Submission by Nic Hart

to the

SI Enquiry for Averil Hart

Averil Hart

21st December 1992 – 15th December 2012

Averil Hart died on the 15th December 2012 a few days before her twentieth birthday, after a courageous battle with Anorexia Nervosa. She is the daughter of Nic and Miranda Hart and loving sister to Imogen and Zoe Hart.

Averil spent ten months in recovery at Addenbrooke's ward S3 and then after regaining her health went to the University of East Anglia to study Creative writing for which she had a marvellous talent.

Averil enjoyed a full life at School partaking in a range of social activities and team sports and achieving six A levels at grade A. She was also a lovely musician and sang beautifully. She enjoyed being part of a wide circle of friends with a loving boyfriend, Alex Highfield.

This series of observations and questions to the SI enquiry is dedicated to finding out why Averil died having spent only ten weeks at University and after such care and attention had been made towards her recovery at Addenbrooke's ward S3 during the previous twelve months.

In particular the questions aim to find out why the MARSIPAN and NICE guidelines that are clearly laid out for the care of patients with Anorexia Nervosa were not followed and find out what failings occurred in both primary and secondary care.

Averil fought for ten weeks to remain at University and study the subjects that she loved, a battle that was fought on many fronts and often it appears without the professional help and medical care that she so badly needed.

My request to the SI enquiry and any investigations that may arise, is that questions are raised and answers found to cover the entirety of Averil's care across service boundaries so that lessons learned may be passed forward to all agencies concerned.

Nic Hart 18th March 2013

Note ** refers to Critical incident concerns

Table 1. Treatment in the community pre-admission to Addenbrooke's SC3.

Ref.	Date		Event	NICE/MARSIPAN guideline reference	Critical incident Consideration	Related Question(s)
1.1	03.08.11	Relapse Risk	Averil attends COPE sessions in Colchester and attends local GP. Weight loss continues rapidly for several weeks despite therapy.	Basic Risk Assessment in Anorexia Nervosa	Averil's referral from primary to secondary care on an urgent basis should have highlighted the rapidity of her weight loss.	Was a table of records maintained within Averil's medical notes as recommended in MARSIPAN ? Was the therapist or organisation aware that therapy below a certain BMI may not prove to be effective (Mental capacity and state) ?
1:2	To 03.08.11	Rapid Weight loss	Phoned by Suffolk health (SH) care team to highlight the high risk and told immediate hospitalisation requirement (told not to drive and remain inactive). Averil is admitted to Addenbrooke's ward S3 for intensive treatment.	* SH team appreciated the very high risk at low BMI's and tendency for patients to over exert themselves risking cardiac and other serious risks to health	Historical notes from this period would have provided important clues to possible problems to be encountered later and once at University in 2012	Were Averil's historical medical notes from this period considered in formulating her care plan and risk analysis at University in 2012 ?

Table 2. Treatment at Addenbrooke's ward SC3

Ref.	Date		Event	NICE/MARSIPAN guideline reference	Critical incident Consideration	Related Question(s)
2.1	03/08/11	Relapse Risk	The team at Addenbrookes S3 saved Averil's life in 2011. The staff worked a miracle to return Averil's blood chemistry to normal and initially stem Averil's weight loss which was very low by the time of admission and then slowly but surely over the period of ten hard months bring Averil back to good health. Averil was discharged on August the 3rd but from comments made to me by Averil, she may not have been ready to handle the transition that was required at University and was struggling to reach her goal weight ?	Fulfilment of many of the MARSIPAN guidelines and recommendations whilst at S3		Once Averil's health had stabilised, was an outpatient option with continued specialist unit visits considered for Averil at UEA (as an interim measure) whilst in a "high risk transition phase" at University?

3. Averil's discharge from S3

A care plan was devised, however, although it stated that Averil had a "high risk of relapse", there is little evidence of a co-ordinated risk analysis or plan in conjunction with primary care in case of relapse or contingencies if the care plan did not operate as anticipated.

