**Case Learning Summary: 'Ms K' 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.

## Case summary

Ms K was in her thirties at the time of her death. She loved dancing and music and was described as a bright, bubbly person who always took pride in her appearance. Ms K had several physical health problems including diabetes, epilepsy and liver disease. Ms K experienced problems with alcohol use in the years leading up to her death, following a bereavement. Her alcohol use affected her relationship with family members and led to Children's Services becoming involved with her child. At the time of death, Ms K's child lived with her ex-partner.

The review focussed on the events of the year leading up to Ms K's death. During this period:

- Ms K was conveyed to/admitted to hospital a number of times, following incidents which included being found intoxicated, collapsed, or unconscious, and experiencing seizures, breathing difficulties, abdominal pain, bleeding, or incontinence. On one occasion Ms K disclosed that she was pregnant, though there is no evidence to support this. Professionals often recorded that she had unexplained injuries which could have indicated she was experiencing domestic abuse.
- Seven safeguarding concerns were submitted to the local authority Adult Safeguarding Team by the ambulance service, hospital, and Children's Services. The concerns identified self-neglect, domestic abuse, poor home conditions, and lack of concern from Ms K's partner. These were either not considered to meet the criteria for a section 42 enquiry, or were closed at the point of triage because Ms K did not want services involved.
- Ms K engaged with some services including substance misuse services. She was discharged from some health services after missing appointments. She declined to access domestic abuse services and support groups.
- Children's Services were involved with Ms K's partner's child and his relationship with Ms K was identified as a risk to the child. Ms K's relationship with her partner was ambiguous - at times they denied that they were in a relationship or that she was living at the address, and Ms K repeatedly denied that she was experiencing domestic abuse. However, she disclosed experiencing domestic abuse in past relationships.
- Police were called for various domestic incidents and concerns for Ms K's welfare and safety. Ms K alleged that she had been raped by a previous partner.
- During Ms K's final stay in hospital, she was referred to local authority housing services and a social worker completed a discharge assessment. Housing services arranged for

temporary B&B accommodation for her, but she left this accommodation to stay with a friend and services were unable to contact her. Shortly afterwards an ambulance attended the friend's address after Ms K reportedly suffered a seizure and became unresponsive. She sadly died at the scene.

It is likely that Ms K experienced domestic abuse, physical abuse, sexual abuse, neglect and self-neglect in the period leading up to her death.

**Key Findings/Lessons**

The review identified some good practice, including Ms K being able to access health services including the same day GP clinic, hepatology early discharge clinic, alcohol detoxification in hospital, and support with managing medication. A personalised approach was taken by some services in response to Ms K's experiences of sexual/domestic abuse: she was offered a female recovery worker and temporary accommodation with private facilities. Housing services showed professional curiosity and were sensitive to Ms K's preferred communication methods.

However, the review also identified that:

- Ms K's youth, gender, appearance and personality meant that **practitioners often did not perceive her as vulnerable**, apart from at points of crisis. This led to a **reactive rather than a proactive approach to her needs**, including her alcohol use and probable domestic abuse. Ms K was **never offered an assessment of her care and support needs**, in part because her needs fluctuated and she was not always perceived as vulnerable.
- There was a **lack of effective multi-agency working** to safeguarding Ms K - services in hospital and the community were not joined-up so her care was reactive not proactive. Hospital discharge summaries were medical only and did not include information about safeguarding concerns.
- **Neither Section 42 of the Care Act nor the Multi-Agency Risk Management (MARM) framework was used** as a mechanism for bringing agencies together to assess risk and develop shared plans. In this case, as Ms K was likely to have met the criteria, Section 42 would have been the appropriate framework to safeguard her.
- There was a **lack of professional curiosity** about the nature of Ms K's relationship with her partner, where she was living and the abuse that Ms K may have been experiencing. The possibility of Ms K experiencing coercive control was not considered. **Professionals found it challenging to take a family approach** as Ms K and her partner did not identify as a family, and were often unclear about the nature of their relationship,
- There was a **lack of a person-centred approach** to Ms K: services showed a limited appreciation of the challenges that Ms K faced in engaging (for example, her alcohol use and health conditions (including her liver disease) would have resulted in poor nutrition and fatigue, which would have had an impact on her capacity to engage).
- The **impact of long-term use of alcohol, ongoing physical ill-health, and previous head injury on Ms K's mental capacity** (in particular executive capacity) were not taken into account.

- There was **limited understanding of hidden homelessness and women's experience of homelessness**. As Ms K had an address, she never met the criteria for wraparound homelessness services open to those in the rough sleeping pathway.
- There was a lack of professional curiosity when Ms K presented as pregnant and spoke about previous miscarriages. **Opportunities were missed to have honest conversations with Ms K about her future pregnancy plans** and contraception options.

**Key Points for Learning & Reflection**

- Do you have a good understanding of when to raise a safeguarding concern and when to use the MARM framework?
- Consider reviewing the Portsmouth domestic abuse pathway and what domestic abuse services are available locally. Have you attended domestic abuse training recently?
- Are you confident in using the Mental Capacity Act when the adult uses alcohol or other substances? Consider reviewing PSAB's resources on alcohol and safeguarding.
- Do you have the skills to manage challenging situations and ask difficult questions? What support do you need to develop these skills? If you manage staff, do you ensure supervision allows time for reflection and critical analysis?
- 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.

**Further information and useful resources**

4LSAB Safeguarding Concerns Guidance (https://www.portsmouthsab.uk/procedures/)

4LSAB Guidance on Responding to Self-Neglect (https://www.portsmouthsab.uk/wp-content/uploads/2024/06/4LSAB-Guidance-on-Responding-to-Self-Neglect-vFINAL-June-2024.pdf)

Alcohol resources (https://www.portsmouthsab.uk/adult-safeguarding-training/alcohol-change-uk-webinars/)

Domestic Abuse resources including Portsmouth referral pathway for adults and families (https://www.portsmouthsab.uk/abuse/domestic-abuse/)

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

7 minute guide to Professional Curiosity (https://www.portsmouthsab.uk/wp-content/uploads/2023/02/4LSAB-7min-Professional-Curiosity.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.**