Bexley Safeguarding Adults Board

7-minute Learning Summary

SAR - Sahara

1. Rationale for Safeguarding Adult Review (SAR):

The BSAB regularly carries out SARs. They are extensive pieces of work, that look in details at cases when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. This SAR was carried out so that the agencies involved in providing services to Paul could learn lessons and improve practice.

Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight.

The overall aim of a SAR is to improve services because of that learning. **What do you do?** Make sure you embed the learning and can evidence to the BSAB especially if you work for an agency that was involved in this SAR.

The full report can be found here –

https://www.safeguardingadultsinbexley.com/protecting-adults/safeguarding-adult-review-learning/

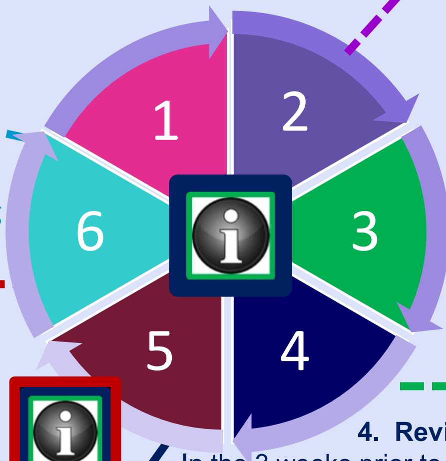
2. What happened in the case of Sahara?

At the centre of this work is a 33 year- old woman who tragically took her own life and that of her unborn baby. She was living with her family, husband and 10 -year old son at the time and had in the few weeks before her death sought help from local health services in relation to severe insomnia. The circumstances of her death will have caused profound distress to her family, but also to the professionals who knew her and tried to respond. I want to extend sincere condolences to Mrs S's family and friends, who've suffered such a significant loss.

Mrs S was known to a number of different health agencies, particularly during the few weeks before her death. This review has led to recommendations on improving communication and the sharing of information between GP, mental health and midwifery services in situations such as this.

3. Involvement of Family and significant others:

The midwifery service made several attempts to contact Sahara's husband via telephone to offer condolences and explain that a review of care was taking place. This was followed up with a Duty of Candour letter and a condolences card on the 8th January 2019. The GP practice also sent a letter of condolence He chose not to attend the Coroner's inquest. The independent chair of the Board wrote to inform him that this review was taking place and to invite him to contribute if he wished. To date there has been no contact from Sahara's family. There was a request to check on the surviving son, however, the school did not engage and refused to sign for the recorded-delivery letter sent by the BSAB.



4. Review of Health Agencies/Involvement:

In the 3 weeks prior to her death, Sahara due to her inability to sleep, sought medical help for this on 9 occasions during this period, including: 4 times with her GP, 3 calls with the midwifery team responsible for her care, 1 attendance at an urgent care centre, and 1 telephone call to a mental health urgent advice line. The treatment she received did not resolve her insomnia or the related anxiety due to her inability to sleep. There was no contact with any other agency outside of health services with Sahara prior to her death. Her son's school had not raised any concerns and may not have been aware of how unwell his mother was feeling. ***Following Sahara's death Oxleas Foundation Trust, Lewisham Greenwich NHS Trust (Queen Elizabeth Hospital site) and the primary GP Surgery, undertook a joint Serious Incident review.** **The review concluded:**

• Sahara had contact via either appointment or by phone with health care professionals 9 times in the three weeks leading up to her death. However, her deterioration could not be recognised as the systems in place did not facilitate the sharing of information about any concerns raised about Sahara's state of mind. There was lack of awareness at the GP or Mental Health Liaison team about prescribing in pregnancy with respect to insomnia.
• Documentation of Sahara's phone calls to the community midwifery team was not on iCare therefore it was difficult to ascertain how many times she had contacted the service. • There did not appear to be a review of the notes about Sahara's mental health history from the GP that were provided to the maternity services. Sahara died during her second pregnancy at 29 weeks gestation. She had been receiving antenatal care at Queen Elizabeth Hospital, Lewisham and Greenwich Trust. At booking her previous mental health history of medicated depression and suicidal ideation were not disclosed or identified from the GP history summary. In the three weeks prior to her death she presented to maternity services, her registered GP practice and the urgent care centre (also part of Lewisham and Greenwich Trust) complaining of insomnia. She had risk assessments completed at her GP surgery and when reviewed by the Greenwich Mental Health Liaison Team where she disclosed no suicidal ideation or concerns about her mood; the primary focus was on her inability to sleep and associated anxiety. There were multiple discussions by the GP surgery and at the Urgent Care Centre about if any medications were suitable to take during pregnancy and a short course of promethazine was prescribed. At the Urgent Care Centre, it was advised that Sahara could try melatonin but this was not given by the pharmacy as it is contra-indicated in pregnancy. She made contact with the Oxleas Foundation Trust crisis line on the day prior to her death and was referred to her GP for further discussion about medications and a plan of care. At the GP surgery she expressed no thoughts of self-harm and a plan made for review in two weeks. Sadly, Sahara took her life the following day by jumping in front of a train.

5. Recommendations:

1. As a result of the Joint Serious Incident Review completed by health colleagues, an action plan was drawn up to improve knowledge about use of medication during pregnancy, to increase mental health knowledge in the community mental health team, to document all telephone contacts on the iCare system, and to improve training for key health professionals on pregnancy and mental health. 2. Key agencies reviewing an immediate response to suicide notification from Police or British Transport Police must consider any potential support required by other adults at risk and/or children in the household. 3. Children's Social Care should offer bereave-ment support.

6. Recommendations for the BSAB:

BSAB to seek updates from partners regarding the embedding of this learning through the BSAB SAR Sub Group.