Practitioner Learning Brief Safeguarding Adults Review (SAR): Megan

2016/2017

Megan's self-harming has escalated by early 2016 and she overdoses, resulting in admission to Mental Health Services where she is subsequently diagnosed with EUPD (emotionally unstable personality disorder).. Megan is struggling to maintain her work, and later in 2016 she discloses a rape to the Police. Unfortunately, the investigation is not completed, and Megan continues to self-harm and overdoses again while admitted to an in-patient Mental Health Unit.

Throughout 2017, Megan undertakes a daily routine of self-harming, binge drinking and drug use. Megan's marriage ends, leading to her moving in with her mother, who seeks services to help Megan. This results in Megan being under the care of the Crisis Home First Team, and she commences weekly GP visits for medication.

Background

- **28-year-old female, youngest of her siblings, described as the most caring person ever by her family.**
- **Worked as a Health Care Assistant caring for elderly people in their own homes.**
- **Trauma and exploitation (childhood and adulthood) led to mental ill health, resulting in substance misuse, multiple self-harm episodes and suicide attempts.**
- **Was married however at the time of her death, was going through a divorce and was living with her mother.**
- **In the year prior to her death, came to the attention of the police, ambulance service and hospital on multiple occasions.**

October – December 2018

In October 2018, Megan's father died, and she was reported to be struggling with her grief. Between November and December 2018, Megan once again took an overdose and she was detained under S3 due to stress of father's death, recent rape allegation, sex work to fund drug habit, concern about exploitation and not being concordant with her medication.
Megan was discharged but took a further overdose following her father's funeral.

Subsequently, she was readmitted to the Mental Health Unit. At this point, Megan had a court order for non-payment of a loan, made a disclosure about child sexual abuse and reported being raped; she was advised to attend the sexual health clinic and was discharged from the Unit 2 days after admission. Megan attended the sexual health clinic and spoke to Police about the rape, however there was insufficient evidence to progress the investigation. There were also reports of her being trafficked and a refuge was contacted, but there were no beds available. Megan also continued to self-harm.

January – September 2018

By 2018, Megan is struggling to maintain her medication and makes attempts to end her life. Throughout admissions to Mental Health inpatient units, Megan continues to self-harm and maintains her drug habit (costing her £200 per day). During this time, Megan is targeted by another patient and unfortunately becomes a victim of financial; a safeguarding investigation takes place, and Megan's father also reports the financial abuse however no further action was taken due to Megan being on the ward. Megan's divorce is also underway.

Between April – August 2018, Megan continues to lose money to another patient, and there are also reports of drugs being supplied by another patient. At this time, Megan was also having relationship issues with her father and stepmother.

In August 2018, Megan was discharged to her mother's home and into community care. Megan continued to self-harm and use drugs (admitting she used on the day she was discharged). She was also reported to be using dating websites and meeting males for sex. During a (Home Treatment Team) visit, Megan admitted having ongoing suicidal thoughts and reported seeing men for money. Megan was also found to have been a victim of internet fraud and a personal care budget was arranged for her.

January 2019

During the last month of Megan's life, she continued to self-harm and misuse drugs and alcohol, leading to admission to hospital, where she attempted suicide, was discharged but readmitted due to continued self-harm.
On 11th January, Megan reported that she had been exploited by other patients; being made to leave the ward and attend a house where she was raped 3 times however the Police found inaccuracies in this report.

Due to further self-harming incidents, Megan was re-admitted to hospital and transferred to another unit on 15th January. When transferred, Megan was on level 3 observations (continuous 1 to 1 eye level) however the receiving ward staff didn't realise this, and this level of observation was therefore not provided. On 16th January, whilst still an inpatient, Megan died after she tied a ligature around her neck.
Megan was only 28 years old when she died.

11 admissions to inpatient psychiatric units during the last 3 years of Megan's life

17 contacts with Ambulance Service during October 2018 – January 2019

4 related offences known to the Police Sexual Offences Team

7 areas for improvement that were identified:

1. Assurance required that the increased level of scrutiny in relation to safeguarding enquiries is sustainable and suitable; suggested this is achieved by regular reporting.
2. Scrutiny of how partner agencies identify and respond to disclosures of sexual exploitation is required; multi-agency discussions should be held to ensure decisions are recorded and support plans in place for the individual making the disclosure.
3. Personalised risk assessments and care planning must place within acute psychiatric units to ensure all staff are aware of possible risks and mitigating actions; for those risks linked to substance misuse, mitigating actions must include the individual attempting to gain access to drugs and safety of personal finances.
4. Increased partnership work to ensure there is shared intelligence about risks to those individuals leaving mental health units to visit local areas.
5. All services must take responsibility and be aware of who is taking on caring responsibilities for an individual with care and support need; ensuring the carer is offered a carer's assessment.
6. Discharge plans for those individuals known to have suicidal tendencies must be demonstrated; to ensure that partners consistently apply Mental Capacity Act to question an individual's capacity to make decisions.
7. Consideration to be given as to how a multi-agency, trauma informed pathway can be developed; to raise awareness of the need to listen to the individuals and recognise the impact of trauma on their ability to keep themselves safe.

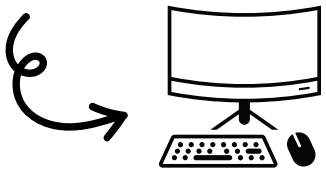
Good Practice:

There have been positive developments within multi-agency working to ensure several safeguarding practices are improved in relation to identifying community risks in locations close to mental health units, safety planning for those individuals perceived to be involved in sex work and addressing the risks of potential perpetrators of exploitation.

There have also been substantial changes to safeguarding systems and processes, increased scrutiny of safeguarding enquiries, a carers framework established and improvements to training and awareness in the areas of sexual exploitation, modern slavery and sexual safety.

It is therefore essential that positive, proactive relationships and inter-agency collaboration continues to develop between all partner agencies involved in supporting people with complex needs, and that safeguarding systems, procedures and training are regularly reviewed and amended/updated when required.

Click here to view the recommendations from this review, which have been themes alongside 5 other concurrent reviews.



Essex Safeguarding Adults Board