Mandy

Learning Event

Summary of Case:

Mandy lived in Suffolk and was a mother to six children. Four of her adult aged children remained in a family home outside of the Suffolk area, and two of the children lived with Mandy and attended education settings in Suffolk. Mandy had taken some equity from the family home to relocate to Suffolk to set up home with a new partner, move closer to wider family networks, and to run her own business. Her relationship ended shortly after moving to Suffolk.

Mandy died when she was in her 50's: the Coroner concluded that she died as a result of metastatic breast cancer and multiple organ failure due to overdose of ibuprofen, and depression. Mandy had previously had a diagnosis of cancer and when she moved to Suffolk and was encouraged to register with a GP Surgery, however she did not follow through with registering, and remained a patient at a previous practice out of area. While Mandy was admitted to hospital, she refused scans and blood test investigations to determine any recurrence of the cancer. Mandy had several admissions to hospital due to her mental health, suicidal ideation (thoughts) and social issues, with her adult children also raising concerns with police about the mental health issues she was experiencing. The Police followed up on the concerns raised and supported Mandy in being taken to hospital, while supporting the two younger children until their older adult siblings came to take care of them.

Mandy reported that her relationship with her adult children was a struggle and that the older children were taking advantage by stealing money via the family home which they were living in. Mandy outlined that she had legal support in this matter but was struggling with the fees. Mandy described her suicidal thoughts but had no plans to act on them and referred to herself as wanting to go to a 'funny farm'. Mandy said that all of the issues had gotten on top of her, and she was going to take further advice about her situation. Mandy had been referred to mental health services for ongoing support and was undertaking her own counselling. Due to Mandy not being registered with a local GP surgery, she was unable to be referred to local Suffolk Mind services.

Mandy was admitted to hospital during experiencing an acute episode of dehydration, she was confused and had not eaten in seven days, resulting in them being frail and weak, and had taken a staggered overdose of ibuprofen. Upon further investigation the cancer had spread to liver and bones along with sepsis, all of which resulted in multiple organ failure. Mandy passed away in hospital.

Learning event outcomes:

1- Learning: Mandy was hidden in plain sight and seen as the parent to her children and not as a person in her own right with needs of her own. The SSP to seek assurances that 'Think Family' as a way of working is embedded in professional practice.

> Action: To Review the referral form to the Multi Agency Safeguarding Hub (MASH), to make clear the no wrong door approach for families.

2- Learning: Concerns about the welfare of children raised by the father with professionals, these concerns were recorded but not acted on.

> Action: The learning from this review will be incorporated into the work of the Inclusion of Fathers Learning and Improvement Group (LIG) Task & Finish Group. This will include where fathers' voices and concerns are not considered in risk management.

3- Learning: Mandy attended Hospital and comments relating to safeguarding were recorded, however the comments were not escalated to the safeguarding team to investigate further. As a result of Mandy's learning event and a recent Domestic Homicide (DHR) Review, the Hospital has introduced a process to ensure people attending Emergency Department (ED) are asked the two following questions.
Do you feel safe at home? (Are you ok)
Do you have any caring responsibilities?
The responses are documented, ensuring that safeguarding is followed up and appropriate referrals submitted.

> Action: Case study to be developed between the hospital and the Suffolk Safeguarding Partnership to share the learning and subsequent good practice across the partnership.

4- Learning: Mandy had multiple agencies involved in her family throughout the period she was living in Suffolk. While there were concerns being raised relating to safeguarding of her and her children, there were no records of partners coming together to discuss this case and utilise the Suffolk escalation processes and protocols in place.

> Action: Partners to review how cumulative referrals, and collaborative casework protocols are being managed when thresholds are not being met for frequent caller processes, ensuring each incident is not seen in isolation (bigger picture).
> To review management oversight record keeping, where MDT and escalation are required.