Report into the circumstances leading to the death of Mr V on 10th-11th December 2014

This report is based on the following sources:

- **The chronologies supplied to the Board by the various professional agencies who had contact with Mr V during December 2014**
- **The discussions which took place during the Professionals' Review Workshop on 16th October 2015 at St Mary's Hospital, Newport**
- **The Serious Incident Requiring Investigation ("SIRI") report, dated 30th April 2015, which was carried out by Isle of Wight NHS Trust into the death of Mr V.**

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1. **Mr V died sometime during the night of 10th-11th December 2014 at his warden-controlled flat in East Cowes. He was 72 years old. His body was found at about 9.00am on Thursday 11th December by a carer who had come to check on his wellbeing. He was lying on his bedroom floor in a pool of vomit. She called an ambulance and Mr V was pronounced dead at 9.17am. The death certificate gave the cause of death as "acute peritonitis" and "small bowel infarction".**
2. **Mr V had been visited regularly at home during the final 10 years or so of his life by carers from Southern Housing Group and from Isle of Wight Council. These people will be referred to within this report as his "agency carers".**

The week leading up to Mr V's death

3. On Saturday 6th December 2014 Mr V's agency carer had reported seeing a "football sized lump" in Mr V's groin area. This was eventually to be diagnosed as an inguinal hernia. Mr V said it was sore but did not want the carer to contact a doctor or 999. He was very insistent and abusive on this point.
4. On Sunday 7th December 2014 Mr V's agency carer persuaded him to allow her to call 111. This resulted in the Out-Of-Hours GP visiting the same afternoon. Mr V would not let him examine the lump properly. Mr V said that he wasn't in pain, that he was eating and drinking OK and that he had passed urine and faeces.
5. On Monday 8th December, with Mr V again in pain, the agency carer again called the GP. An advanced nurse practitioner came to visit, and again could not persuade Mr V to be examined properly, nor to go to hospital. Both the Out-of-Hours GP on the 7th, and the advanced nurse practitioner on the 8th, advised the agency carer to call 999 if there was a significant deterioration in his condition.
6. On Tuesday 9th December 2014 Mr V's agency carer reported that he had been sick all over himself, his bedding and the floor, so she called 999 as previously advised. There then followed a lot of toing and froing as the 999 service assessed the requirements as an ambulance not being required, so the carer should phone Mr V's GP. Mr V's GP

receptionist advised that the GP wouldn't be available for a long time and advised trying 999 again. After much persuading on the part of the agency carer an ambulance was eventually sent. During this time (approximately 2-3 hours) Mr V was described as "not very co-operative" and "moaning and curled up on bed".

7. The paramedics together with the agency carer persuaded Mr V to go to hospital and he was admitted to the Emergency Department (ED) at about 1.00pm. It would appear he agreed to being admitted, but refused treatment, other than a small amount of pain relief. The ED registrar who examined him felt that on balance he lacked capacity to make a decision about his own treatment at that point. Later that afternoon he was transferred to an in-patient ward, where he remained overnight.
8. On the morning of Wednesday 10th December Mr V was seen by a consultant, who decided on balance that he did have capacity to make decisions about his own treatment. He was also examined by a physiotherapist and a nurse. Mr V was adamant that he did not want any treatment, so according to his wishes he was discharged during the afternoon and was visited at home by an agency carer at 4.00pm. Mr V said he was tired but did not want any food or drink and did not want his pad changed. He was left in bed, and was described as being "sleepy but looked comfortable".
9. That was the final time Mr V was seen alive.

