DORSET SAFEGUARDING ADULTS BOARD

EXECUTIVE SUMMARY OF SERIOUS CASE REVIEW IN RESPECT OF AN ADULT FEMALE LW WHO DIED ON 28 FEBRUARY 2011

1. Introduction

This Executive Summary provides a brief headline summary of the main findings, conclusions and recommendations of the Serious Case Review (SCR) that was commissioned by Dorset Safeguarding Adults Board (DSAB) following the death of a female adult LW in February 2011.

2. Background Summary

1. LW was 26 year old woman who had a long and extensive psychiatric history. She had a diagnosis of Borderline Personality Disorder (BPD) although this diagnosis was under review towards the end of her life. She was under the care of both Dorset HealthCare University NHS Foundation Trust (DHUFT) from 2004 - 2008 and Dorset Community Health Services (DCHS) from 2008 - 2011. During this period she also had regular contact with her GP and the Urgent Care Service (UCS), with Dorset Adult and Community services, with the police and ambulance services, and with Dorset County Hospital (DCH).

2. LW had a difficult early family life, she was diagnosed with Attention Deficit Hyperactivity disorder at the age of seven, she spent periods in care, and she committed a number of criminal offences and spent nine months in prison. She had numerous admissions to psychiatric hospital between 2004 and her death in February 2011. Her condition was characterised by frequent episodes of self harm and substance misuse, and difficulties in engaging with the psychological interventions offered. There was an increase in her distress and an escalation of her disturbed behaviour towards the end of 2010 and the beginning of 2011, prior to her death.

3. The circumstances of LW's death were complex and are set out in more detail in the full Review. In summary, she was admitted informally to psychiatric hospital on 17 February 2011 during the night, saying she was low in mood and planning to kill herself. She was detained under section 5 (2) of the Mental Health Act and this was subsequently converted to a section 2 on 22 February. On 25 February in the context of LW appearing to be more settled and relaxed, she was allowed two towels and went to take a bath. She was found collapsed in the bathroom twenty five minutes later, with a ligature around her neck and an injury to her head. LW was taken to Dorset County Hospital but never regained consciousness and she died on 28 February 2011.

3. Key Issues

The following key issues were identified during the review:

Inter-Agency Communication and Information Sharing

LW's care was shared between specialist mental health providers (both in-patient and community services), and generalist services. This created significant challenges for ensuring good communication, which was not always achieved, although there is also some good evidence set out in the full report that this aspect of LWs care was taken seriously and systems were put in place to ensure that all parties were aware of the need to offer a consistent and coherent response to LW. Specific examples are set out in the full report.

Risk Assessment and Risk Management

1. This was a challenging aspect of LW's care. LW received significant support while in the community but implementing risk management protocols was complex due to the demands made on the wide range of agencies involved, including out of hours services. The agreed management plan reduced but did not eliminate risk and it was challenging for all agencies to understand and consistently implement the agreed plan. Considerable efforts were made to achieve this but there were examples of poor or missed communication, as well as a lack of understanding about the role and powers of the police service, which increased risk.
2. Examples of good risk management practice were identified including multidisciplinary risk management conferences attended in part by LW, and multidisciplinary community management plans.

Decision-Making and Actions Taken

Issues identified by the review included lack of appropriate information sharing between agencies which led on occasion to the inadvertent undermining of the community management plan and lack of clarity about how to respond to LW's demands, however the management of LW's care during her final admission prior to her death was in line with the agreed management plan. There was also variable understanding and use across agencies of the Pan Dorset Safeguarding Adults at Risk Policy revealed during the review, with a common view that the formal procedures did not apply in this case.

Coroner's Verdict

Unusually, the Inquest in this case did not result in a single verdict but in a narrative verdict. In summary, the Coroner was not satisfied beyond reasonable doubt that LW intended to kill herself and was therefore not

able to give a verdict of suicide. The Coroner's verdict is attached as an appendix to the full report.

Conclusions

1. LW's history meant that she was a high management risk both in hospital and in the community, and the nature of her demands on statutory services tested them to the limit. She had made numerous attempts to kill herself over a period of several years. Nevertheless the summary of events in the full report illustrates the genuine efforts made by a wide range of agencies to respond appropriately in managing LW's care.

2. The records show that there were some issues in providing consistent care for LW including diagnosis and treatment issues, her behaviour and response to care, and decisions made about treatment in hospital and in the community and the impact of this on a wide range of agencies. Information sharing was also not always as good as it could have been in spite of the fact that the importance of this was recognised and great efforts were made to achieve good communication. It is not easy to answer the question of whether LW's death could have been avoided on this occasion, but her history showed she was at high risk of killing herself.

3. Although no case is 'typical' this review process and the scrutiny given to practices and decision making across all the agencies have enabled important lessons to be learned and services will be improved as result.

4. **Recommendations**

1. Two generic recommendations have been made as follows:

   - Improve the understanding of the wider remit and value of Safeguarding Adults policies and procedures, across all the agencies represented on the Board.

   - Improve information sharing and co-ordination of care and support across all agencies including emergency and 24 hours services for the small number of people identified with multiple and highly complex needs, to ensure all relevant agencies can work together effectively and overcome the general and specific difficulties service boundaries create.

2. In addition individual agencies have identified good practice and made a number of specific recommendations and action plans that will result in improved practice that will benefit existing and future users of their services.