Ronnie case study – Safeguarding Adults Review extract 2022

Who was Ronnie?

Ronnie was a 44 year old white British man, he was a son and a father to his daughter, and his family were very important to him. He was a carer for his mother, who he visited every day to cook for her. He had a long history of substance misuse. Ronnie needed hospital treatment a number of times, after assaults and drugs overdoses. Since 2002 Ronnie had spent periods as a rough sleeper, but always had a goal to live independently in his own flat. Ronnie's support worker said he engaged well and during the Covid "Everyone In" directive in 2020, Ronnie was housed by the local authority, along with other rough sleepers. Ronnie wanted to be liked, which often led to him being exploited, and during this time, residents would borrow money from him, which would lead to conflict. He was a victim of regular assaults in the community, and at times he was a perpetrator of violence and domestic abuse. He found seeking help from police and health services particularly difficult.

Ronnie died in June 2022 after being assaulted. In the months leading up to his death, Ronnie was assaulted a number of times and received medical attention for this and for overdoses.

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.

Family Members' concerns:

- Response of Housing support staff following the assault that led to his death
- Appropriateness of the accommodation
- Ineffectiveness of services in protecting Ronnie from the assaults he experienced
- Length of time for police investigation and lack of support to the family during this time.

Identified Good Practice:

- Ronnie had a close relationship with this support worker and engaged well
- Ronnie had a person-centred support plan
- Hospital staff practice was praised for their care in challenging circumstances
- Ambulance response was good
- GP had been diligent in making referrals to the Emergency Department

Findings of the Review:

- A level of desensitisation to violence in homeless settings may have led to Ronnie not being identified as vulnerable, and staff may not have exercised professional curiosity, which may have allowed safeguarding concerns to be referred to the Adult Multi Agency Safeguarding Hub (MASH)
- Some evidence of unconscious bias from professionals towards male-on-male violence, insofar as males are less likely than females to be perceived as vulnerable, and 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 for risk to self and risk of exploitation are not always effective. There is not always an effective multi-agency approach to risk.
- Multi Agency Risk Management Framework (MARM) could have been considered, but was not, and it was unclear what prevented this happening.

- Lack of suitable commissioned services to meet Ronnie's specific needs
- Ronnie's 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 police and homeless services could be improved. Police did not appreciate the urgency of some reports, and were not able to bring prosecutions because Ronnie was afraid to engage with police.
- Staff in homeless accommodation provision can feel unsupported by other services in managing high risk situations
- Information was not shared between agencies, which meant Ronnie's needs and presenting risks were not fully known
- Services may not have considered the impact of repeated head injuries and executive functioning when assessing Ronnie's mental capacity.

Recommendations:

- Embed MARM to frontline practitioners, guidance, supervision and training (all agencies)
- Improve "red flags" risk assessment framework (Housing)
- Increase provision of peer mentors (Public health)
- Raise awareness of how families can help support clients (with consent) (Housing)
- Understand gaps in housing support offer esp for diverse client group (Housing)
- Raise staff awareness of unconscious bias (all agencies)
- Raise staff awareness of carer's needs (all agencies
- Develop information sharing protocol, to co-ordinate appropriate family liaison (Housing)
- Review rough sleeping pathway and inform Homelessness Strategy (Housing)

How can this review of Ronnie's death help you in your practice?

How might unconscious bias around male to male violence impact your practice?

Thinking about information sharing, are you satisfied that you receive all the information you need to provide support? And provide information to partners where appropriate to deliver the required support?

How can you help overcome fears that clients may have to engage with other services?

You can read the full review on the PSAB website.