

Clive and Richard SAR - 6 Step Briefing



The Background

At the time of the incident, Clive was a 46-year-old male living in shared housing. He 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 behavioral 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.

The Incident

Clive and Richard were involved in several incidents preceding the trigger for the SAR. 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, 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. He told the author of the report that he had felt perpetually threatened by Clive, as Clive had told him that he was a famous boxer.

Safeguarding Concerns

Both Clive and Richard were highly vulnerable adults with a wide range of emotional, social and medical needs, including substance misuse.

As early as 2018 it was suggested that alternative accommodation be sought for Richard, as the current accommodation was unsuitable. Professional concerns about the accommodation, in terms of there being insufficient oversight, control and care were enduring.

Even though agencies were aware of the risks posed by Richard, it was never seriously considered even after his assault on Clive in May 2019 that he posed a risk to others. For example, Richard was bailed back to the same address after his first assault on Clive without a pre-release risk assessment to consider the risks to both parties and other residents.

The Review

This Safeguarding Adult Review (SAR) concerns the effectiveness of inter-agency practice in relation to engagement and care of two vulnerable adults. The Southampton Safeguarding Adults Board Case Review Group recommended that this case met the criteria for a Statutory SAR and this was agreed by the Southampton Safeguarding Adults Board (SSAB). The timeframe for the period under review was 1st September 2017 to 29th May 2019.

Findings

There was an inability - or lack of will - to carry out the decision made at the Safeguarding meeting held in October 2018 “that alternative sources of accommodation be sought” for Richard. Referrals were not made 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. Hampshire Constabulary 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 co-habitation”. 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.

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.

HHCT 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 SARC and tried to support for a return visit.

Useful links for Best Practice

- [Clive and Richard Full Report and Recommendations](#)
- [Care Act factsheets - GOV.UK \(www.gov.uk\)](http://www.gov.uk)
- [4LSAB 7 Minute Guide to Professional Curiosity](#)
- [Mental Capacity Guidance – Bournemouth University](#)