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.

1. 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.

2. Criteria for undertaking a SAR:

A Local Safeguarding Adults Board must undertake reviews of serious cases in specified circumstances under Section 44 of the Care Act 2014 which sets out the criteria for a Safeguarding Adults Review (SAR). This includes circumstances involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult has died.

Under one of the criteria, a Safeguarding Adults Board may arrange for there to be a review of any case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs). Each member of the Safeguarding Adults Board must co-operate in and contribute to the carrying out of a review under this section with a view to:
(a) identifying the lessons to be learnt from the adult's case,
and
(b) applying those lessons to future cases.

3. Decision to hold a Safeguarding Adults Review (SAR), Terms of reference, and methodology:

The circumstances relating to this case were considered by the SAR Sub Group in July 2019 and a recommendation was made by partners to the Independent Chair, that this case met the requirements for a SAR. It was agreed that due to the relatively

limited involvement of agencies the review should be led by the Independent Chair, who agreed and then wrote to statutory partners and agencies known at the time of death, that she would be the independent reviewer on this case in order to capture the learning. The agreed terms of reference are:

a) establish lessons to be learned from the case of Ms. S, in terms of how professionals and organisations worked, both individually and together, to safeguard the adult at risk and prevent harm

b) identify required improvements and the timescales in which they will deployed, identifying how and what is expected to change as a result, and agreeing required monitoring systems

It was agreed that this SAR would be conducted as learning process, with involved agencies being asked to complete their own review, and those reviews being brought together and considered at several joint meetings.

The outcome of this is captured in this final report. Summaries of involvement were received from:

1. London Borough of Bexley - Child Death Over-view Panel decision
2. Oxleas NHS Foundation Trust – Mental Health Services
3. Lewisham and Greenwich Trust Midwifery and Emergency Services
4. GP Practice (Bexley CCG)
5. Coroner's Office
6. London Ambulance Service
7. London Metropolitan Police Service

4. 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.

5. Background /summary:

Sahara's background and circumstances are outlined in the medical assessments and notes. According to those her parents were originally from Sri Lanka but now live in Denmark with her two older sisters. Sahara was born in Sri Lanka. She moved to Denmark when she was fourteen years old and moved to the UK to join her husband around 2006. When she was first seen by mental health services in 2016, she said

that she was in a happy relationship with her husband and their seven- year old son, and that they lived with her husband's family. She also said she had a diploma in business administration and was working at that time in a school. She reported her family and her husband's family were supportive.

She first sought help from her GP in November 2016 for severe insomnia. Over a short period, she was seen by her GP, accident and emergency department and mental health services. Treatment in the form of anti-depressants was given, as well as advice and a referral made for counselling which Sahara did not follow up. There were 2 brief health contacts following this episode.

In June 2018, Sahara was pregnant and was advised by her GP to make a self -referral to midwifery services. She booked for midwifery care on 25th July 2018 when she was 10 weeks pregnant. She disclosed to the booking midwife that she had had a panic attack in 2017 but that the problem had resolved. No further mental health issues were disclosed by Sahara at this time. Sahara was seen by her named midwife at 17 weeks and 25 weeks and also attended the birth clinic at 30 weeks.

During November 2018, Sahara rang her community midwives as well as the maternity helpline, reporting that she was unable to sleep. During November 2018, Sahara was also seen by a GP on 3 occasions with the same complaint. Sahara attended the accident and emergency department and an assessment was carried out by the Greenwich Mental Health Team on 23rd November 2018 which concluded that Sahara was suffering from anxiety due to sleep issues. A plan was made for the assessment summary to be sent to the GP and a short course of Melatonin tablets were prescribed to aid with sleep.

An email was sent to her community midwives to request follow up by the Best Beginnings Perinatal Mental Health Team intermittently during the pregnancy due to Sahara having a history of depression. Contact details were provided to Sahara for the Mental Health helpline and a crisis card provided. The email was received by the Best Beginnings team and, pending a formal referral, the case was due to be allocated to the Best Beginnings team at a meeting on 29th November 2018.

On the 28th November 2018 Sahara died after jumping into the path of an oncoming train and suffered multiple injuries. She was pronounced dead at the scene. She was 29 weeks pregnant. The unborn baby also died. A Coroner's inquest was held on 28th August 2019 and concluded that the cause of death was suicide, while the balance of her mind was disturbed.

6. Key events:

21.11.16	Seen at GP surgery complaining of severe insomnia, not sleeping for 5 days, threatening to commit suicide	Referred to accident and emergency
21.11.16	Seen in accident and emergency	Not clear from GP note outcome of visit
25.11.16	Seen in accident and emergency	Referred to mental health team and assessed
25.11.16	Assessed by mental health team. Described as low mood, anxious with episodic suicide thinking precipitated by the news of niece being taken into care in Denmark.	Referred to home treatment team, and given 3 days zopiclone
25.11.16	Seen by Bexley crisis and home treatment team	Not accepted for service, GP requested to refer to Improved Access to Psychological Therapies (IAPT) for counselling
30.11.16	Brought in by ambulance with husband to accident and emergency, feeling depressed, suicidal thoughts	Referred to mental health team within A&E
30.11.16	Seen by mental health nurse	No suicidal risk identified
30.11.16	Seen by GP	Prescribed anti-depressant (mirtazapine) and referred to counselling
20.12.16 and 22.12.16	GP secretary telephoned to information for counselling referral	
23.12.16	Saw GP, worried losing weight	Referred to dietician, advised to take anti-depressants for 4- 5 months
3.1.17	Did not attend dietician	
9.12.17	Saw GP, complaining of insomnia, but reporting good mood	Prescribed medication to improve sleep, not anti-depressant

13.3.18	Saw GP, insomnia review, mood good, weight increased	
25.6.18	Saw GP re pregnancy	Advised to self-refer to midwifery
25.7.18	1st appointment with midwife	Sahara described having panic attach in 2017, now resolved
13.9.18	Routine midwife appointment	
1.11.18	Routine midwife appointment	
9.11.18	Saw GP complaining of insomnia	Advice given
12.11.18	Sahara telephoned midwife complaining of insomnia	
16.11.18	3 phone calls from Sahara to midwife re insomnia	Urgent GP appointment made
16.11.18	Seen by GP	Advice and small amount of promethazine given
21.11.18	Sahara rang maternity helpline re insomnia	Advised to contact GP or come to hospital for obstetric review
21.11.18	Saw GP	Advice given
23.11.18	attended urgent care centre and seen by Greenwich mental health liaison team. Full assessment done	Advised to try melatonin, referred to best beginnings team for follow up
27.11.18	Sahara phoned Oxleas Foundation Trust crisis line	Advised to see GP or midwife
27.11.18	Saw GP, says hasn't really slept in 10 days, thinks linked to her past depression but stopped taking medication because of pregnancy.	Advice given, including to see midwife
28.11.18	Sahara died at a nearby train station at approximately 11.00am	

On 5th December 2018 Bexley Child death Over-view Panel (CDOP) considered the case and decided that this did not meet CDOP or rapid response criteria. The panel noted that arrangements had been made to collect Sahara's son by a family liaison officer from his school.

7. 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.

8. 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.

9. 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.

10. 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.

   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:

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 consider and ensure a child that has bereavement from a close family member has follow-up and support.

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

Eleanor Brazil
Independent chair Bexley Safeguarding Adult Board
February 2020