

A Life Cut Short

Investigation of C.A. – A Student in District of
Columbia's Sharpe Health School

August 13, 2004

University Legal Services, Inc.
220 I Street, NE Suite 130
Washington, D.C. 20002

The Protection and Advocacy Agency
for the District of Columbia

This report was authored by University Legal Services Consultant and Nurse Investigator, Andrea Procaccino, R.N., J.D.

Other ULS staff who worked on the report and investigation of C.A.'s death were Elizabeth Greczek, Mary Nell Clark, Kelly Bagby and Tiffany Pertillar. For more information or additional copies, please contact:

Jane Brown
Executive Director
University Legal Services
(202) 547-0198

University Legal Services undertook an investigation of the death of C.A. that included a review of records provided by the District of Columbia Public Schools, Sharpe Health School, and the District of Columbia Child and Family Services and interviews with the District of Columbia bus transportation staff, as well as with C.A.'s foster mother.

Sharpe Health School is a District of Columbia day school that provides services to students in wheelchairs with cognitive deficits who have complicated medical needs.

INTRODUCTION

C.A. was 13 years old at the time her death. She was diagnosed with spastic cerebral palsy, developmental delay, microcephaly, history of a seizure disorder, gastrointestinal reflux with dysphagia, kidney disease, and hypertension. She was nonverbal. C.A. was placed into the custody of the District of Columbia Child and Family Services in April, 2000.

C.A. died on September 26, 2003. According to the autopsy report, the cause of death was "Volvulus (torsion of the mesentery of the small bowel) causing necrosis of the bowel." Volvulus is an abnormal torsion or twisting of a segment of bowel, which can lead to necrosis (death) of the tissue and release of bacteria. If not treated timely, the dead tissue turns gangrenous which causes an overwhelming infection which leads to death.

The symptoms are usually acute in onset and include severe abdominal pain, nausea and vomiting. Other symptoms include abdominal distention and rigidity. Rapid recognition of a volvulus and prompt surgical intervention are essential to decrease the

fatality rate associated with this condition. If prompt, appropriate treatment is rendered, the condition can be successfully treated.

SUMMARY

A review of the records reveals that on the day C.A. died, the nurse on duty at Sharpe Health failed to accurately assess and monitor C.A.'s condition in a timely manner, failed to take appropriate action when C.A.'s vital signs were unstable and she was exhibiting symptoms of significant pain, and failed to have her transported to an emergency room, even though the nurse's written note indicated that she believed C.A. needed immediate medical care at an emergency room.

Instead, C.A. remained at school throughout the day without medical treatment and was placed on the bus when school ended. According to the transportation staff, they were not informed by the nurse or other school personnel that C.A. was experiencing pain or that she needed medical attention. C.A. most likely experienced significant pain the day of her death and died on the bus on her way home from school.

REVIEW OF THE RECORDS/INTERVIEWS

According to the records, C.A. arrived at school on the school bus on the morning of September 26, 2003. C.A.'s foster mother reported to ULS that C.A. vomited a small amount of liquids prior to school but that otherwise she seemed fine. The foster mother stated that prior to sending C.A. to school, she checked the residual from C.A.'s tube feeding – a process where a syringe is attached to the g-tube and the amount of liquid food in the stomach is checked to determine if the tube feeding is being properly absorbed. The foster mother stated that there was no residual liquid food in her stomach, indicating that C.A. was absorbing her food. She also stated that C.A. did not appear to

be in pain. The foster mother stated that she called the school later that morning to inform them that C.A. had vomited clear liquids and that she wanted the nurse to check on C.A.

The records indicate that the school received the call at 9:20 a.m. and that the foster mother spoke to an administrative assistant at Sharpe Health School. The records indicate that the administrative assistant wrote down the message; however, there is nothing in the record to indicate that this information was relayed to the nurse or that the nurse went to assess C.A. until she was called by the teacher at 12:30 p.m.

The records indicate that C.A.'s classroom teacher stated that upon arrival to school C.A. was crying and sleeping alternatively, more than usual. It is not clear why the nurse was not called and/or did not assess C.A. as soon as she exhibited these symptoms, especially since the school had received a call from C.A.'s foster mother.

The Sharpe Health teacher states that she took C.A. out of her wheelchair at noon, placed her on a mat and began her tube feeding. The teacher also stated that at that time she noted that C.A. was crying and that "her eyes looked weak" so she called the nurse to assess C.A.

The records contain a single brief nurses' note for the day of C.A.'s death which is dated 9/26/03 at 12:45 p.m. and that states, "H.U. alerted re: student crying at intervals and appeared uncomfortable. T 99.6. BP 80/50, Resp 28 and whining at intervals. TC to foster mom [] at 1p.m. re: C.A.'s condition requesting TC from mom. No return call from mom. Referral sent home."