Table 3 Averil's discharge from S3

Ref.	Date		Event	NICE/MARSIPAN guideline reference	Critical incident Consideration	Related Question(s)
3.1	03.08.12	Relapse Risk	Addenbrooke's S3 Discharge care plan states "High Risk of relapse"	Basic Risk Assessment in Anorexia Nervosa following discharge. NICE 1.1.1.2 Risk at transition.		Was this risk of relapse understood fully by the NCEDS RMO taking over responsibility for care of Averil at University ? If the risk was appreciated, what special measures were put in place to ensure that relapse did not take place?
3.2	31.07.12	Rapid weight loss	CPA Care plan of the 31/07/12 states "Averil's weight loss may be sudden and she may become frail and prone to falls"	MARSIPAN "ensure that robust plans are in place" NICE 1.1.1.4	Primary and secondary care co-ordination.	Did NCEDS understand the risk of sudden weight loss in Averil's case history and discharge (reference her initial weight loss prior to admission to S3) ? Was this critical part of the care plan passed to the UEA medical team for monitoring at the primary care level ? and what feedback was required on a weekly basis ?

3.3	31.07.12	Weekly weight check	CPA Care plan of the 31/07/12 states "to be weighed weekly and have bloods every two months during the early stage of discharge and at University"	Basic Risk Assessment in Anorexia Nervosa following discharge. With management of family concerns. Agreement in writing between health care professionals for monitoring which should be shared with the patient and where appropriate the family. NICE 1.1.1.4 NICE 1.2.4.5 NICE 6.4.13.2 People with AN and their carers should be informed if the risk to their state is high.		How did the primary and secondary care teams communicate to ensure that Averil's care plan was progressing satisfactorily on an on-going basis, particularly with regards to the health parameters that had been requested ? Was information sharing with the family about Averil's high risk considered in the discharge care plan ? Why was the high level of risk not made known to Averil's family as part of her care plan, making contingency arrangements with them in case of relapse ?
3.4	31.07.12	Follow up	Instructions were issued to primary and secondary care agencies as above.	Agreement in writing between health care professionals		Did S3 identify if the new Care co-ordinator and RMO appreciated the high risk of relapse in Averil's case and her prior history of rapid weight loss ? Having spent ten months caring for Averil and arranging a hand-over to NCEDS and UEA medical centre, what follow up was undertaken to ensure that these agencies had received, understood and importantly that they would undertake the instructions imparted in the discharge care plan ?

4. University 23rd September 2012 to November 27th 2012 (NCEDS)

Averil's health care was transferred to NCEDS, a specialist team that are experienced in managing patients with severe eating disorders and commenced University at the UEA in Norwich, Norfolk.

MARSIPAN is clear that such transitions are particularly hazardous for patients in moving between services and also undergoing major life changes.

Despite all the known risks in such transitions, Averil commenced university without proper initial care and her health was allowed to decline in the very first weeks with no intervention and without the proper monitoring specified in her care plan.

As term progresses Averil struggled to stay at University rather than return to the "half life" she called her time in ward S3.

The medical and professional help that she required and that was outlined in her care plan appears not to have been provided (from the case notes so far provided to me). There appears to be very little or no record of the main health parameters being recorded on a weekly basis (either in the case notes or on a graphical basis).

Monitoring of these medical parameters form a vital part in monitoring the health a young person with Anorexia Nervosa in the community and going through stressful life changes.

Table 4. University 23rd September 2012 to November 27th 2012 (NCEDS)

Ref.	Date		Event	NICE/MARSIPAN guideline reference	Consideration	Related Question(s)
4.1	30/07/12	Transfer to NCEDS	Dr Spencer at S3 wrote to Dr. Serfontein concerning the transfer of Averil's care to NCEDS. This gives plenty of time for her care plan to be provisioned and established. Dr. Spenser also refers to setting up a primary care path.	Transition care NICE 1.1.1.4 as above		Given nearly two months prior notice why was Averil not seen by NCEDS until three weeks after she commences university ?

