Portsmouth Safeguarding Adults Board

'Kim' Safeguarding Adults Review

What is a Safeguarding Adults Review?

The primary purpose of a Safeguarding Adults Review (SAR) is to draw out organisational learning about how the local agencies are working together, to support improvement.

Under section 44 of the Care Act 2014, Safeguarding Adults Boards (SABs) must arrange a SAR when an adult in its area with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. They may arrange a SAR for other cases under section 44(4), for example where there is important learning to be identified.

The Portsmouth Safeguarding Adults Board (PSAB) SAR subgroup considered the case referral for Kim at their meeting on 14.09.22. As the death of Kim also involved the death of her unborn baby, the PSAB met again with the Portsmouth Safeguarding Children Partnership (PSCP) Learning from Children and Practice Committee on 11.01.23, when it was concluded that the above criteria had not been met. It was decided to carry out a discretionary review under section 44(4) of the Care Act.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

Who was Kim?

It is important for the SAR to place Kim at the centre of the work. Kim's family have been involved with the review throughout, and it was the family's wish that Kim's name be used in this report, instead of a pseudonym. Kim was a White British woman. Her sister attended the workshop for practitioners and provided some information about her life and personality. The information is summarised in this section.

Kim was 36 years old when she passed away in August 2022. All her family miss her and wish that both her and her baby boy were here with us today.

Kim was my younger sister, she was blonde haired, pretty and had a real mischievous side to her. From the moment she was born she had us laughing with things she would say and do, she had so much fun and laughter in her from the very start. 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.

One of my memories of Kim is that she was a huge fan of Michael Jackson growing up and that never changed, if a song of his came on the radio she would sing it on the top of

her lungs and would imitate his dance moves, she didn't do a bad moonwalk… but her singing was a different story!

Kim was always able to make friends easily and she was a good friend to have. She could talk to anyone, it didn't matter where or who she was with. She was kind, she was loyal and would give you the shirt off her back if you asked. Even times when Kim was struggling and going through tough times, she was still always polite and respectful to people she interacted with.

Kim loved her family. In the later years we didn't always see her that often, but we know she cared and I like to think she knew how much we loved and cared for her too. 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.

Kim did well with her first two pregnancies. For the first pregnancy she lived with her dad. Kim was able to go through the term of her pregnancy with just methadone[1] to help control her addiction. Kim maintained this after the baby's birth and took really well to motherhood but eventually she did slip and moved out from her dad's when her son was around 4 years old. Her son remained with his nana and grandad who were eventually granted special guardianship.

During Kim's second pregnancy, she was given housing at a hostel for vulnerable families experiencing homelessness, where she did well. Kim was able to complete the term of her pregnancy once again with methadone to help control her addiction. Kim was a good mum for many months and coped well but eventually she started to slip into old patterns. Eighteen months later Kim had to move into other accommodation [where alcohol was allowed] where her son could not go with her. He came to live with me, Kim's sister, on a temporary basis whilst Kim took steps to change her lifestyle, but unfortunately this didn't happen and I was eventually granted special guardianship.

Key events leading up to Kim's death

- September 2021 - Kim was released from prison and was placed at the Registry[2] by Portsmouth City Council Housing services.
- December 2021 - Kim reported difficulties with sleep and anxiety and spoke to the Solent NHS Homeless Health Care Mental Health Nurse.
- January 2022 - There were concerns about Kim's increased substance misuse including incidents when Kim was found unconscious. Regular multi-agency meetings were taking place, coordinated by Integrated Offender Management (IOM).[3] A referral was made to the Adult Multi-Agency

[1] Methadone is a synthetic opiate manufactured for use as a painkiller and as a substitute for heroin in the treatment of heroin addiction.

[2] The Registry is a service commissioned by Portsmouth City Council and provided by the Society of St James. It accommodates up to 41 adults at risk of rough sleeping and provides a high level of housing-related support.

