

EXPERT'S REPORT

of the

PD INCIDENT

By:

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November 10, 2010

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A. INTRODUCTION

On May 17, 2008, 46 Year old PD, diagnosed with multiple disabilities, was taken from his residential group home by a direct care provider on a community outing. During this outing PD was given pizza and a beverage for a meal and left unattended. The food selection and the manner in which it was presented to him were contraindicated to his dietary restrictions. While eating this food, he suffered anoxia, due to airway obstruction, and died on March 16, 2009.

Robson Forensic was retained to determine if the caregiver, HB, employee of XXXXX Inc., violated the standard of care for health and safety and supervision in a manner that caused PD's death.

B. MATERIALS AVAILABLE FOR REVIEW

1. PD's Individual Support Plan
2. Medic Rescue Ambulance Service Report
3. Commonwealth Medical Center Medical Rescue Report
4. Police Department Incident Report

C. BACKGROUND

PD was a 46 year old man diagnosed with profound mental retardation, dysphasia, impulse control disorder, cerebral palsy, mild hearing loss, and depression. He resided in a residential group home owned and operated by XXXXX, Inc located at XXXXXXXXX, Pennsylvania. At the time of this incident, HB, an employee of XXXXX, provided direct care for PD. As a direct care provider she was considered part of the rehabilitation team that supported PD's individualized goals.

PD's overall goals were reflected in his Individual Support Plan (ISP) which is essentially a blueprint of his personal goals, functional strengths and functional limitations.

HB was part of a community support team involved in helping PD to meet his goals of increased travel. Intermediate overnight trips were recommended in his ISP in order for him to be able to build up the endurance for longer trips. These trips were also viewed by staff as an opportunity to afford him more 1:1 attention/time with staff (ISP;29). Staff chosen to assist PD on "vacation" should be familiar with his wants/needs (ISP;30). HB had taken PD and another disabled adult from the residence on this trip.

According to the police report, at the time of incident, PD and another adult male with a disability were in the home of HB's friend. HB gave PD pizza without cutting his food into dime sized pieces or adding a thickening agent to his beverage as per specification within his ISP. She then left PD and went onto a separate floor in the home, tending to the other individual, leaving PD unattended with his food.

Police investigation reports that HB said she heard PD cough and choke. After 1-2 minutes the coughing stopped and she heard a thump. (PR; 4) It was at that point that she descended the stairs and found PD unconscious, unresponsive and blue. She conducted a finger sweep of his mouth and called 911.

She did not perform CPR or First Aid. Emergency medical reports indicate that they arrived within one minute after the call and found patient in cardiac arrest and supine on the floor. They initially removed ten large pieces of pizza from PD's mouth and that each time CPR was attempted; more pizza surfaced making the clearing of his airways difficult. The pizza was removed with a laryngoscope and forceps in order to reach between the patient's vocal cords to remove additional food prior to intubation. (PR;5) PD was brought to the hospital for emergency care and died of anoxia due to airway obstruction the following day.

D. ANALYSIS

PD's injury was the result of being given inappropriate, ill prepared food and then having been left unattended. As a result, he obstructed his airway with food and choked.

As services by direct care staff are often provided on a 24/7 basis, workers will vary according to shifts and coverage. In order that care is provided on a consistent and reliable basis, all staff is responsible to know the contents of the plan. According to PD's Service Plan, he required extensive 24/7 supervision in both his group home and while in the community due to safety issues. PD's ISP included a personal goal of increased travel in the community. This was to include overnight trips into the community setting. When taking an individual into a community arena, direct care staff is required to have all safety/medical emergency information in their possession and to increase their vigilance in supervision to ensure safety in the community. (ISP; 28-33).

In order to comprehend PD's functioning ability as it relates to this particular incident, it is important to understand three of his diagnoses; the classification of mental retardation, the restrictions of dysphasia and the nature of an impulse control disorder.

A diagnosis of **mental retardation** is comprised of two areas; intellectual functioning and adaptive functioning. The ability of a person's brain to think, process and make sense of their world in combination with the person's ability to perform activities of daily living. According to standardized intelligence testing, an average Intelligence Quotient (IQ) score of measurement is 100 (Cole, Cole & Lightfoot). An IQ score of 70-75 is considered to be in the range of mental retardation. According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-1V), mental retardation varies in severity. An individual classified with profound mental retardation, like PD, has an IQ score under 20-25. An individual with this diagnosis *may* be able to develop basic self-care and communication skills with appropriate support and training but will require a high level of structure and supervision. The American Association on Mental Retardation (AAMR) classifies mental retardation in a functional manner and reports that an

individual with profound mental retardation requires life-long daily support for most adaptive areas.

