Portsmouth Safeguarding Adults Board

'Ronnie' Safeguarding Adults Review

What is a Safeguarding Adults Review?

The primary purpose of a Safeguarding Adults Review (SAR) is to draw out organisational learning about how the local agencies are working together, to support improvement.

Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. They may arrange a Safeguarding Adults Review for other cases under section 44(4), for example where there is important learning to be identified.

The PSAB SAR subgroup considered the case referral for Ronnie on 14.09.22 and concluded that the above criteria had not been met. It was decided to carry out a discretionary review under section 44(4) of the Care Act.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

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 to cook for her. He 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 found him polite, pleasant and respectful. His support worker described him as having a wicked sense of humour. Ronnie had a brother, who had been in and out of prison for much of his life. Ronnie wanted to be liked and as a result he was often exploited, with other residents borrowing money from him. He was the victim of regular serious 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.

Local context - services

There are several supported housing services in Portsmouth, provided by organisations commissioned by Portsmouth City Council. These services include "general needs" provision for all adults threatened with homelessness and also more specialist settings commissioned for service users with additional or specific needs,

such as those in recovery from substance or alcohol dependency or requiring support with their mental health.

The Council commissioned a rough sleeping support service in Portsmouth following the Covid-19 pandemic, during which there was a significant increase in the numbers of single adults seeking assistance due to homelessness, and an "Everyone In" directive from central government requiring all homeless people to be provided with accommodation to mitigate the risk of infection.

The rough sleeping pathway comprises several sites in the centre of Portsmouth providing supported temporary housing, with varying levels of staffing cover. This includes a service called the Registry, which accommodates up to 41 adults at risk of rough sleeping and providing a high level of housing-related support.[1] Ronnie was provided accommodation within this setting during the final months of his life.

Key events leading up to Ronnie's death

- Early 2021 - Ronnie attended the Emergency Department (ED) and outpatient departments at hospital due to physical health concerns, in part related to alcohol misuse.
- September 2021 - Two incidents resulted in Ronnie sustaining head injuries while intoxicated, requiring ED attendances. He was admitted for alcohol detoxification but self-discharged from hospital against medical advice.
- October 2021 - Ronnie shared that he was unhappy living at Kingsway House and moved to the Registry. He restarted his Methadone prescription. He also attended ED via ambulance with head injuries after being assaulted and then hitting his head after collapsing.
- December 2021 - January 2022 - Ronnie reported feeling more positive, was engaging well with his support worker and with substance misuse services. There were two 111 contacts due to health concerns. Ronnie reported difficulties in his caring role for his mother.
- February 2022 - further health concerns are recorded. Ronnie was engaging with mental health services.
- February 2022 - there were concerns about Ronnie as a perpetrator of domestic abuse. The police investigated and there was a referral to the Multi Agency Risk Assessment Conference (MARAC).
- March 2022 - Ronnie overdosed and Naloxone[2] was administered. He was taken to hospital but did not stay for treatment. Ronnie was offered a room in a shared house which he viewed with his support worker. The offer was withdrawn because of his overdose. Ronnie suffered a further assault in the community. The day after this assault he was arrested by Police as he was carrying a weapon, but he was taken to hospital from custody due to his injuries.

[1] Housing related support includes help with independent living skills, budgeting and managing a tenancy, emotional support, and support to access other services such as health care and substance misuse services.
[2] Naloxone is a medicine that rapidly reverses an opioid overdose.

- April 2022 - Ronnie again overdosed in the community. Ronnie was present at a fight in which his brother was arrested for assault.
- Early May 2022 - an ambulance was called for Ronnie by Registry staff due to a suspected overdose, but Ronnie declined medical intervention. Ronnie sustained a further assault in the community. There were concerns about his increasing drug and alcohol use and his disengagement with Registry staff.
- End of May 2022 - Ronnie overdosed at the Registry and Naloxone was administered.
- Ronnie was taken to hospital following a physical assault by two other residents of the Registry in early June 2022. He sadly died two days later.
- Ronnie had had no prior history with the perpetrators, but there had been concerns escalated to the police by the Society of St James (SSJ) the previous day about their behaviour including threats made to staff.

Review methodology

- Review of scoping information detailing each agency's involvement with Ronnie.
- Questionnaire to gather the views and experiences of practitioners who worked with Ronnie.
- Dialogue with Ronnie's family to ascertain their views.
- Workshop including a pen picture of Ronnie and to explore strategic issues involving SSJ, Hampshire Constabulary, Portsmouth City Council Housing Department, Public Health and Adult Social Care.
- Further workshop to explore his health issues.
- Meeting to finalise recommendations.

The review was facilitated by a senior manager who had no connection with any of the services involved at the time of Ronnie's death.

Involvement of family members

The reviewer met with Ronnie's mother and aunt to explain the purpose of the review and about the review process. A further meeting took place to feed back on the findings and recommendations. Ronnie's mother and aunt were invited to give their perspective on the review. Their main concerns were:

- the response of the Registry staff following the incident (these concerns have been investigated and no evidence found to support their claims)
- the appropriateness of the accommodation
- the ineffectiveness of services in protecting Ronnie from the assaults he experienced
- the lack of family support and communication following the death and the length of time the police investigation has taken.

Good practice identified

- Ronnie had a close relationship with his support worker and engaged well.
- Ronnie had a person-centred support plan.

- Portsmouth Hospitals University NHS Trust Critical Care staff were diligent in maintaining Ronnie's dignity and confidentiality towards the end of his life under challenging circumstances.
- The South Central Ambulance Service call handler had been very calm and professional and issued clear instructions to others in a difficult situation.
- The GP had been diligent in making referrals to ED.