[3] Integrated Offender Management (IOM) brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together. IOM involves working closely with each offender and partner organisations to identify the root cause of offending including any

Safeguarding Hub (MASH). This was triaged and, as a result, the use of the Multi-Agency Risk Management Framework (MARM) was recommended, but the referral was closed by the MASH as there were already a range of professionals supporting Kim.

- January 2022 - Kim was experiencing domestic abuse and a referral was made to Stop Domestic Abuse, the specialist domestic abuse service. She was offered 'Respite Rooms'[4] accommodation but declined this. Kim said she wanted to move into Recovery Housing, but this pathway was assessed as being insufficient to meet her need for 24-hour support.
- Late January 2022 - Kim's pregnancy was confirmed and a referral was made to Children's Services. Kim requested detoxification for alcohol and benzodiazepines.
- February 2022 - an inpatient alcohol detoxification was agreed. Kim missed appointments with midwifery and physiotherapy. Kim's medication was reviewed. Children's Services allocated a social worker to Kim and a pre-birth assessment was started. It was recommended that the unborn baby should be subject to Child in Need Planning with escalation to Child Protection Planning later in the pregnancy due to the risk of harm from Kim's use of substances and the domestic abuse.
- March 2022 - Kim completed an in-patient alcohol detoxification and moved into abstinent housing as part of the recovery pathway. Contingency plans were put in place for alternative accommodation in case Kim were to relapse. On leaving hospital, Kim was unable to access her Methadone prescription due to confusion about which pharmacy the prescription would be available from and the fact that this could not be rectified as it was the weekend. She then used substances to manage her opiate withdrawal.
- March 2022 - Portsmouth City Council housing department concluded that Kim was "non-priority" status (ie not considered to be "vulnerable" for the purposes of the legislation, and therefore not owed a full rehousing duty by Portsmouth City Council).[5]
- April 2022 - IOM ended their involvement with Kim as she had not committed any IOM-qualifying offence for 18 months. IOM's involvement with Kim's partner also ended at this time. Kim reported that other residents at the abstinent accommodation were using substances and expressed the wish to move to mother and baby supported accommodation.
- May 2022 - Kim experienced physical abuse from her partner. Referrals were made to Stop Domestic Abuse and the Children's Services Family

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other complex needs and vulnerabilities. Safety plans are then developed and interventions put in place unique to each offender which aim to reduce re-offending.

[4] 'Respite rooms' provide safe accommodation with specialist support in single gender spaces, for women at risk of rough sleeping who are experiencing domestic abuse and multiple disadvantage..

[5] Vulnerability in homeless legislation has a very specific meaning and context and the Homeless Code of Guidance suggests [chapter 8.16]) that when assessing vulnerability, authorities consider whether "an applicant would be significantly more vulnerable than an ordinary person would be if they became homeless. The assessment must be a qualitative composite one taking into account all of the relevant facts and circumstances, and involves a consideration of the impact of homelessness on the applicant when compared to an ordinary person if made."

Safeguarding Team, but Kim did not want to pursue these as she felt there were too many professionals involved with her. Safety advice was given and Kim was advised to call if her situation changed. A referral was made to Adult MASH but was triaged as needing no further action as the Care Act statutory criteria were not met. She also disclosed using substances.