Dysphagia is a condition that affects an individual's ability to swallow.

(<http://www.oralflo.com/dysphagia.htm>) In PD's situation, according to his ISP, this condition required that his solid food be cut into dime sized pieces ("no bigger no smaller") and that a thickening agent be added to his beverages (p.18). When eating he was to drink periodically throughout his meal. These measures were instituted to ensure safe swallowing techniques and to minimize the risk of food aspiration.

An **impulse control disorder** is an inability to resist an impulsive act or behavior that may be harmful to self or others (DSM-IV).

PD had a combination of disabilities which required ongoing 24/7 supervision. (ISP; 7, 19) The need for this level of supervision was reflected through the directives in his ISP because he was unable to make decisions regarding his own health and safety. Due to the manifestations of the dysphasia, his ISP clearly defined his dietary restrictions and the techniques that were to be implemented to prevent food aspiration. For his safety, his food was required to be cut up in dime sized pieces, no bigger, no smaller. He had to have a thickening agent applied to his beverages and he was to drink periodically throughout his meal to wash the food down. It was important that PD did not store food in his mouth while he ate, including a finger sweep of the contents of his mouth if necessary.

PD's profound mental retardation limited his ability to understand that the food was not specifically prepared according to his dietary restrictions and his impulse control disorder limited his ability to wait. Without the ability to understand the consequence of his actions and the knowledge of his own safety, he basically saw the food, wanted the food, and ate it without the ability to protect himself.

Health and Safety

As a direct care service professional, HB had the responsibility for the safety and care of PD. In assuming this role, she was responsible to know and understand the manifestations of his disabilities as well as the content of his Individualized Service Plan. This knowledge should have provided the basic tools that she required to provide the necessary care for PD. However HB did not implement the basic safety measures clearly defined in PD's ISP regarding basic survival; eating and drinking, nor did she have a practical understanding of how his combined disabilities affected his behavior. Additionally, HB did not employ basic FA and CPR, a 'best practice' training for all individuals who work with a disabled population, especially in a residential facility. During this emergency, this lack of knowledge and ineffective response to PD's choking resulted in his eventual death.

Supervision

PD's ISP defined a normal staff: resident ratio of 1:2. He required this intensive care as a result of the functional limitations imposed by his multiple disabilities and his inability to make appropriate decisions regarding his health and safety in the home and in the community. When PD participated in a community integration experience, he was not capable of providing self identification information when needed or in knowing the names and dosages of his medication prescriptions. He did not know social and physical safety rules of the environment, especially a

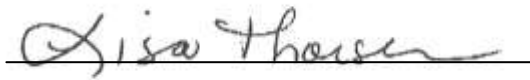
new environment. As a result of these limitation, it was the responsibility of the care giver to know this, provide the boundaries when necessary, protect him in every environment, especially unfamiliar ones, and have his medical documentation in her possession at all times. This documentation should have included medical diagnosis, medications and allergies. HB had no emergency medical information in her possession. As a result, the emergency medical staff did not have this information available to them during PD's initial treatment. In effect, they were treating PD without the full knowledge of his medical history or ramifications of his multiple disabilities.

E. FINDINGS

Within the bounds of reasonable technical certainty, and subject to change if additional information becomes available, it is my professional opinion that

HB violated the Standard of Care for Health & Safety & Supervision in a manner that resulted in the death of PD:

- a. While responsible for PD's care, HB did not implement the safety measures that were necessary for PD's basic survival; eating and drinking.
- b. Once HB became aware that PD was in physical distress, she failed to perform First Aid or CPR techniques.
- c. Once medical professionals arrived on the scene, she did not have the necessary medical documentation in her possession to assist emergency medical staff for treatment.
- d. HB did not provide the level of vigilance necessary in supervising a severely disabled individual on a community outing.



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RESOURCES

American Association on Mental Retardation (AAMR)

Cole, M., Cole, S., & Lightfoot, C. *The Development of Children*. New York: Worth Publishers, 2005.

Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association. 4th edition.