4.2	03/08/12	Care co-ordinator	Dr. Spencer writes regarding Averils dischare plan and follow up arrangements. He states: NCEDS will follow up when she starts university in mid September. A ***care co-ordinator*** will be assigned then.			Who was assigned as the care ***co-ordinator*** and Averil's RMO ? Was the assignment of the care co-ordinator documented ? Was Averil's care co-ordinator fully appraised of the high risks that Averil faced ? Did Averil's care co-ordinator make themselves known to Averil's family members to assist in the overall care plan ?
4.3 **	03/08/12	Basic Monitoring	Dr. Spenser's discharge letter states "GP please check Averil's physical health every week. ***Weight, BP, heart rate and level of physical strength – squat test.*** "Please monitor her bloods every 2-3 months including U&E's, bicarbonate, LFT's, bone profile, muscle CK, Magnesium and phosphate".	MARSIPAN recommendation 2 "Physical risk assessment in these patients should include BMI, physical including muscle power, blood tests and ECG		Were these vital checks undertaken weekly ? Did the care co-ordinator liaise with the primary health team at the university to maintain these records? Did the health care co-ordinator pass the results of any of these vital checks and measurements on to the RMO at NCEDS for review? Did the RMO at NCEDS respond to any information concerning these vital checks and pass instructions on changes to Averil's care plan to the rest of the NCEDS or UEA medical team ?
4.4	23/09/12	Risk Assessment	In the case notes to her counselling psychologist Averil expresses her concerns about the challenges of attending university.	Basic Risk Assessment in Anorexia Nervosa. Transitions – coping with change.	Risk assessment at discharge from ward S3 clearly states: "High Risk – on own relapse possible"	Given the anxiety and apparent stress that Averil was under in her new environment, what assessment was made of this on her mental and physical health ? So why were measures not taken to minimise the risk and protect Averil, with a proper brief to the team of necessary measures and checks to ensure that she maintained her weight and health, and ensure that "relapse" did not occur ?

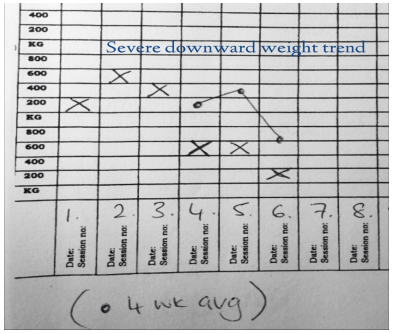
4.5	23/09/12	Transfer to NCEDS	Averil enrols as a student at UEA and her medical care is transferred to NCEDS	MARSIPAN states when a patient is transferred from one service to another there should be a properly conducted and recorded meeting between the representatives of the two services and the family, so that it is very clear what will happen during and after the transfer of care and who is responsible for what. Such meetings should be continued until after the transfer is satisfactorily achieved.		Did Dr. Serfontein or the RMO meet Averil at the handover to Norfolk NCEDS ? Was a properly recorded meeting held ? Why were Averil's family not invited to attend the handover meeting ? (Note This is clearly recommended in the MARSIPAN guidelines).
4.6**	27.09.12	UEA Medical	Dr. Sarah Beglin writes to Dr. Zan Edmonds of the UEA medical centre on 27.09.12. In her letter Dr. Beglin requests "medical monitoring of this patient". Dr. Beglin encloses a copy of the discharge summary which requires: "check Averil's physical health every week. ***Weight, BP, heart rate and level of physical strength – squat test"*** Please monitor her bloods every 2-3 months including U&E's, bicarbonate, LFT's, bone profile, muscle CK, Magnesium and phosphate".	MARSIPAN Basic list of observations.		Why did Dr. Edmonds or one of his colleagues at the UEA medical centre not carry out (on an ongoing basis) the monitoring and health care requested by Dr. Beglin ?

