportive cultures in which good safeguarding practices can thrive.
- Friday: Celebrate the Safer Cultures - shine a spotlight on examples of good practice.

Further reading: [Ann Craft Trust - Safeguarding Adults Week 2025]

Multi-Agency Safeguarding Hub (MASH): A Good Practice Case Example from Northumbria Police

Summary: cases were discussed in a MASH Triage meeting which led to the identification and conviction of the offender for 3 separate crimes committed against vulnerable older people.

Details: Three incidents were reported over a 2-week period whereby a male had entered 3 separate Supported Living Properties in the Silksworth area and stolen from elderly residents (aged 81, 92 and 85 years). Two of the crimes were recorded as fraud, the third as theft.

When discussing the Adult Concern Notifications from these cases which Northumbria Police make in the MASH Triage, it was theorised that the same individual was responsible for all 3 crimes, as the method of crime was almost identical in each case.

CCTV footage and a custody photo were used to confirm a link, a file of evidence was built, and the case against the individual was taken forward to court, which resulted in a 7-year conviction for 6 offences of Burglary at a Crown Court in South West England on 27.11.24 (the offender had fled there from Sunderland, where he was apprehended).

Focus On: Cuckooing

Cuckooing (may also be known as 'home takeover' or 'home invasion') involves criminals taking control of another person's home in order to use it for criminal activity. This criminal activity could involve offences relating to drugs, sexual abuse, and weapons. Criminals might also use the property to store money or stolen goods, or simply as a place to sleep.

Cuckooing can also be part of County Lines activity (County Lines are criminal operations where illegal drugs are moved from one area to another by people (could be children, young people or adults) who have been coerced into criminal activity by gangs).

Cuckooing involves taking control of another person's home without their consent. In UK law, a person cannot consent to their home being used in a certain way if:

- They are under 18 years old.
- They do not have capacity to give consent.
- They do not have sufficient information to enable them to make an informed decision.
- They have not given consent freely
- They have withdrawn their consent.

UK law also recognises that a person cannot freely give consent for their home to be occupied if this consent is obtained by coercion, deception, or other forms of abuse.

Who do criminals target for Cuckooing?

Criminals might target:

- People with drug or alcohol addictions
- People who are struggling financially. In this way, cuckooing can be a form of financial abuse
- The elderly
- People with mental health issues or learning disabilities, or significant physical disabilities which limit their ability to stop others using their home

How does Cuckooing Work?

A criminal organisation, or an individual criminal, will take control of another person's house to use it for criminal activity.

The criminal might trick the person into giving control of their house, through manipulating the person into thinking of them as a friend (this is an example of "mate crime").

Or, the criminal might use threats of violence or abuse – or actual violence or abuse – to intimidate, control, and coerce the person into giving up their home.

Using another individual's house for criminal activity helps criminals avoid police detection.

What To Do If You Think Someone You Know is a Victim of Cuckooing

Cuckooing is a criminal offence. So if you suspect cuckooing activity is taking place in your community, or if you think someone you know is a victim of cuckooing, you need to let the police know as soon as possible.

There are a number of ways you can do this:

- Talk to a police officer in person
- Visit your nearest police station
- Call 101 to report your concerns
- If you think someone is in immediate danger, call 999
- If you want to remain anonymous, you can call Crimestoppers on 0800 555 111.

Further Reading

- In February 2025, the UK Home Office and Ministry of Justice published a factsheet outlining their intentions to strengthen the law around cuckooing, and related offences. The factsheet was updated in July 2025 - read it here

- West Yorkshire Police produced a short animated YouTube video explaining how cuckooing works, and it includes a case study
- Newcastle Safeguarding Adults Board, Newcastle Safeguarding Children Partnership & Safer Newcastle Board (Community Safety Partnership) have produced two animations about cuckooing, one aimed at professionals and the other aimed at children
- The University of Leeds has produced a free toolkit to help professionals understand, prevent, and disrupt cuckooing activity. The toolkit contains an information booklet, a risk identification tool, an introduction to the cuckooing safeguarding process, and some posters and leaflets to help spread awareness.

Note: whilst the processes and procedures referenced in the above resources from other areas are not exactly the same as in Sunderland, the issues around cuckooing are the same and can still be used to gain knowledge and raise awareness. Please reference SSAB's Multi-Agency Safeguarding Adults Procedures for local detail.

Acknowledgements to the Ann Craft Trust for the above information on Cuckooing.

Useful Resources

Please note, these links are being provided as a convenience and for informational purposes only; they do not constitute an endorsement or an approval by SSAB of any of the products, services or opinions of the Board or its representatives. SSAB bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Please contact the external site for answers to questions regarding its content.

Mental Capacity Act Guidance Notes from 39 Essex Chambers (Barristers)

- Mental Capacity Guidance Note: Best Interests – published **12 May 2025** Mental Capacity Guidance Note: Best Interests | 39 Essex Chambers
- Mental Capacity Guidance Note: Assessment and Recording of Capacity – published **12 May 2025** Mental Capacity Guidance Note: Assessment and Recording of Capacity | 39 Essex Chambers. The purpose of this document is to provide for social workers and those working in front-line clinical settings an overview of the law and principles relating to the assessment of capacity. Its focus is on:

(a) how to apply the MCA 2005 principles when assessing capacity;

and

(b) how to record your assessment, primarily in the context of health and welfare decisions.

Healthwatch Sunderland: 'Support for People with Memory Difficulties or Dementia' Booklet

The booklet 'Support for people with memory difficulties or dementia' has been developed by local carers and professionals who support people living in Sunderland with memory difficulties or dementia. The booklet is now available online and (in limited supply numbers) as a hard copy for members of the public, only if they cannot access the digital copy. Please call Healthwatch Sunderland on 0191 514 7145 if you are a member of the public and need a hard copy.