- June 2022 - Kim's substance misuse increased and she had a number of positive drug tests. She was asked to leave the abstinent accommodation due to alcohol and substance use, and having her partner stay on the premises (he had been banned due to the risks to Kim and her unborn baby). Kim returned to stay in the Registry.
- Early July 2022 - Kim did not sleep in her room in the Registry and spent two nights rough sleeping in a tent with her partner. Police made a referral to Children's Services due to the risk to Kim's unborn baby. A multi-agency strategy meeting was held and Children's Services started a section 47 Child Protection enquiry.
- Late July 2022 - there were further incidents where Kim did not sleep at the Registry and on one occasion Kim was reported as a Missing Person. She returned to the Registry the following day. Staff called the Police when Kim's partner arrived at the Registry looking for her. Kim was twice found semi-conscious by Registry staff at the end of July. Kim also called 111 for pain and swelling in her leg and was referred to her GP.
- End July 2022 - Kim was admitted to hospital as a safety precaution due to recent high levels of intoxication and risk management for unborn baby.
- Early August 2022 - Kim was detained by the Police having been caught shoplifting. The following day Kim was admitted to the Emergency Department at the hospital for a suspected opiate overdose.
- Mid August 2022 - SSJ staff called 999 due to a cut on Kim's leg following a fall in her room. She was experiencing pain and swelling in her legs. She was admitted to hospital and found to have an infection. The baby was also being monitored due to a low heartrate. A referral was made to Perinatal Mental Health services, and Kim was assessed. It was agreed there would be follow up from the perinatal psychiatrist. Kim was discharged from hospital a week later.
- Mid August 2022 - Plans were made by professionals for the birth of Kim's baby, including applying for a court order after the birth so that the baby could be placed in foster care. Plans were later made to place the baby into the care of Kim's sister under a Special Guardianship Order.
- Late August (3 days prior to Kim's death) - The social worker submitted a safeguarding concern to Adult MASH due to domestic abuse and substance misuse and Kim feeling unsafe at the Registry. Further information was still being sought by Adult MASH at the time Kim died. The social worker also submitted a referral for supported housing in a mother and baby unit.
- Late August (2 days prior to Kim's death) - Kim was followed up by the Perinatal Mental Health consultant psychiatrist. It was concluded that there was no ongoing role for this service and online substance misuse support groups were suggested.

- Late August (1 day prior to Kim's death) Kim attended a medical review with the substance misuse services and spoke to her Health Visitor on the phone.
- Kim was found unconscious in her room at the Registry by staff making a welfare check. An ambulance was called and Naloxone and CPR were given. Sadly, paramedics pronounced Kim and her unborn baby deceased at the scene.

Review methodology

It was agreed that the review would address the following themes:

a. Hospital discharge including risk management and multi-agency planning and communication.
b. Involvement of mental health services.
c. Availability of and responsiveness of services for people who misuse substances.
d. Pre-birth planning.
e. Whole family approach.
f. Involvement of, communication with, and support for family carers.
g. Appropriateness of accommodation.
h. Consideration of Kim as a vulnerable adult.
i. Availability and use of Naloxone.
j. Response of agencies following the death including the various review processes (including debrief meetings and identified actions).
k. Consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.
l. How Kim was supported as a victim of domestic abuse.
m. Duty of candour process whilst waiting on an agreed investigation.

The following methodology was used:

- Review of scoping information detailing each agency's involvement with Kim.
- Workshop for frontline practitioners who were involved in supporting Kim, which included a pen picture of Kim from her family.
- Further workshop with senior managers from each agency to explore strategic issues.
- Meeting of key agency representatives to finalise recommendations.
- Dialogue with Kim's family throughout the process to understand their questions and ascertain their views.

The review was facilitated by two senior managers (from Portsmouth City Council Adult Social Care Department and the Hampshire and Isle of Wight Integrated Care Board (ICB)), neither of whom had any operational responsibility for any of the services involved at the time of Kim's death.

Questions from Kim's family

As part of the review, Kim's family had several questions they wanted answering. The family submitted a detailed letter with their questions which informed the scope of the

review. Some of these questions were about the actions of single agencies and about Kim's final hours, which have been directed to the relevant agencies to answer.

Two of the key questions were highlighted by Kim's family and are summarised below, in the words of Kim's sister.

1. **Why was Kim accommodated in the Registry during this pregnancy?**

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. She would often have other residents knocking on her door and Kim, being the kind of person she was, friendly but also very easily tempted by whatever might be available, would always let them in. 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? Remembering, she'd already had two successful pregnancies where she'd been content in her circumstances and felt safe in her surroundings.

