Case Learning Summary: 'Kim' Safeguarding Adults Review

What is a Safeguarding Adults Review?

Safeguarding Adults Boards have a responsibility to ensure that organisations that work with adults at risk can learn from their own practice and that of others. When adults with care and support needs die or are seriously harmed in certain circumstances, the Care Act requires us to undertake a review. 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 and learn lessons from what went wrong, so that services and practice can be improved to reduce the risk of future harm. For this review we also worked with the Safeguarding Children's Partnership, in view of Kim's pregnancy and the involvement of services in planning for the care of her unborn baby. Links were also made with some other SARs which covered similar issues.

Case summary

Kim was a 36-year-old White British woman who was eight months pregnant at the time of her death. She had a history of homelessness, substance misuse and mental health conditions, and had previous involvement with the criminal justice system. Kim's sister described her as 'blonde haired, pretty and [she] had a real mischievous side to her ... she had so much fun and laughter in her … She certainly made some mistakes and sometimes she did the wrong thing, but the real Kim was kind, caring, funny and a person that many people loved to be around'.

Kim had been successfully supported by services in her two previous pregnancies, and maintained contact with her children who lived with family members under Special Guardianship arrangements. Kim's mother, father and sister were closely involved in supporting her. Kim became pregnant again 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 plans for her baby to be placed with Kim's sister at birth. Kim was found unconscious in her room at the Registry by staff making a welfare check. An ambulance was called and emergency first aid was given. Sadly, paramedics pronounced Kim and her unborn baby deceased at the scene.

Key Findings/Lessons

There was a considerable amount of good practice identified, including early identification of Kim’s pregnancy, continuity of care, good rapport with Kim's family, and good Pre-birth planning, Child in Need planning and Child Protection planning. However, the review also identified that:

- **Multi-agency working was not always effective** - despite numerous professionals involved, there was a lack of robust oversight, coordination and accountability around the plan for Kim, who could be considered an adult at risk in her own right.

- **Services did not take a person-centred approach to domestic abuse -** services recognised Kim's partner as a risk to her and her unborn baby but did not consider his own needs and risks. They did not involve him in pre-birth planning or consider the fact that Kim may have been more willing to engage with domestic abuse services if their needs had been considered as a couple.
- **Services did not support Kim's family effectively after her death** and in line with the Duty of Candour, and review processes were not coordinated effectively.
- **The Care Act was not used effectively** to safeguard Kim or secure the support she needed - there was a lack of understanding of relevant legal frameworks, Portsmouth Safeguarding Adults Board (PSAB) policies and procedures, and operational processes within Adult Social Care. This meant opportunities were missed to seek advice, to make effective referrals for assessments and for safeguarding, and to use existing frameworks such as a multi-agency risk management framework (MARM).
- There was a **lack of access to Methadone at the weekend.**
- There is a **lack of appropriate accommodation and support options for adults with complex needs who are experiencing homelessness.**
- Where there is evidence of **marginalisation, stigma, and unconscious bias**, this creates a barrier for individuals experiencing homelessness seeking effective support from services.

Key Points for Learning & Reflection

- Are you and your team familiar with MARM and confident on how to use it to support multi agency working and risk management? Have you watched the MARM podcast and reviewed the MARM toolkit?
- For staff who work with children, are you familiar with the law and local policies and procedures in relation to safeguarding adults? Think about ways that you might expand your knowledge, such as e-learning, networking opportunities or work shadowing.
- Spend time in your team on raising awareness of unconscious bias and the importance of not labelling/appropriate use of language. What steps could you take to make your service more accessible by people who are homeless? How could you reduce feelings of stigma and shame for individuals experiencing homelessness?

Further information and useful resources

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

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

Thematic Review Following the Deaths of Mr G, Mr H, Mr I and Mr J full report: (https://www.portsmouthsab.uk/scrs-2/)

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

Managers are encouraged to explore the learning points in team meetings and supervisions. If you require further information about the case, please contact PSAB@portsmouthcc.gov.uk.