

WAKEFIELD & DISTRICT

# Safeguarding Adults Board

Serious Case review- Re Ms C

Ian Holden-Chair

August 2008

## **Summary**

Ms C, an active 41yr old woman lived at care home A. She has been described as happy and gregarious. She attended day services and had a reasonably close family. She was quite happy and able to ask for help when she needed it. She had complex medical needs including Down's syndrome and diabetes. In the past Ms C had told staff that she had feigned illness because she missed her family. (This was subsequently corroborated by the company (The care home) managing the care home where she lived when they produced an 'additional care plan' dated 3 July 2007, this states 'staff must never totally disregard any complaints of illness') The extent to which this information was shared, in what way, its appropriateness and how it was interpreted was felt to be significant in the series of events leading up to Ms C's death.

On 7<sup>th</sup> September 2007 at 10.05 she was taken to A&E at a local hospital. Her history was taken and she was examined. She was discharged home at 12.35 two and a half hours after arriving.

She collapsed 30 minutes after her return to the home and an ambulance was called at 13.45. She arrived back at hospital at 14.43 and was given an emergency gastroscopy. Admitted to high dependency/intensive care unit at 20.15 on the 7<sup>th</sup>, Ms C died at 1.30 on the 9<sup>th</sup> September 2007.

The cause of death was certified as; multi organ failure, pneumonia and respiratory failure, recent GI bleed and Downs Syndrome. The coroner did not suspect abuse or neglect and did not convene an inquest.

The serious case review was invited to consider whether the professionals dealing with Ms C gave her the best care available and to determine whether her disability affected the care she received.

**The terms of reference for all serious case reviews are;**

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults
- To review the effectiveness of procedures (Both multi-agency procedures and those of the individual organisations)
- To inform and improve local inter-agency practice
- To improve practice by acting on learning (developing best practice)
- To prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action

A Serious Case review panel comprising officers from Family Services, CSCI, the Police, the company managing the care home and the NHS trust managing the hospital (Mid Yorkshire NHS Trust ) met on 14<sup>th</sup> February 2008. CSCI and the Police also attended the panel as members of the Safeguarding Adults Board. Family Services, CSCI, the company managing the home and the NHS trust all submitted chronologies covering the period from June or August 2007 up to the time of Ms C's death.

The concern addressed was "This case is being referred due to the serious nature of the circumstances which lead up to the death of this vulnerable woman. Ms C had a learning disability and was in contact with both Health and Family Services' in the lead up to her death."

Those who knew Ms C were concerned at the suddenness of her demise, there were concerns that her disability and previous history may have affected the way she was treated.

The process followed.

The members of the panel met once, considered the chronologies in turn and considered and discussed the events as described and looked at any differences of fact or interpretation. In discussion clarification about the events and their interpretation was reached.

## **A Summary of the discussion.**

It was noted that in the period leading up to the second attendance at A&E Ms C was examined by a number of qualified health professionals. Although they were aware that she had said that she feigned illness there is no evidence that either this, or her Down's syndrome affected their response or her treatment. The home had a clear and agreed approach to her requests for medical attention and it was the staff at the home and the Community Team Learning Disability nurse who were convinced that Ms C's claims were genuine, rather than 'behavioral' or 'attention seeking' because her presentation was atypical.

Ms C herself was not able to give a reliable account of her symptoms, at times, and it was acknowledged that the emergency GPs, paramedics and A&E would not have had access to her primary care medical records.

Information which care staff may give about Ms C "feigning illness" could have affected the treatment she received. The paramedic who checked her, was told about her behaviour in this respect and found nothing wrong and describing her symptoms as "behavioural".

On her first attendance at A & E there was no malaena (altered blood) present which would indicate internal bleeding. The blood present on her first A&E examination was red, indicating 'fresh' blood and this was said by Ms C to be due to her having scratched herself. It was suggested that 'bloods' might have been taken for testing on her first attendance and Ms C referred to a Consultant. When asked about this decision A&E Clinical Director said that with presenting symptoms would not have taken bloods.

On Ms C's first attendance there was no indication of pneumonia.

It was noted that the A&E notes make no reference to her becoming 'hysterical' when she was told she could go home. The accounts from the home, however, indicate a prolonged period of quite disturbed behaviour. It would have been normal practice for health professionals to make a note in the clinical record of disturbed behaviour or to complete an incident form and neither was done. On her second attendance there was malaena present which would indicate internal bleeding.

Notes from the home suggest that a carer present while Ms C was in Intensive Care was asked about Ms C's 'Quality of life'. The Serious Case Review panel was told that this was not usual practice when people approached the end of life but a view was expressed that given Ms C's disability the question could have been taken to suggest that her life is worth less than that of others. Following the Serious Case review the representative of the NHS Trust discussed the issue of the 'quality of life question' with a lead intensivist. Usual rule of health professional working in intensive care is to avoid using the term 'quality of life' as can evoke differing perceptions and misunderstandings. An understanding of an individual's health, well being and lifestyle prior to illness is necessary for an intensivist to gauge levels of co-morbidity and whether the patient can cope with aggressive levels of intervention required.

It was not possible to obtain reports from the GP or Ambulance Service and these omissions are regrettable.

The panel wished to commend the staff of home A on their prompt and caring response when Ms C said she was ill. It was acknowledged that there were situations in the tragic course of events when a more assertive approach to fellow professionals in securing C's best interests may have been beneficial but there is no evidence that this affected the eventual outcome

## **Conclusions**

- The care home acknowledges that on occasions their recording could have been more specific with regard to, for example, dates, times and observed behaviour.
- It is acknowledged that there were situations when a more assertive approach may have been beneficial, for example when it was suggested by the paramedic that Ms C 'self harmed' or when her behaviour was regarded as 'behavioral'.
- The home should continue working to ensure Care Plans are clear, objective and detailed, particularly in regard to life history.
- The NHS Trust should review current practice regarding asking the 'quality of life' question and gaining the required information sought.
- In this case there was little continuity from the NHS staff attending to Ms C, (4 different doctors and 1 paramedic in a few days) so without access to notes each person relied on information which could be partially accurate or anecdotal.  
It was accepted that this is an operational issue which proposed national IT developments are intended to improve.
- There is a lack of clarity regarding the sharing of information regarding Ms C's "feigning illness". The home did have a care plan which covered this but how and the circumstances under which this was shared does not appear to have been fully considered.
- The main issue arising from this review concerns the way in which people with a learning disability are supported when they attend for any form of health care. Often they need a person who knows

them well to ensure that communication is clear and that no 'diagnostic overshadowing' is present. There are training issues concerning the skills needed by NHS staff treating people with a learning disability.