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'Gross failure' in man's care led to death from constipation

Article by Amelia Hill

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Inquest into death of man with Down's syndrome criticises care home and hospital over his treatment

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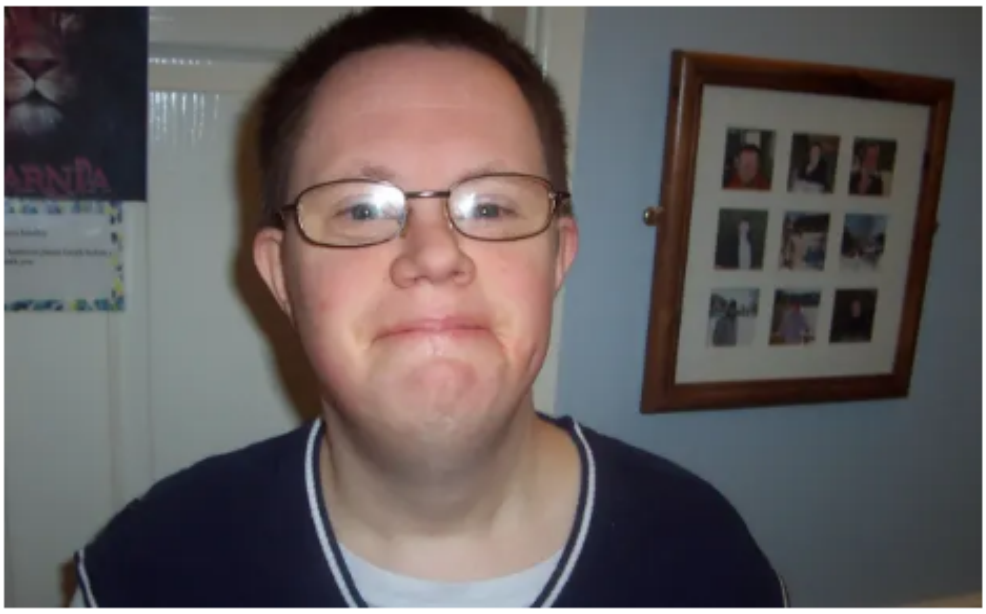

Richard Handley died suddenly in Ipswich hospital in November 2012. Photograph: Family

An inquest into the early and preventable death of Richard Handley, a young man who had Down's syndrome and suffered lifelong constipation, has found "gross [and] very significant failures" at almost every stage of his care.

The coroner, Peter Dean, criticised Mr Handley's care provider, GP practice, psychiatrist, social workers and staff at Ipswich hospital when he recorded a narrative verdict at Ipswich coroners court. The multiple omissions of care, he said, created an "extreme and tragic situation" that led to Mr Handley's death from constipation, a "condition that one is not expected to die of".

Aged just 33, Mr Handley died suddenly in Ipswich hospital in November 2012 after a heart attack caused by inhaling his own liquid faeces, vomited up because his bowel was severely obstructed by faecal impaction. His abdomen was, one doctor noted, the size of that of a woman who was 40 weeks' pregnant.

The coroner made a finding of gross failure in the actions of Ipswich hospital. The inquest heard that the hospital did not respond appropriately to Mr Handley's increased Modified Early Warning Score (Mews), designed to flag any deteriorating changes in a patient's condition.

Changes to Mr Handley's diet and the decreased monitoring of his bowel movements at his care home also contributed to his worsening constipation

and ultimately led to his death, law firm Hodge Jones & Allen said.

The coroner criticised Bonds Meadow, a care home where Mr Handley lived from 1999. Bonds Meadow deregistered and became a supported living facility in 2010. That transition, he said, led to "significant changes" in Mr Handley's care.
facility, and unknown to his family, Mr Handley was taken off his strict diet. The court heard that careful monitoring of his health was downgraded or stopped, and his medication was changed to one with a known side-effect of constipation.

In evidence heard by the coroner, Mr Handley's key worker admitted he did not know he had the chronic bowel condition that would go on to kill him.

In the days leading up to his death, the coroner stated that there were many opportunities to save Mr Handley. Instead, the court heard evidence that he was failed by everyone responsible for his care.

The coroner said there were "gross failures" on the part of Ipswich hospital after Mr Handley was admitted days before his death. "The evidence we heard was that [Richard] still should have survived when he was attended with appropriate management," said the coroner. "[But] potentially life-saving treatment that should have occurred was missed ... that could have been conducted before Richard's condition worsened and his death from complications of the condition occurred."

The inquest heard that two days before Mr Handley died in 2012, medics removed 10kg of faeces from his bowels. That turned out to be just a small amount of the total in his body: the postmortem revealed that much more had become impacted in his bowel.

After the operation - while receiving what the hospital has admitted during the inquest was inadequate care - Mr Handley vomited up, then inhaled, liquid faeces. He had a heart attack from which he never regained consciousness. He died shortly afterwards.

▲ Richard Handley with sisters Emily and Lucy. Photograph: Family handout

Mr Handley's mother, Sheila, said: "Given the evidence we've heard in court, and the gross failures and missed opportunities noted, we are profoundly disappointed that the coroner felt unable to make a finding of neglect. The coroner did, however, recognise that without our diligence and persistence, many of the reviews into Richard's death would not have occurred and the inquest would not have been able to explore the extent of the failings in his care."

His sister, Emily, a senior clinical psychologist employed in a mental health service for people with learning disabilities, agreed. "Richard died an appalling death. It is difficult and harrowing to imagine how much pain and discomfort he must have been in, for quite some time," she told the Guardian.

The coroner said he was unable to record a finding of neglect as the cause of Mr Handley's death because "it's difficult to aggregate smaller failures by different agencies at different times to make one gross failure; there were undoubtedly failures at different times. What is significant is the fact that different agencies involved in Richard's care have undoubtedly worked hard to learn lessons from the circumstances of Richard's tragic death," he added.

Sheila Handley said: "Richard was wholly reliant on health and social care services to exist, and now he doesn't."