Sandwell Safeguarding Adults Board

Learning Brief
Thematic Safeguarding Adults Review: 'Kim'

The Review

The Care Act 2014 requires Safeguarding Adults Boards to arrange a Safeguarding Adults Review if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. Sandwell SAB concluded that the circumstances surrounding the deaths of both Kim and another case, that of Morgan, met the mandatory criteria for undertaking a SAR under Section 44 of The Care Act 2014. Commonalities existed in the two cases (e.g. they both revolved around self-neglect and substance misuse), therefore the SAB decided to undertake a thematic review.

Background

Kim died at the age of 33 in hospital. Kim's death certificate records the cause of death as severe sepsis and refractory shock. Kim was dependent on injected opiates, was HIV positive and additionally using crack cocaine. She had been referred to the local substance misuse service as far back as 2015 and had irregular contact with them over the years up until her death.

Although she had a tenancy, for much of the period under review she led a street-based life. Reference is made to untreated abscesses and to Kim being blind in one eye and partially sighted in the other. She was underweight and in very poor physical health. It identifies self-neglect of personal care, including self-discharges from hospital, and observes that she had been vulnerable to sexual exploitation. Information provided by agencies includes an alleged assault by a partner in 2015 and a period when she was missing.

Arguably, the biggest challenge with Kim was that, despite contact with multiple agencies, she could be hard to engage into constructive interventions. Kim repeatedly missed appointments, failing to pick up or take medication, and refusing to take steps to keep herself safe. On two occasions she left hospital with medical procedures incomplete; on other occasions she refused admission to hospital for treatment. In 2019 and 2020, services were consistently failing to find her when they tried to make contact, for example, through visits to her home.

No assessment of Kim's care and support needs appears to have been undertaken, despite concern for her wellbeing. The chronology of Kim's life highlights two safeguarding referrals. However, equally significant are the occasions when safeguarding concerns were not referred. Similarly, there is no evidence of a formal capacity assessment having been undertaken. At times it appears that capacity was assumed rather than assessed and there were points at which a capacity assessment should have been considered but was not.

The last months of Kim's life were lived under the restrictions imposed by the first Covid-19 lockdown. Kim's chronology highlights that this did impact on her engagement with services and suggests that the restrictions may have limited her social contact.

Key Messages to Front Line Practitioners

1. Professionals should ensure that they are using professional curiosity to understand the complex backgrounds and needs of people like Kim.
2. Professionals need guidance on “What works with hard to engage clients”.
3. Best practice with clients like Kim will require a response that is built on assertive outreach.
4. Continued failure to engage by complex clients requires escalation. This may be through standard agency management processes but clients like Kim will benefit from escalation to multi-agency management.
5. Frontline professionals require training in best practice in working with chronic, change resistant and dependent drinkers and drug misusers.

Key Messages for Management and Strategic Development

1. Health and social care commissioners should consider an expansion of local assertive outreach capacity to people who are vulnerable to abuse, neglect and exploitation, and substance misusers in the area.
2. Health and social care commissioners should ensure that there is a clear pathway for the multi-agency management of complex clients which makes use of the network of existing multi-agency groups in Sandwell.
3. SSAB should lead the development of local procedures that guide professionals on how to respond to clients that are hard to engage but are very vulnerable or pose significant risks. These procedures should include a structure for determining the level of vulnerability associated with a client, which will then guide the level of persistence that is used to follow-up these individuals. The procedures should include the need to escalate those who are more vulnerable to abuse, neglect and/or exploitation and coercion, and/or hard to engage, to a local multi-agency forum for joint management.

Messages from the Family

Kim’s mother provided a statement about her daughter.

Kim was a great kid; so loving… a mommy's girl. She grew up to have three children and was a good mom. I was so proud of her. Her life changed when she turned 26 years. Kim and her partner broke up after five years together and Kim didn't take it well. She started using drugs around the age of 26 and her life would never be the same again. She lost her home, her children and herself. She had very bad depression, so couldn't keep herself together. Everything just got too much for her…depression and drugs took over her life...she was in and out hospital over the years. My lovely daughter, my only child, went from a happy-go-lucky lady to a 5 stone little girl. She phoned me every day no matter how ill she got. Her dad died just 10 months before her. Never for one minute did Kim or myself think she would die so young and not knowing what happened to my daughter is even harder. Her children still cry for her as do I.