Changes made since Ronnie's death

- There is now a more effective and multi-agency approach to risk management when individuals move into the rough sleeping pathway accommodation than was the case at the time of Ronnie's death. Risk plans are now stored on the database. Cases requiring the use of the Multi-Agency Risk Management (MARM) Framework are now identified and MARM meetings initiated in a more proactive and structured way.
- SSJ is introducing a comprehensive risk identification framework.
- SSJ has commenced a retraining programme for all staff.
- It is now possible to use non-protected licenses under certain circumstances, which was not the case at the time of Ronnie's death.[3]
- A Police Constable has been assigned as the Single Point of Contact for the Registry and the collaborative professional relationship between Police and accommodation staff has improved.

Context - other reviews

In 2022, the Portsmouth Safeguarding Adults Board (PSAB) published a Thematic Review into the deaths of four adults who were experiencing homelessness, all of whom died in 2020. That review looked at the national learning about homelessness and had gathered information from homeless people, staff and family members. Some of the findings of that review are pertinent to this review: the impact of the stigma experienced by people experiencing homelessness; the challenges of commissioning accommodation for people with complex needs; and the need for services to take a whole family approach. Significant progress has already been made on an action plan in response to the findings of the thematic review.

Alongside this review of Ronnie, PSAB has also been carrying out another SAR in relation to the death of an adult which took place some months later at the same

[3] A condition of the grant funding provided to Portsmouth City Council to commission its rough sleeping services included the requirement to provide protected accommodation licence agreements to anyone housed in the pathway. This type of licence agreement cannot be terminated by a landlord without recourse to a court order, following the expiry of a 28-day notice to quit. Individuals presenting a risk to others could not therefore be excluded or evicted from the pathway accommodation following a serious incident (and where so doing would support the management of such risks). More recently, Portsmouth City Council has worked with the Department of Levelling Up, Housing and Communities (DLUHC) to secure agreement to be able to provide some pathway residents with a non-secure licence agreement, instead, in exceptional circumstances. This type of agreement can enable temporary or permanent exclusions of residents who may present an unmanageable risk to others within the pathway.

accommodation. Similar findings have been identified, including: missed opportunities for multi-agency risk management; evidence of unconscious bias from professionals towards adults who are experiencing homelessness and who have complex needs; a lack of appropriate accommodation options for adults with complex needs; and communication with families following a death.

Findings

- Within some homeless services, including larger accommodation settings and hostel buildings, there can be a level of desensitisation to violence. This may have an impact on victims, perpetrators, their families and communities, and how services and staff are able to support them. 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 (MASH).
- 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 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.
- Some victims are unlikely to want to be rehomed outside the area due to strong family and community ties.
- 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 could indicate escalating risk, due to staffing changes, staffing structures, and recording constraints. In Ronnie's case, use of the Multi Agency Risk Management Framework (MARM) could have been considered, but was not commenced. There may be insufficient awareness of MARM, insufficient MARM training at the right level, a barrier due to bureaucracy associated with MARM, and a lack of accountability for actions among partners.
- Support plans are in place and are person centred, but for Ronnie there was not the multi-agency support and common understanding to support him to realise his aspirations within the support plan, and there was a lack of suitable commissioned services to meet his specific needs.
- Ronnie was offered support from the homeless social worker and a Care Act assessment but did not accept this. Ronnie's mother was offered but did not accept a Care Act assessment. 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 seeking effective support from services.

- The relationship with the police and homeless services could be improved. Police did not always appreciate the urgency of some reports from SSJ staff and were unable to bring prosecutions against the perpetrators of assaults because Ronnie was afraid to engage with police.
- Staff in homeless accommodation provision sometimes feel unsupported by other services in managing high risk situations.
- Although Ronnie received clinically appropriate healthcare from health services, interventions were reactive rather than proactive. Information was not shared between agencies, so the full picture of Ronnie's needs and presenting risks was not known, and patterns such as the repeated head injuries and leaving hospital without receiving care were not identified.
- Services may not have considered the impact of repeated head injuries and executive functioning when assessing Ronnie's mental capacity.

Recommendations

1 Seek assurance from partners that MARM has been embedded, including in frontline practice, internal guidance, supervision and training. The PSAB Quality Subgroup to audit impact (PSAB)
2 Implement new 'red flags' risk assessment framework and ensure it is embedded into day to day management oversight including supervision (SSJ/Housing)
3 Increase provision of peer mentors, ensuring that anyone who is actively using substances has access to a peer mentor (Public Health)
4 Raise awareness among housing staff of how families can be engaged in supporting clients, with their consent, to better understand their wider circumstances (Housing)
5 Work to understand the gaps in the current supported housing offer and identify what additional provision is required to meet the needs of a diverse client group, by making use of relevant funding opportunities where available (Housing)
6 Raise staff 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 (PSAB/all agencies).
7 Ensure professionals recognise people as carers and offer appropriate support, including referral for a carers assessment (all agencies able to identify carers and Adult Social Care/Health able to deliver referrals).
8 Develop an information sharing protocol in the event of the death of an adult who is homeless or is living in supported housing provision, to ensure there is a lead senior manager to coordinate the response and decide who will liaise with the family (Housing).
9 Hold a Citywide review of the rough sleeping pathway and commissioned supported housing, to include Adult Social Care, Public Health and Children’s Services colleagues. Review to inform the new Homelessness Strategy, due to be published by the end of December 2023 (Housing)