# SAR SAHARA

Case Review Summary, Learning Points and Recommendations

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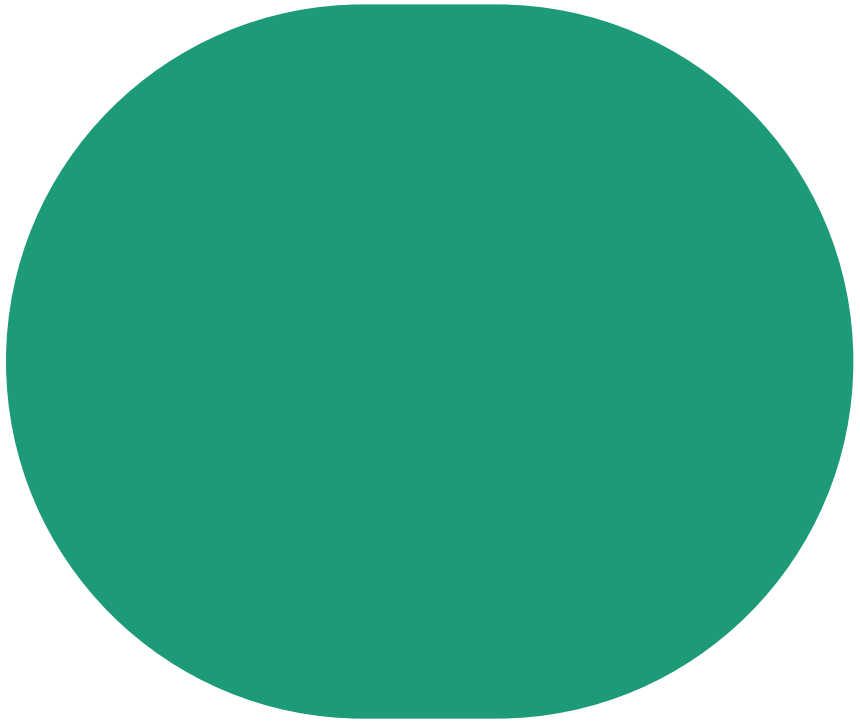

Safeguarding Adults Local Learning Review –
Sahara
2020

Key Factors in the Review:
Mental Ill Health, Trauma History, Cultural Considerations, and Suicide

Statutory Safeguarding Adults Review (SAR) Report and Findings in respect of an individual to be known as Sahara

This report has been prepared under the statutory requirements of the Care Act 2014 by Internal Reviewer, Eleanor Brazil, independent chair of the Bexley Safeguarding Adult Board.

# Introduction

•This Safeguarding Adult Review (SAR) was carried out so that the agencies involved in providing services to Sahara could learn lessons and improve practice. The report is anonymised to ensure no individuals can be identified.  Agencies have 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 and importantly, to improve services as a result of that learning.

•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 have 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.

Why we called a SAR?

# Involvement of Family Members 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.

# Review of involvement by health agencies:

In the 3 weeks prior to her death, Sahara due to her inability to sleep, sought medical help for this on nine occasions during this period, including: four times with her GP, three calls with the midwifery team responsible for her care, one attendance at an urgent care centre, and one 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.

# Summary:

- Little is known beyond what is in the health notes of Sahara's life and feelings. The assessment undertaken on 23rd November 2018 noted that she described her home life as good and the family being very supportive. She had spent time with her extended family at their home in an attempt to sleep well, though did not help with sleep difficulties. Her husband was described as very supportive, encouraging her to attend local yoga classes for relaxation.

- She felt that the trigger for her depression was low mood related to issues with/ her niece in Denmark. Sahara did not describe any other concerns other than the extreme difficulty in sleeping. There did not appear to be anything more in Sahara attitude or appearance, or that of her husband who attended with her, to indicate that she was a suicide risk.

- Sahara's husband accompanied her to most if not all of her appointments. The panel agreed that it did not matter that he attended the appointments with her as many professionals observed that had a 'good' relationship – i.e. making jokes, laughing and being generally supportive .

Conclusions:

1. This is a tragic situation of a young pregnant woman seeking help during a short period prior to taking her own life.

2. She was responded to on each occasion when she made contact but the information about her mental health and severe insomnia was not shared fully and in a timely way between the GP, accident and emergency, midwifery and mental health services.

3. Sahara often took referrals for support but either didn't attend the appointment or denied any support needed when at the appointment .

4. There are records of Sahara experiencing insomnia in November 2016, November 2017 and November 2018. It appears likely that this was a particularly difficult time of the year for her, possibly linked to anxieties about a niece who was taken into care in Denmark at that time in 2016. This pattern was not noticed.

5. No referrals were made to children's services by any of the professionals involved which may have resulted in additional information being shared by her son's school. However, there was no reason to raise those concerns given the view that Sahara lived in a supportive family, and any such referral would need to have been discussed with the family.

## 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. These actions will address the key points of learning from this review. The only additional recommendation in respect of the wider system I would make is that:

3. 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.

4. Children's Social Care should consider and ensure a child that has bereavement from a close family member has follow-up and support .

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