The records indicate that, when interviewed, the Sharpe Health nurse stated that when she went to the classroom, she found that C.A.'s vital signs were stable but that she

was breathing more rapidly than normal. The record indicates that the nurse took C.A.'s vital signs only one time throughout the day. The recorded vital signs (see note above) are NOT what are considered stable vital signs, but to the contrary, indicate that C.A. was in a medically unstable state. A blood pressure of 80/50 is below the normal range. Although some children have low blood pressures, the records indicate that C.A. was taking medication for high blood pressure since at least 2002. (Medical records prior to that date were not available at the time of ULS' review, although the DC Child and Family Services fatality review report indicates that C.A. was hospitalized in December, 2001, for a bowel obstruction and weight loss. A history of a bowel obstruction placed C.A. at further risk of developing an obstruction or a volvulus. It would be incumbent upon the nurse to familiarize herself with C.A.'s medical history which should have been in the school records).

A consultation note from her nephrologist dated 8/15/03 states that C.A. had kidney disease and hypertension (high blood pressure) and that her blood pressures were typically ranging from 120-140/80-90. Therefore, a blood pressure of 80/50 would be alarmingly low for C.A.

In addition, the Sharpe Health nurse did not record a pulse rate, which is standard procedure when taking vital signs. A pulse rate is critical in determining whether a person is stable or in critical condition. Also, a respiratory rate of 28 is high, and along with a low blood pressure, a rapid respiratory rate and the appearance of significant pain, indicated that C.A. was medically unstable and in need of immediate medical attention.

There is nothing in the record to indicate that the Sharpe Health nurse conducted a proper assessment. A proper assessment would have included a physical examination of

C.A. including palpation of the abdomen (pushing on her abdomen to determine the extent of her pain), and checking her g-tube feeding for residual. There is no indication in the records that the Sharpe Health nurse did an assessment, despite the information the school had received from the foster mother that C.A. had vomited in the morning, that her vital signs were unstable and that she was observed to be crying in pain throughout the day.

The records indicate that the Sharpe Health nurse, when interviewed, stated that after she left C.A., she called the foster mother at 1 p.m., got no response and left a message. She stated that at 2:30 p.m., she got off duty and that she had not received a call back from the foster mother so she sent a note home with C.A. A copy of the note is in the records and it states, "Appears very uncomfortable- crying at intervals-also seems lethargic, respirations rapid. Please evaluate re: emergency room ASAP. T.C. to [foster mother] at 1 p.m. re: same- no return call as yet."

The records indicate that at 3 p.m., C.A. was placed on the DCPS bus to go home. The foster mother and the transportation staff indicated that the average time of the bus ride home was normally 1 to 1.5 hours. The bus driver told ULS that when they loaded C.A. on the bus, that her "eyes did not look right," and that she was concerned. The driver states that she told one of the Sharpe Health School aides (she could not recall the person) that C.A. did not look right to her. The driver states that the aide told her that C.A. always looked like that and that she was fine. The driver and the bus attendant stated that at no time did anyone inform them that C.A. was ill or that they should assess her more closely on the ride home. Aside from her own observations, the driver stated that she had no idea that anything was wrong with C.A. that day. She was not aware of

any note being sent home with C.A. on the day of her death or even on the day that ULS interviewed her months later.

In her written statement in the records, the driver stated, “I noticed that C.A., for some reason, didn’t look right to me in her eyes so I kept an eye on her the whole time. She was making a whining sound when she was brought to the bus and all the way until I left [another student off at home.]” The attendant stated that he did not observe anything unusual about C.A. on the ride home or when he was unloading the other children at their stops.

The DCPS driver stated that when they arrived at C.A.’s stop and began to unload her, they noticed that C.A. was blue and was not breathing. They stated that they ran to the house to get help and that the foster mother called 911 and started CPR. In her interview with ULS, the foster mother stated that C.A. was cold and stiff when she arrived home. She stated that she did not discover the note that was sent home until hours later and that she found the note at the bottom of C.A.’s backpack. The foster mother also stated that she did not receive a message from the Sharpe Health nurse the day of C.A.’s death and that her caller ID did not indicate that the nurse had called her house or her cell phone.

