# ‘Kim’ Safeguarding Adults Review

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DAVID JONES AND SARAH SHORE

**Sarah Shore**

**Interim Deputy Director Quality and Safeguarding**

**Hampshire and Isle of Wight ICB**

**David Jones**

**Independent Consultant**

# What is a Safeguarding Adults Review?

The Care Act s44 requires Safeguarding Adults Board to arrange a review when adults with care and support needs die or are seriously harmed in certain circumstances.

The Care Act also gives us the power to review other cases where there may be learning.

The reviews help us

- learn from good practice
- learn lessons from what went wrong, so that services and practice can be improved to reduce the risk of future harm

Because Kim was pregnant when she died, we worked with the Portsmouth Safeguarding Children Partnership on this review.

Two Independent Reviewers worked on this review

# How did we do the review?

Looked at information from agency records

Met with the family to make sure their voice was heard and to shape the terms of reference and make sure Kim was at the heart of the review

Two workshops over two days – with practitioners and managers, involving the family

Recommendations development meeting

Further discussions and statements from Kim’s family

Engagement and consultation on recommendations

# Who was Kim?

- 36 year old White British woman
- Eight months pregnant at the time of her death
- A history of:
  - Homelessness
  - Substance misuse
  - Mental health conditions
  - Involvement with the criminal justice system
  - Being a victim of Domestic Abuse
- Two older children, living with other family members under Special Guardianship, but maintained contact
- Close relationships with family

# What was Kim like?

*she was a huge fan of Michael Jackson*

*Even times when Kim was struggling and going through tough times, she was still always polite and respectful*

*She's left behind two sons who both miss her. They have fond memories of family bike rides round the park and trips to the cinema.*

*she had so much fun and laughter in her*

the real Kim was kind, caring, funny and a person that many people loved to be around

# Who knew Kim?

| | | | | |
|---|---|---|---|---|
| Society of St James (Registry / Recovery Hub) | PCC Housing | PCC Adult Social Care | PCC Children and Families Services | Solent NHS Trust |
| Hampshire and IOW Constabulary | Portsmouth Hospitals NHS Trust | South Central Ambulance Service NHS Trust | GP | National Probation Service |
| | Southern Health NHS Trust | Domestic Abuse Services | Pushing Change | |

Kim became pregnant in early 2022 and Children's Social Care began planning for her unborn child.

Kim completed an alcohol detoxification and moved into abstinent housing early in her pregnancy, but her substance misuse later escalated and she experienced domestic abuse from her partner.

She was then accommodated in the Registry, a service commissioned by Portsmouth City Council as part of the Rough Sleeping Pathway.

Later in her pregnancy she had several hospital admissions.

Professionals made a plan with Kim for her baby to be placed with Kim's sister at birth.

Kim sadly died at the Registry.

# What was happening in Kim's life?

# What did Kim’s family think?

**Kim’s accommodation**

*Kim really struggled with living at The Registry and she was quite vocal about it. There was far too much temptation for her to cope with, in the form of alcohol and drugs... I often wonder, had she been given the same opportunity as she had in her previous pregnancies and had moved into a hostel or perhaps another property, would there have been a different outcome?*

**Access to methadone at the weekend**

*It worries me that there isn't some kind of emergency procedure or someone to contact in the event of something like this happening, I really feel that there is something missing here or at the very least, better communication is needed.*

# What were the findings?

## Good practice

- early identification of Kim’s pregnancy
- continuity of care
- good rapport with Kim's family
- good pre-birth planning, Child in Need planning and Child Protection planning

# What were the findings?

## Areas for improvement

- multi-agency working was not always effective
- services did not take a person-centred approach to domestic abuse
- services did not support Kim's family effectively after her death
- the Care Act was not used effectively to safeguard Kim

# What were the findings?

## Areas for improvement

- lack of access to methadone at the weekend
- lack of appropriate accommodation and support options for adults with complex needs who are experiencing homelessness
- Kim reported experiencing marginalisation, stigma, and unconscious bias

Based on what you have learned, take a few minutes to think about what will **you** do differently to improve outcomes for people like Kim that you work with in the future?

Think about:

- Are you and your team familiar with MARM and confident on how to use it?
- Are there ways that you might expand your knowledge about the law and policies on safeguarding adults?
- What steps could you take to make your service more welcoming to people experiencing homelessness?

# Planning for future practice

# For more information and resources:

Kim report and learning briefing (https://www.portsmouthsab.uk/scrs-2/)

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

Family Approach protocol and toolkit (https://www.portsmouthsab.uk/procedures/)

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

Training (https://www.portsmouthsab.uk/adult-safeguarding-training/ and https://www.portsmouthscp.org.uk/5-training/)