Case Learning Summary: 'Ronnie' Safeguarding Adults Review

What is a Safeguarding Adults Review (SAR)?

Safeguarding Boards have a responsibility to ensure that organisations that work with adults at risk can learn from their own practice and that of others. When adults with care and support needs die or are seriously harmed in certain circumstances, the Care Act requires us to undertake a review. The reviews help us learn from good practice and learn lessons from what went wrong, so that services and practice can be improved to reduce the risk of future harm.

The PSAB SAR subgroup considered the case referral for Ronnie and concluded that although the above criteria had not been met, a discretionary review should be undertaken under section 44(4) of the Care Act. The methodology used was a learning review with workshops involving practitioners and their managers to reflect on the themes that had been identified and to collectively develop recommendations. Links were also made with some other SARs which covered similar issues.

Who was Ronnie?

Ronnie was a 44-year-old White British man. He had a long history of substance misuse. He had first approached housing services for support in 2002 and was accommodated in the rough sleeping pathway following the 'Everyone In' initiative. He was a son and a father, and his family were hugely important to him. He was a carer for his mother and visited her every day and was also devoted to his daughter. His goals were to live independently in his own flat so that his daughter could stay with him. Ronnie engaged well with his support worker and the staff at the Registry[1] found him polite, pleasant, and respectful. His support worker described him as having a wicked sense of humour. He wanted to be liked and as a result, was often exploited, with other residents borrowing money from him. He was the victim of regular assaults in the community and was also at times a perpetrator of violence and of domestic abuse. He was reluctant to seek help from health services or the police. Ronnie was taken to hospital following a physical assault by two other residents of the Registry. He sadly died two days later.

Key Findings/Lessons

- Within the large homeless accommodation, there is sometimes a level of desensitisation in relation to the level of violence amongst victims/perpetrators, families, the community, services, and staff. This led to Ronnie not being identified as vulnerable by services and therefore opportunities to exercise professional curiosity, rather than making assumptions, were not taken, and safeguarding concerns were consequently not referred to the Adult Multi-Agency Safeguarding Hub.
- There is some evidence of unconscious bias from professionals towards male-on-male violence. This can lead to a different approach being taken from that which is used for other

[1] The Registry is a service commissioned by Portsmouth City Council as part of the Rough Sleeping Pathway.

forms of violence such as domestic abuse, where services, legislation and approach leads to more effective interventions.

- There is some evidence of unconscious bias insofar as males are less likely than females to be perceived as vulnerable. They are also less likely to be considered as parents even where they have children.
- Risk assessments and risk management plans are not always updated after incidents. Risk management plans in respect of risks to self and risks of exploitation are not always effective. There is not always an effective multi-agency approach to risk.
- It is not always easy to identify patterns which may indicate escalating risk, due to staffing changes, staffing structures, and recording constraints. There could have been significant benefits in utilising the Multi Agency Risk Management (MARM) processes. The barriers may have been insufficient awareness of MARM, insufficient MARM training at the right level, or because of perceived bureaucracy associated with MARM, and a lack of accountability for actions among partners.
- Although support plans were in place, there was insufficient common understanding to support Ronnie to realise his aspirations, and there was a lack of suitable commissioned services.
- Ronnie's potential needs as a carer were not fully considered.
- Where there is evidence of marginalisation, stigma, and unconscious bias, this creates a barrier for homeless clients in seeking effective support from services.
- Although Ronnie received clinically appropriate care from health services, interventions were reactive rather than proactive. Information was not shared between agencies, so the full picture of his needs and presenting risks was not known, and patterns such as the repeated head injuries and leaving hospital without receiving care were not identified. Therefore, services may not have considered the impact of repeated head injuries and executive functioning when assessing Ronnie's mental capacity.

Key Points for Learning & Reflection

- Are you familiar with MARM and confident on how to utilise it to support multi agency working and risk management?
- For staff working for Society of St James or Portsmouth City Council Housing, is the new risk assessment framework embedded into day-to-day management oversight including supervision?
- Do you know how to access peer mentors for anyone who is actively involved in substance misuse?
- For housing staff, are you aware of how families can be engaged in supporting clients, with their consent, to better understand their wider circumstances?
- Spend time in your team on raising awareness of unconscious bias (including misconceptions and assumptions surrounding the vulnerability of males with multiple needs) and the importance of not labelling/appropriate use of language.

- Are you confident in recognising when people are carers? Do you know what support is available for carers and how to refer for a carers assessment?

Further information and useful resources

Thematic Review Following the Deaths of Mr G, Mr H, Mr I and Mr J full report: (https://www.portsmouthsab.uk/scrs-2/)

Homelessness - 4LSAB Housing Practitioner Briefing (https://www.portsmouthsab.uk/wp-content/uploads/2022/07/Homelessness-4LSAB-housing-practioner-briefing-vFINAL-May-2022.pdf)

Homelessness Reduction Act 2017 (https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer)

MARM Framework and toolkit (https://www.portsmouthsab.uk/procedures/)

Carers and safeguarding: a briefing for people who work with carers (https://www.local.gov.uk/parliament/briefings-and-responses/carers-and-safeguarding-briefing-people-who-work-carers)

Managers are encouraged to explore the learning points in team meetings and supervisions. If you require further information about the cases, please contact PSAB@portsmouthcc.gov.uk