

# SANDWELL AND WEST BIRMINGHAM NHS TRUST

## Quality and Safety Committee: 27 March 2024

### Patient Story

#### Failure to recognise a deteriorating patient with a learning disability / autism

*“People with a learning disability have a significantly lower life expectancy than the public. If this is to change, it’s vital that we review these deaths so that we can learn from them, and to ensure that best practice is followed wherever possible.”*

Professor Andre Strydom, Professor in Intellectual Disabilities at King’s College Institute of Psychiatry, Psychology and Neuroscience

#### **Summary of Story**

Richard was a 29-year-old man who died following a wound infection. The cause of Richard’s death was listed as multi-organ failure, severe septic shock and an infected amputation stump. The story is relayed by Richard’s Aunt, Sharon.

Richard slipped on ice fracturing his ankle in January 2021. He was an obese gentleman with diabetes and a learning disability / autism. He had also suffered a recent and significant bereavement. Richard was taken to Sandwell Hospital where as a result of the fall, he underwent surgery to his ankle and pins and plates were inserted. A few weeks later Richard returned to Sandwell Hospital with an infection. Further surgery was carried out, which was also unsuccessful. Richard’s immune system meant anti-biotics were not effective in fighting infections.

In February efforts were made to discharge Richard back home with equipment sent, despite Richard living with only his father, who had broken his arm and also had a learning disability. He was therefore unable to care for Richard. Richard therefore remained in hospital before being transferred to a care home for elderly people.

Richard underwent below the knee amputation in March 2021 with a neighbouring Trust. Richard’s infections became more problematic and was returned to Sandwell Hospital from where he was allowed to discharge himself back to the home, without a proper assessment of his capacity to make this decision.

In June 2021, Richard returned to Sandwell Hospital with a further wound infection to his amputation stump. During that admission, Richard’s physical and mental health deteriorated. Richard’s behaviours changed from him being a polite and pleasant young man into someone who displayed aggressive and sometimes violent behaviour.

Richard stayed in the care setting from the injury in January 2021, in between acute hospital and care home until his death in July 2021.

Family had made efforts to highlight deficits in his care and treatment, also that behaviour displayed was far from normal for Richard. Sharon describes Richard, and his family not being

listened to and that the person that staff saw and treated was not the person Richard was and that this impacted upon Richard's care provision.

Specific learning identified the following needs:

- Employment of learning disability nurses to support the clinical teams and patients;
- Learning disability assessments need to be clear so the team caring for the patient understand them and provide the right support for patients and families;
- Lack of recognition of a learning disability by some staff resulted in lack of reasonable adjustments and appropriate mental capacity assessment;
- All Safeguarding reviews should be shared with the teams and uploaded to the patients Unity record, so it is available for interdisciplinary working and future decision making;
- All patients must have a consultant review within 14 hours of admission;
- Unity documentation requires improvement;
- All complaints must be circulated via Group including the Group and Directorate Triumvirate prior to investigation; approval should be sought from Group Triumvirate prior to Executive sign off;
- Review of all learning disability patient deaths.