2. **Why was there no weekend procedure to access Methadone in an emergency?**

Kim left The Registry in March 2022 and entered into an alcohol detox program at Queen Alexandra Hospital. She successfully completed the program and was to move straight into abstinent housing. Kim was full of optimism at this point, she honestly thought she had a chance of succeeding. She felt she was older and wiser than in her previous pregnancies and she was convinced that this time round it was going to be different. Unfortunately, the day after her release from Queen Alexandra Hospital Kim went to collect her methadone script from the chemist, but it wasn't there. Due to it being a Saturday there wasn't anyone who could help Kim which led to her downfall on that first weekend and her using, she hadn't used since finding out she was pregnant up until this point. 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.

These questions are addressed in the findings set out later in this report and the recommendations (numbers 8, 10 and 11).

Good practice identified

The workshop for practitioners identified a number of areas of good practice in how agencies worked together to support Kim:

- There was generally good communication between the Health Visitor, social worker, and maternity services.
- Kim's other children were within the family unit and Kim had contact with them.

- Kim was motivated to undertake alcohol detoxification and was listened to in relation to this.
- The Alcohol Specialist Nurse Service spoke to the consultant and was able to secure an alcohol detoxification placement for Kim although she did not meet the criteria. There was prompt booking once referred and a good patient centred plan. Kim did engage well with the Health Visitor and Social Worker and completed the inpatient alcohol detoxification.
- Kim felt 'safe' in hospital.
- There was early notification and awareness of the pregnancy by agencies.
- There were appropriate follow ups regarding the missed maternity booking.
- There was continuity of care in the maternity service/community midwife, lead consultants, and social worker.
- Children's Social Care (CSC) developed regular contact and rapport with all Kim's family.
- Pre-birth planning, Child in Need planning and Child Protection planning were in line with good practice.
- Stop Domestic Abuse was involved and supported professionals with Domestic Abuse advice.
- Specialist social workers from the family safeguarding service gave advice and support to the Children's Social Worker.
- Children's Services ensured that Kim kept the same social worker throughout, even though the standard process is a change in social worker.
- When Integrated Offender Management (IOM) were coordinating, there were weekly multi-agency meetings, dedicated to Kim. IOM also worked with Kim's partner.
- There was a good level of communication (especially with accommodation support providers) and emotional support between partners/professionals.

Changes made since Kim's death

A number of changes have already been made by services in response to Kim's death:

- At Portsmouth Hospitals University NHS Trust (PHUT), the Emergency Department now inform Maternity of all attendances of pregnant women over 12 weeks' gestation.
- At PHUT's Maternity department, a consultant now reviews all complex cases prior to discharge.
- The PHUT Maternity department now has increased knowledge and better developed communication arrangements with the homeless health navigator service in the hospital.
- Monthly reviews of all alcohol services users within PHUT are being held between the alcohol team, the Portsmouth Community Assessment Team (PCAT) and the safeguarding team, commencing in May 2023.
- There are now defibrillators at the Registry and other homeless accommodation in the city.

- There is now increased Naloxone[6] access at the Registry: it is now available on every floor and at both ends of the building as well as in the office. Service users also have their own Naloxone.
- Society of St James (SSJ) staff are now trained in emergency first aid in addition to general first aid.
- All PPN1s (police concerns) submitted to the Adult Multi-Agency Safeguarding Hub (MASH) about an adult who has been previously known to Adult Social Care are now added on the adult's file so that Adult MASH have a fuller picture of risk and to ensure concerns are not being triaged in silo.
- The Portsmouth Safeguarding Children Partnership (PSCP) now has a process for any child death/referral to ensure there are arrangements and places for staff to share reflections and be supported, aside from any case review process.
- SSJ has introduced a more comprehensive risk identification framework.
- SSJ has commenced a retraining programme for all staff on the changes that have been made.
- There is now a greater awareness of the Multi-Agency Risk Management Framework (MARM) amongst Housing staff and MARM is used more systematically.