4.7		Family	Averil was in regular contact with her Mother, Sisters and regular but more occasional contact with her father.			Was NCEDS made aware of the family dynamics and circumstances and did they take this into account in their communication and risk strategies ?
4.8		Key Contact information	No contact was made between NCEDS and members of the family to provide contact details for the family with Averil's care co-ordinator, RMO, Dr. Serfontein or other key team members.	MARSIPAN	By not providing information of NCEDS to both parents and other family members what contingency plan was made for emergency situations.	Why was key contact information and team responsibility and structure at NCEDS not passed to all the family members ?
4.9 **	04/10/12	Delays in commencing Averil's care plan	Averil commences university initially without apparent significant elements of the care that had been devised in her care plan (from the medical notes so far provided). On 4th October Averil is sent a letter from Dr. M. Tatham apologising for the delay in her treatment program, and suggesting an appointment for the 15th October 2012.	Lack of Basic transition care. Immediate weight loss and reduction of BMI sets in. MARSIPAN recommendations on transfer of patients between services	The transition phase is well understood amongst AN health professionals as a high risk area but appears to have been neglected by NCEDS at this critical time	Why did it take three weeks for the care plan to be initiated at this critical transitional phase, particularly after the original timely direction from Dr. Spenser in July, earlier in the year.
4.10		Relapse(s)	Note: Dr. M. Tatham had discussed relapse issues in NCEDS at a family day at Brooke House, Cambridge in December 2011, and was aware of the problems and crisis that had occurred previously with two other patients in the Norwich area.	See table 8 concerning "Systems Q's"		Why were there no lessons learned from prior incidents in Norfolk which resulted in patients being taken to A&E and re-admitted to specialist units after apparent neglect under community care, especially when the risks were well communicated at the family days ?

4.11 **	23/09 to 27/11/12	Primary Care	Averil registers with UEA medical centre.	MARSIPAN recommendation 5. "The role of the primary care team is to monitor such (AN) patients and refer them early. MARSIPAN Management of AN in primary care to include monitoring of ECG for patients with a BMI <15 NICE 1.1.1.4 as above		Did any member of NCEDS visit UEA primary care to discuss Averil's care plan ? (* NCEDS office is less than five miles from UEA). Did UEA medical centre receive a copy of Averil's discharge notice from S3 requesting weekly checks of vital health parameters? What initial health check did Averil receive on commencing university at UEA ? Did UEA centre or other clinician perform an ECG at any stage during Averil's care ? Did UEA medical centre or other clinician perform a SUSS test during Averil's care ? Did UEA medical centre or other clinician perform blood tests called for in Averil's discharge plan ? What co-ordination was arranged between the UEA primary health care team and NCEDS to review Averil's care plan on a regular basis ?

4.12 **	23/09 to 27/11/12	Changes to monitoring	In her letter of the 26th October 2012 to Averil, V.Powell (VP) (Trainee counselling psychologist), states that "GP visits do not need to include taking your weight"	This is in direct contradiction to Averil's discharge plan from S3, and could be considered a factor that introduced HIGH RISK to Averil' health care plan. NICE 2.1.4 AN mortality rates approach 10% which is 3 times higher than other serious psychiatric illnesses	Critical change to care plan (authorised by whom) Anorexia is one of the most dangerous mental illnesses in terms of mortality – and so changing a care plan requires careful clinical consideration	On what basis and whose authority did V. Powell suggest that weigh-ins and monitoring on a weekly basis at her GP should be abandoned. Did Averil's RMO know that she was not being weighed regularly by her GP ? Did Averil's care co-ordinator know that she was not being weighed regularly by her GP ? What changes were made to Averil's care plan to ensure that her vital health parameters would be monitored elsewhere ? Were the UEA medical centre informed of this change in regular weekly health checks ?
4.13	23/09 to 27/11/12	Weight BMI	In the notes supplied to me there appears to be no record of changes to Averil's care plan to reflect to the new regime of weight monitoring, eg BP, tests of muscular function and blood tests.			What record was made in Averil's medical notes of the change to her care plan wrt her routine weight measurement ?
4.14	23/09 to 27/11/12	Weight BMI	Apparent lack of external weight monitoring.		Increased risk	Was a new risk assessment made in Averil's care plan to include the change to her weight measurement. Regime (ie no primary care involvement).
4.15	23/09 to 27/11/12	Weight BMI	From the notes provide to me, Averil attended weekly meetings with the NCEDS Psychologist VP. With six recorded sessions.			Who with specialist **medical** knowledge of Anorexia saw Averil during her time at UEA prior to being hospitalised ? If there were other visits or meetings by medical personnel within the NCEDS team were these visits properly recorded with basic parameters that were called for in Averil's discharge plan ?

