Safeguarding Adult Review of Clive and Richard

Who are Clive and Richard?

Clive was known to the police as a vulnerable adult, who had presented as the suspect in a wide range of offending for many years. His was a lifestyle in which violence, offending, difficulties managing emotions, substance misuse and homelessness were endemic and enduring. Homelessness services described Clive as easy to work with, and reported that Clive would enthusiastically partake in activities, such as gardening, to distract him from problems he was facing. Clive's own difficulties with mental health issues, and social, medical and behavioural problems were mirrored by his assailant, Richard, who lived in the same shared housing. Richard was diagnosed as suffering from schizoaffective disorder and substance misuse, and has had a long history with mental health services. He was marginalised and disordered, engaging in begging, shoplifting and chaotic drug use. It was suggested, in a Safeguarding Meeting in 2018, that alternative accommodation be sought for Richard, but this never materialised – he remained in the shared housing despite universal misgivings about its suitability.

Clive and Richard were involved in several incidents preceding the trigger for the review. In 2017, and later in 2019, Richard reported he was raped by Clive. In May 2019, days after being informed that the police investigation was closing, Richard punched Clive in the head. After being ejected from the room by other residents, he re-appeared wearing a mask and used a hammer to try to gain entry to the room. In June 2019, Clive reported Richard for theft. The following day, Clive was seriously assaulted by Richard, causing loss of sight in both eyes. Clive now requires around-the-clock care and is currently in a residential care home to receive this support. Richard was subsequently arrested and detained indefinitely under the Mental Health Act.

A safeguarding adults review (SAR) was commissioned. The purpose of a SAR is to draw out organisational learning about how local agencies are working together, to support improvement.

Identified good practice

- Police officers showed a sensitive harm reduction and community-based approach in their interactions with Richard, frequently articulated in meetings their concern that his accommodation was unsafe and unsuitable, and tried to contact Richard several times in relation to his allegations of sexual assault.

- The last allocated Mental Health Social Worker displayed tenacity and resilience in working with Richard and his family, and quickly recognised the serious nature of the situation and responded accordingly.

- The Homeless Health Care Team conducted a home visit to Clive as he had not been seen for some time by them and had at least one long term member of staff who knew him and his background well. They used this long-term knowledge and adopted a proactive approach entirely appropriate with this hard-to-reach group of service users.

- The Home Group Support Worker engaged with Richard's mother who has, since the incident, kept in touch with her. This member of staff persuaded Richard to attend on one occasion at the Sexual Assault Referral Centre and tried to support for a return visit.

Findings of the Review:

- There was an inability - or lack of will - to carry out the decision made at the Safeguarding meeting in Oct 2018 "that alternative sources of accommodation be sought" for Richard.
- Accommodation referrals were not made for Richard until February 2019 and both residential units applied to, declined him due to his drug use. Richard was never found alternative accommodation or additional support and remained at the shared housing despite universal misgivings about its suitability.
- The supported accommodation's contract was recommissioned, moving from on-site support staff to twice weekly visits based on individual needs. Consequently, staff were not always on-site, or their attention was on individual 'customers' rather than the residents as a group.
- Responsibility for the premises and the care and supervision of its public spaces was neglected and not effectively policed. The community's most needy, disadvantaged, and isolated were brought together into properties with insufficient oversight, care, and control.
- Concerns over suitability were raised on multiple occasions but were never addressed.
- Regardless of the police's decision as to capacity, Richard should have been offered an opportunity to have his sexual health needs assessed at a Sexual Assault Referral Centre, where specialists in working with a full range of vulnerable victims may have been able to engage him.
- A Safeguarding meeting was held in May 2019, after Richard had reported his rape. Police felt that the comments recorded in the meeting downplayed the risks to Richard, and that they "fail to represent the high level of concern that the police continued to feel at this time about Richard's and Clive's continuing cohabitation". After Clive was arrested for punching Clive, the police re-raised these concerns and sent a text to the Senior Client Services Manager responsible for housing management of the shared house asking how they planned to safeguarding other residents when Richard was released, but no reply was recorded
- There was a lack of collaboration with involved family members, who can help with early flagging of risk
- Lack of effective support, supervision and oversight of Richard's daily life and worsening mental health, despite concerns by community mental health social worker/care coordinator regarding Richard's deteriorating mental health
- Clive was not informed that Richard had made allegations of sexual assault against him, so he was not aware of heightened risk of retaliation

Recommendations:

- Review of quality checks and assurances for the safeguarding of adults at risk
- Review protocols for referral into the AMHP Service for assessments under Mental Health Act 1983, with clear escalation and resolution process in cases of professional disagreement
- Training for staff on application of Mental Capacity Act assessment especially in cases of fluctuating capacity
- Consider asking Clive to help train staff by recording his story and the impact of this assault
- Review GP Practice standards to strengthen guidance on medicine management for those with substance misuse and mental health concerns not collecting prescriptions
- Sexual Assault Referral Centre to deliver training to professionals on services and pathways following an allegation of sexual assault
- Review MARM arrangements for adults at risk with complex needs

- Safe City Partnership to consider how to support housing providers and partners to respond and best manage the safety of residents.

Questions:

How might you support and ensure relevant information is gathered in cases where there are signs of escalation of risk?

How will you ensure that your concerns are raised and acted upon?

Are you aware of MARM?

Are you aware of the referral pathways to flag urgent concerns?

Full report can be accessed here: A Safeguarding Adult Review of Clive and Richard (southamptonlsab.org.uk)