Findings

- **Multi-agency working was not always effective (Recommendation 1, 11).**
  - There were a considerable number of agencies involved in supporting Kim, and she felt that there were too many professionals involved in her life. Despite numerous professionals involved, there was a lack of robust oversight and coordination, as there was no lead agency or professional identified.
  - Although during the period that IOM was involved, regular multi-agency meetings were held, these did not involve all relevant partners, did not have senior level oversight from all partners who attended, and so did not ensure all partners were accountable for the effectiveness of the plans. Once the involvement of IOM ceased, no documented risk management plan was passed to the remaining agencies still involved. However, Kim's probation officer did continue her involvement.
  - The referral for family supported housing was made too late, which was a result of the lack of multi-agency coordination of the plan for Kim.
  - While there was a robust Child Protection Plan in place to consider the needs of the unborn baby. The focus was on the unborn child rather than on Kim's needs as a vulnerable person with her own needs.
  - The use of MARM was recommended by Adult MASH but was never implemented by any agency. MARM was not well understood and professionals did not feel confident in using it. Had the MARM framework been used there would have been senior level oversight and risk would have been documented. A multi-agency approach which

[6] Naloxone is a medicine that rapidly reverses an opioid overdose.

    - took into account risk could also have been taken at the point of hospital discharge.
    - Short/medium/long term approaches with the goal of enabling Kim to keep her baby had been discussed by agencies and with Kim in the early stages of her pregnancy, while she was open to IOM. However, a robust plan with actions and accountability was not produced, shared or followed.
- **Services did not take a person-centred approach to domestic abuse (Recommendation 2, 3).**
    - Services recognised Kim's partner as a risk to her and her unborn baby but did not consider his own needs and risks. He was not involved in the birth planning. Kim did not want to leave her partner and perceived that services were trying to keep them apart. Services did not appreciate the extent to which Kim's partner's rough sleeping increased the risks to her. Kim may have been more willing to engage with domestic abuse services if their needs had been considered together.
- **Services did not support the family effectively after Kim's death and in line with the Duty of Candour. Review processes were not coordinated effectively (Recommendation 4, 5).**
    - Following Kim's death, there was confusion about practical arrangements and information sharing with the family. Kim's death took place at a bank holiday weekend which contributed to this. The family lacked a single point of contact.
    - The learning and review processes following the death were not clear, nor were they open and transparent. Although prompt referrals were made to the PSAB for the consideration of a SAR, the decision was postponed while a Serious Incident Review process took place within health. It was not clear who was leading this and communication between agencies, the PSAB, and the family, was poor, leading to a delay in the commissioning of the SAR.
- **The Care Act was not used effectively to safeguard Kim or secure the support she needed (Recommendation 1, 6).**
    - Professionals lacked understanding of relevant legal frameworks, 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 like MARM.
    - Although referrals were made to Adult MASH by the police, due to processes at the time, not all PPN1s (police concerns) were uploaded to Adult Social Care records, meaning a chronology of concerns was not available to evidence the level of risk. Had a fuller picture been known, Adult MASH would have considered initiating a MARM. This process was changed after initial scoping by the Adult MASH into Kim's death.

- **There was a lack of access to Methadone at the weekend (Recommendation 7).**
    - Kim was unable to collect her methadone at the weekend when she was discharged from hospital. Although it appears that in this case this was due to a misunderstanding or miscommunication between Kim and her Recovery Worker about which pharmacy would have the prescription, there is a wider issue that there is no emergency out of hours access to methadone in the City.
- **There is a lack of appropriate accommodation and support options for adults with complex needs who are experiencing homelessness (Recommendation 9, 10).**
    - Portsmouth City Council's Housing services were experiencing significant operational pressures at the time and have since allocated more resources to address the marked increase in customer demand. They should have assessed Kim as being in 'priority need' for Housing due to her pregnancy. However, a correct priority need assessment would not have resulted in different temporary accommodation being provided; there was a lack of appropriate housing available for Kim, as her need for support was so high due to the scale of her substance misuse and the domestic abuse she was experiencing.
    - Staff in the homeless accommodation felt under significant pressure to manage high risk situations, such as the medical detoxification and the birth plan.
- **Where clients perceive there is marginalisation, stigma and unconscious bias, this can create a barrier for them when they are seeking effective support from services (Recommendation 12).**
    - Kim's family reported that Kim had perceived some professionals as rude and dismissive when she was seeking treatment.
    - At times Kim was signposted to other services, when it has been found as part of previous reviews that signposting is often ineffective for people who are experiencing homelessness and more direct support is needed.
    - Services missed opportunities to involve Kim's partner, partly because he was experiencing homelessness and substance misuse.