The digital copy of the booklet can be accessed here, along with a video explaining the work. On the same link, 'easy to print' mini booklets are also available to download for each section of the booklet.

Mental Health Crisis Text Service (Shout)

People who find themselves in a mental health crisis can now get urgent support by text, thanks to a partnership between the NHS North East and North Cumbria Integrated Care Board (ICB) and a national mental health provider.

Simply texting 'CALMER' to 85258, people can get free, confidential, 24/7 text support if they find they are struggling to cope.

Anyone in the North East and North Cumbria region experiencing anxiety, stress, loneliness, depression, self-harm, suicidal thoughts, or other mental health challenges can use the service by texting the word ‘CALMER’ to 85258 at any time of day or night.

The partnership is designed for people who may prefer to seek support via text and provides immediate and anonymous support for those who are waiting for further help. Text conversations are taken by mental health professionals, overseen by clinical supervisors.

The service is funded by the ICB, and delivered by the innovative digital service called Shout, which is powered by the charity Mental Health Innovations.

This text service does not replace other mental health support such as the NHS 111 mental health service or Talking Therapies.

How does it work?

Shout is a free and confidential text messaging support service that’s there to help anyone in the North East and North Cumbria region who is struggling with how they feel.

If someone is sad, worried or lonely, they can text the word ‘CALMER’ to 85258 to start a conversation with Shout:

Once a person sends the text, they will get four automated messages. They’ll be connected with a mental health professional as soon as one is free.

They will send a message to introduce themselves and ask how you're feeling. You will then message each other back and forth, silently and privately. You can tell them about anything that might be upsetting you and only need to share what you want.

The mental health professional will listen to how they're feeling, talk to them about it and help make a plan for after the chat ends, once they feel calmer and safer. Conversations with Shout usually last between 45 minutes and one hour.

Their conversations will be saved in their messages if they ever need to look back and Shout is there 24/7 if they ever want to text again.

If someone's life is at risk, call 999 immediately.

Carers Assessment Online Portal

The Carers Assessment Online Portal has been launched on Sunderland City Council's website, where carers are able to complete their own carers assessment online at a time and place they feel comfortable.

What is a carer's assessment?

It is your opportunity to discuss how being a carer affects your life and outline any changes you would like to make and how you they can be achieved. This is not an assessment of your capabilities. The carer's assessment simply looks at the care and support you provide and contains information to support you in your caring role. Assessments can be face to face or via phone with an assessor. Contact Sunderland Carers' Centre on telephone: 0191 549 3768 or email: contactus@sunderlandcarers.co.uk to arrange an assessment with a member of their assessments team, or using a self-assessment form on the new online portal in the link above.

Washington MIND Training Courses: September 2025

Washington MIND is currently promoting their September 2025 training offer. Please see below for courses and dates, which can be booked on their website at Booking our training - Washington Mind. For any queries related to these courses, please contact Washington MIND direct by going to their website washingtonmind.org.uk or telephone: 0191 4178043

COURSE	DATE AND VENUE
A Life Worth Living – Suicide Prevention	3rd September 2025, Washington Mind
Mental Health Awareness	9th September 2025, Marley Park Community Fire Station
A Life Worth Living – Suicide Prevention – Young People	16th September 2025, Marley Park Community Fire Station
Emotional Resilience (Investing in You)	18th September 2025, The Tansy Centre
Building Resilience in the Workplace	24th September 2025, Washington Mind

mind Washington

A LIFE WORTH LIVING

SUICIDE PREVENTION TRAINING

Both nationally and regionally we are challenged with preventing suicide. By training our community we can tackle the stigma associated with suicide and reach many more people and their families. This half day training course focuses upon a community approach to suicide prevention and intervention.

Find out more and contact us

To find out more about Washington Minds's training programme visit our website at: **washingtonmind.org.uk or call us on: 0191 417 8043**

"It has saved at least 2 lives in our organisation so well worth attending"
A LIFE Worth Living Delegate

mind Washington

INVESTING IN YOU
EMOTIONAL RESILIENCE
TRAINING

MENTAL WELLBEING
This course will be beneficial for those who wish to invest in the mental wellbeing of self and others.

SELF-CARE
We will discuss personal boundaries, why boundaries are important for self and others and why self-care is the cornerstone for resilience.

STRESS
During the session we discuss stress, it's impact as well as tools and techniques to manage it.

RESILIENCE
We will explore the concept of emotional resilience and how investing in YOU can strengthen and build resilience.

FIND OUT MORE AND CONTACT US
To find out more about Washington Mind's training programme visit our website at: washingtonmind.org.uk or call us on: 01914178043

Sensitive Topics

Report a Concern

Everyone has a responsibility to safeguard children, young people and adults who may be at risk of abuse.

If you are worried about someone:

· In an emergency call 999

· If there is no immediate risk, call the police on 101

If you are a professional wishing to report a safeguarding concern regarding an adult, follow the link below to the on-line Portal for Providers and professionals: Worried about someone? (sunderland.gov.uk)

If you are a member of the public and worried about your own safety or about the safety of someone else, you can call Sunderland City Council on 0191 520 5552. Alternatively, you can also visit the Sunderland City Council website and complete the member of public online referral form.

If your concern relates to a child, please call 0191 520 5560.

Future Articles

If you have an idea for an article for a future publication of this Newsletter, please contact the Strategic Safeguarding Team: strategic.safeguarding@sunderland.gov.uk