Relevant background information

10. It is clear that Mr V was not an easy man to deal with. He had a long history of not caring for himself very well. He was frequently aggressive and abusive to people who tried to help him. His own family, although they lived nearby, had gradually lost touch with him. He had a history of schizophrenia, mild learning disabilities and traits of autism.
11. Despite all of the above, it was notable at the Professionals' Review Workshop on 16th October that many people spoke of him in affectionate terms. His agency carers, some of whom had known him for 10 years or more, had clearly developed techniques for dealing with him which involved compromises, negotiations, bargaining and knowing when to push and when to hold back.
12. There was lots of good practice in evidence. Mr V's carers (the people who came to see him every day, or every month as appropriate) had evidently found a way of working with him effectively. Such approaches seem to have been replicated to some extent by the Out-of-Hours GP on the 7th, the advanced nurse practitioner on the 8th and the ED registrar on the 9th, even though they had only just met him.
13. Although different decisions might have been made during the period 1st-10th December 2015, it is not possible to predict the eventual outcome.. Perhaps Mr V's death could have been delayed, but it is impossible to say whether it could have been prevented completely. What follows are observations and suggestions, rather than criticisms of professional practice.

Observations

14. The approach of everyone who attended the Professionals' Review Workshop on 16th October was highly commendable. It must have been a daunting experience to have to

come and justify one's own actions to other people who might not know the full story, or appreciate the bigger picture. But there seemed to be genuine willingness to be honest and open and to learn from each other.

15. With that in mind it was disappointing that the hospital ward in which Mr V spent the night of 9th-10th December was not represented at the workshop. The Workshop was left with the feeling of a jigsaw with pieces missing from an important part of the pattern. Of course it is appreciated that the hospital itself had already conducted a SIRI, and those professionals may have felt they had already accounted for their actions. But it would have been really helpful to have their input too.

16. It was an oversight on our part not to have invited a representative from the Ambulance Service, but it was fortuitous (and much appreciated) that a representative was able to join us for part of the Workshop at very short notice.

Key learning points, listed in chronological order

a. If a GP has made a decision that a significant deterioration in a patient's condition would necessitate admission to hospital via 999 ambulance (as happened on 7th December) then the GP's notes must be very explicit in stating this. Explicit, unambiguous notes may have prevented the "toing and froing" that occurred on the morning of 9th December.

b. It would be helpful if the Ambulance Service were able to link 111 and 999 calls (this has already been identified in a different SIRI which was referred to during the Professionals' Review Workshop on 16th October).

c. It may have been helpful for the various health professionals who saw Mr V in the ED on 9th December, and in the in-patient ward on 10th December, to have liaised with a specialist learning disabilities nurse. He or she may have been able to offer them extra support in communicating with Mr V.

d. It might have been helpful to medical staff to have a quick and easy way of recording an assessment of mental capacity, which could have been seen and used by any other member of staff who might have dealt with Mr V during 9th-10th December. Just by way of an example, James Paget Hospital in Great Yarmouth has recently developed a bright yellow form, on sticky paper, which is A5 sized and can be quickly filled in and stuck on the outside of the patient's file.

e. It is still not clear on what basis Mr V was deemed to have capacity to decide about his own treatment on the morning of 10th December. This point is also picked up by the SIRI. Again, it may be that the prospect of having to complete lengthy documentation, on a busy Wednesday morning, was a factor in this. It would appear that the assessment was in fact done, and it is entirely possible that the assessment was correct at the time, but that the recording of that assessment was very brief.

f. It remains unclear what the prognosis was for Mr V when he was discharged on the afternoon of 10th December. Was he being discharged to die? Was he being discharged with a watching brief? Either way, it would have been helpful if the people who knew him best (ie his agency carers) had been involved in the discharge plan. They ought to have been told very clearly what kind of care they would be expected to offer Mr V over the coming days and weeks. In the event it appears they were simply informed

that he was about to be discharged. Mr V's GP should also have been given this information.

g. Similarly, a referral to the hospital social work department could have been considered as part of the discharge plan, as they could have liaised with his agency carers, and/or with his GP, to make Mr V's return home more supported. The social work department, if they had been involved, could also perhaps have questioned the basis on which he was deemed to have capacity to decide about his own treatment.

h. A final observation is that a good knowledge of how to implement and record the Mental Capacity Act has been a feature of this whole case. Isle of Wight Council has commissioned a series of Mental Capacity Act training sessions during 2015/16, aimed at social care staff in the statutory and independent sectors. Overall take-up of places has been low, and at least two sessions have had to be cancelled because of this. There may be an argument, budgets permitting, in favour of opening up these courses to health professionals as well.

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