Context - other reviews

- In 2022, the PSAB published a Thematic Review into the deaths of four adults who were experiencing homelessness, all of whom died in 2020. That review looked at the national learning about homelessness and had gathered information from homeless people, staff and family members. Some of the findings of that review are pertinent to this review: the impact of the stigma experienced by people experiencing homelessness; the challenges of commissioning accommodation for people with complex needs; and the need for services to take a whole family approach. Significant progress has already been made on an action plan in response to the findings of the thematic review.

- Alongside this review of Kim, PSAB has also been carrying out another SAR in relation to the death of an adult which took place some months earlier at the same accommodation. Some similar findings have been identified, including: missed opportunities for multi-agency risk management; evidence of unconscious bias from professionals towards adults who are experiencing homelessness and who have complex needs; a lack of appropriate accommodation options for adults with complex needs; and communication with families following a death.

Recommendations

1. PSAB and PSCP to work with all agencies to ensure that MARM has been embedded in practice, is in their safeguarding training and discussed at case management supervision. This will be supported by a task and finish group and the workforce will be consulted on how MARM can be more widely and appropriately used to identify and manage vulnerability and risk. (PSAB and PSCP).

2. PSAB and PSCP to ask their partners to raise within their organisations the importance of assessing the adults they work with who are victims of domestic abuse to identify the support they may require from their agency to manage the risks posed by their abusive partner (All agencies).

3. Include the voice of the partner in pre-birth planning and risk management, even when they pose a risk or do not engage (Children's Social Care, Maternity, and Health Visiting).

4. Housing and Police to develop an information sharing protocol in the event of the death of an adult who is homeless or is living in supported housing provision, to ensure there is a lead senior manager in Housing to coordinate the response and decide who will liaise with the family and/or other key individuals as their single point of contact (Housing and Police).

5. Put in place a process to identify a key contact for adults referred to PSAB for review, to lead on contact with the family and provide the SAR subgroup Chair with regular, formal updates in relation to any additional or parallel review processes (PSAB).

6. Seek assurance that the recommendations from the 'YL' SAR[7] have been included in training and embedded in practice by Children's Social Care, particularly in relation to the understanding of Care Act 2014, eligibility criteria, and how to refer for Care Act assessment (PSCP).

[7] YL action plan identifiers YL8 (ASC to work with CSC to ensure the Family Safeguarding Service Lead and Team Leads can review the findings and disseminate the learning across the whole service) and YL9 (ASC to support CSC to increase their understanding of the Care Act 2014, particularly in relation to the assessment of care and support needs for adults)

7. ICB to review commissioning and funding issues relating to emergency access to methadone both a) when there is an existing prescription and b) when someone needs a prescription out of hours (ICB).
8. To ensure that the IOM process supports multi-agency risk management by engaging with Probation about their understanding of MARM and the processes in place when withdrawing from IOM (PSAB).
9. To hold a citywide review of commissioned supported housing, including the Rough Sleeping Pathway, and which will consider the housing offer for pregnant women. The learning from the review to be embedded in the new Homelessness Strategy (Housing).
10. Review the current supported housing offer and identify what additional provision is required to meet the needs of a diverse client group, by making use of relevant funding opportunities where available (Housing).
11. Review the discharge planning process for pregnant women who are homeless and/or misusing substances where there are identified risks to provide assurance that it is robust and safe (PHUT).
12. Raise staff awareness of unconscious bias and the importance of not labelling/appropriate use of language by providing assurance that it is embedded in staff training (PSAB/all agencies).

A detailed 'SMART' action plan will be developed with the input of all agencies and will be monitored by the PSAB Quality Assurance Subgroup.