‘Annie’ 7 Minute Briefing

What has changed since Annie’s death?

Significant change since Annie’s death includes:

1. Increased staff awareness and championing equality of access to services for learning disabled people.

2. The purple pathways (created by Imperial College Healthcare Trust) expanded to GPs, outpatients and pre-operative assessment; reported to be making a difference

3. **Systems and governance processes for the delivery and monitoring of annual health checks strengthened**

Who was Annie?

Annie was a lady with a severe learning disability who also had multiple physical health conditions and could only communicate using her eyes and facial expressions.

Annie was dependent on professionals for all her care and support needs.

Annie was described as a beautiful person with a positive energy and personality that people naturally warmed to.

What happened?

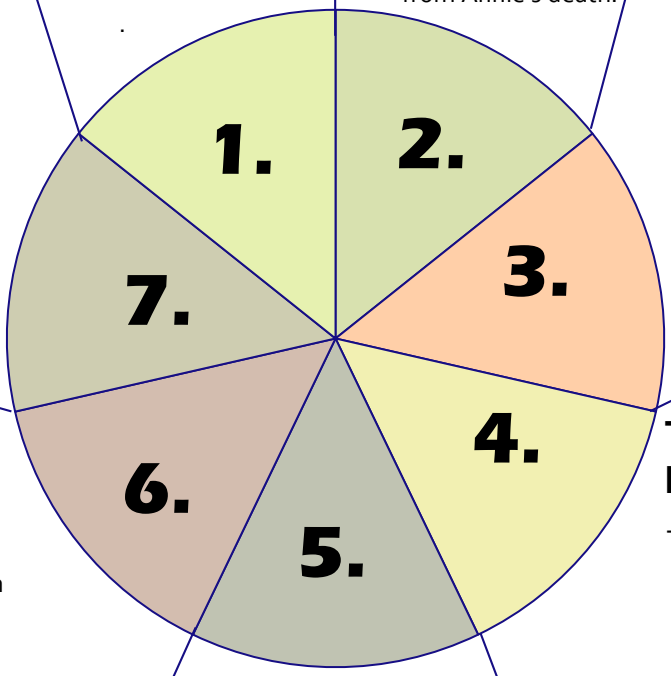
Annie was a young lady when she died from previously undiagnosed bowel cancer. Annie had been admitted to hospital from her care setting just 3 days beforehand.

A safeguarding enquiry was undertaken due to concerns about neglect. The case was then considered under Section 44 of the Care Act as it was established there were lessons to be learned from Annie’s death.

Undertaking a Review

The Safeguarding Adults Executive Board commissioned a **Learning From Lessons Review (LLR)** into Annie's death.

The aim of the LLR was to promote effective learning and build trust to ensure people with profound and multiple disabilities have equal access to services and treatment for their health needs, so as to prevent future deaths or serious harm occurring again



Learning

Annual Health checks for Patients with Learning Disabilities

Research shows that people with a learning disability have poorer physical and mental health than other people. Annual health checks were introduced as a reasonable adjustment to improve health outcomes for learning disabled people.

A working group was set up to review the process for annual health checks and to implement a checklist section within hospital discharge summaries so GP’s can review health plans for patients when required.

GPs can flag learning disabled patients when referring to other services.

Learning

Reasonable Adjustments and Best Interests

The review established professionals didn’t plan and implement reasonable adjustments to enable Annie to access diagnostic tests. Annie could not consent to treatment and so required professionals to act in her best interests when making care decisions. Key areas for learning were the need for:

1. Clear referral pathways for assessment
2. Reasonable adjustments to be put in place
3. The Purple Pathway used to understand the needs of learning-disabled people

Themes from the LLR

The LLR identified **significant gaps in practice and processes** by the services Annie was known to. Annie had been referred for investigations 12-18 months before her death but the **extent of her physical and also her learning disability was not considered** at key times when she was seen by professionals. This resulted in the symptoms reported by Annie’s carers and family not being fully investigated.

The LLR found there was **a lack of coordinated partnership working and multi-agency response to Annie’s needs.**

SAFEGUARDING ADULTS EXECUTIVE BOARD

NHS Imperial College Healthcare NHS Trust

NHS North West London Clinical Commissioning Group

NHS Central London Community Healthcare NHS Trust