SUMMARY OF SHARPE HEALTH NEGLECT

1. It is not clear from the record if the nurse ever received the message from the mother that C.A. had vomited in the morning. If she had been notified, the nurse could have properly assessed C.A. after the foster mother had called the school at 9:30 a.m. A proper assessment could have revealed symptoms indicating that

- C.A. was experiencing a bowel volvulus, i.e., a hard abdomen with pain on palpation and abnormal vital signs.
2. The Sharpe Health teacher, noted that C.A. was crying and sleeping more than normal throughout the morning, yet the records indicate that she did not call the nurse until 12:30 p.m.
 3. When C.A. was seen by the Sharpe Health nurse at 12:30 p.m., there was no indication that the nurse assessed her or responded appropriately to C.A.'s abnormal vital signs. Again, if she had examined C.A. at 12:30 p.m., she most likely would have noted that C.A. was experiencing symptoms of a bowel volvulus. The Sharpe Health nurse stated that C.A. seemed to be experiencing great discomfort, one indicator of a serious medical problem, yet she inexplicably did not assess C.A. to find out where her pain was or what was causing it. Ascertaining the location, duration and cause of pain is critical when assessing a child that cannot verbally communicate.
 4. In addition, the records indicate that the Sharpe Health nurse took C.A.'s vital signs only one time and that she concluded that they were "stable" when in fact C.A.'s blood pressure was low and her respiratory rate was elevated. The nurse should have also been familiar with C.A.'s medical history for a bowel obstruction and high blood pressure, both of which would have further indicated a need for immediate medical intervention.
 5. According to the records, the Sharpe Health nurse stated that she left a telephone message for C.A.'s foster mother at home and sent a referral home instructing the foster mother to take C.A. to the emergency room as soon as possible. The

transportation staff stated that the nurse did not inform them that C.A. was in need of medical attention. The foster mother stated that she found the note hours after C.A.'s death in the bottom of her backpack.

6. The Sharpe Health nurse's actions the day C.A. died violate the standards of nursing practice. A nurse has a responsibility to accurately assess and monitor a child exhibiting symptoms of a serious illness. Furthermore, a nurse, or any school personnel must ensure that a child who is in need of immediate medical attention receives it. It defies all nursing standards and common sense to place a child that needs emergent care on an hour long bus ride with buried instructions for the parent to seek emergency medical treatment.

TRANSPORTATION STAFF CONCERNS

The DCPS bus driver and the attendant that I interviewed both expressed deep concerns regarding the lack of training that they receive to transport children with disabilities. The DCPS bus attendant stated that he received no training regarding transporting disabled children and that he believes that it is critical that all persons providing services to these children should be properly trained. He also stated that some of the children have significant medical issues that the transportation staff persons are not informed of.

The DCPS driver stated that she frequently does not know any medical information about the children she is transporting. She stated that in addition to training, she would like mandatory meetings instituted with the school nurse, teaching staff and

transportation staff (with the option of parents and guardians attending) to provide pertinent health information for each child riding on a bus.

RECOMMENDATIONS

Policies and procedures must be in place before school starts on September 1, 2004, to ensure the safety of students who require medical attention during school hours. Given the seriousness of the situation, immediate, intensive training by highly qualified professionals must be provided to all nurses at Sharpe Health School, with student-specific instructions. Some of these children are the most vulnerable individuals in the District of Columbia and they require proper care and services. Similar training must be provided to all nurses serving DCPS wherever medically fragile children attend.

Moreover, DCPS must ensure that nurses providing services to all children in D.C. schools are highly qualified and trained. Teachers and bus drivers must receive student-specific training where there are potential concerns about a specific child. In addition, DCPS must provide training to all teachers and bus drivers so that they are able to identify sick children, and they must be trained in the appropriate responses, including notifying nurses and parents and notifying emergency services immediately when needed.

Furthermore, the Child and Family Services Administration must monitor the safety of children in its legal custody, ensuring that schools have critical medical information about each child and are responding with appropriate care.

History and Authority of University Legal Services

In 1996, ULS was designated the protection and advocacy (P&A) program for the District of Columbia. The federal P&A grants require ULS to investigate allegations of abuse and neglect of people with disabilities. Moreover, ULS provides administrative and legal advocacy to protect the legal and human rights of individuals with disabilities. The P&A's authorities include Protection and Advocacy for Individuals with Mental Illness Act (PAIMI); the Protection and Advocacy for Developmental Disabilities Act (PADD); and the Protection and Advocacy for Individual Rights (PAIR).

Under our P&A grants, ULS staff directly serve hundreds of individual clients annually, with thousands more benefitting from the results of investigations, class action litigation and group advocacy efforts. ULS staff address client issues relating to the improper use of seclusion, restraints, medication, abuse and neglect, community integration, wrap around services, accessible and affordable housing, financial exploitation, access to health care services, individual choice, employment, benefits, special education, and the care and treatment of people with disabilities.