4.16	23.09 to 27.11.12	Weight BMI	Regarding Averil's weight measurement at weekly psychological & therapy meetings .	MARSIPAN : Weight and BMI recording	Also see table 8 regarding systems.	If VP was responsible for weighing Averil, was she trained to do so and aware of the problems associated with weighing AN sufferers ? Did VP actually weigh Averil on each occasion ? Was Averil weighed with or without outer garments and or with or without shoes or boots on ? How and where did VP actually measure Averil's weight ? When were the weighing scales last calibrated ? What is the policy for calibrating the scales (is it performed annually) ? Were the same scales used each time ?
4.17	23.09-27.11	BMI	Weight and BMI recording at weekly meetings			Did the measurements that were taken appear to be at odds with Averil's physical and mental state and capacity ?
4.18	23.11.12	Weight BMI	Averil knew that she was losing weight (and this was communicated to her family members) and she appeared to know that there was a risk of being transferred back to Addenbrooke's S3 if her BMI fell below a certain level. Therefore given the nature of AN, there was a high risk of her water loading or other techniques to falsify her weight.			What steps were taken to ensure accurate and true weight measurements were recorded and that none of the classic AN techniques for falsifying weight were not being used by Averil ?

4.19	23.11.12	Psychological care	Averil's weight recorded at 38.2Kg BMI of 14. Ineffective therapy at low BMI thresholds	NICE 1.2.2.4 Requires competency of health care professionals to assess physical risk	From meetings at S3 in 2011 we were informed that as BMI reduces below a certain level, so therapy and psychological care is unlikely to be productive (as mental capacity is impaired)	What measures were considered to change the care plan as Averil's weight reduced below a critical level. Was the Psychologist aware of the potential problems of continuing solely with therapy sessions below a threshold BMI ? What experience of determining this critical point did the NCEDS team have ? At what point did the care plan and risk analysis call for a change from weekly Psychologically based sessions to a more medical/clinically based approach given that it is unlikely that a sufferer is to be able to engage therapeutically at a low BMI ?
4.20	23.09-27.11.12	Weight BMI	The data for Averil's weight measurements whilst in the care of NCEDS appears to be scant, however, indications are that Averil's weight had declined considerably, particularly with doubt surrounding the validity of the last recorded weight on 23.11.12  Copy of the only weight chart from Averil's medical notes as provided to me.		Data TABLE of Weights	How many weight measurements were taken over the ten week period that Averil was in the care of NCEDS ? What was the trend of these observations ? What was the comment from the RMO on this trend and at what point was action to be taken if the trend continued ?

4.21 **	23.11.12	Medical Cover	In the notes of the session with VP on 23.11.12 VP states that she will "not be available for session next week"	GMC guidelines are clear that : "You must be satisfied that when you are off duty, suitable arrangements have been made for your patients medical care"		Given that Averil's weight, BMI and health were deteriorating seriously at this point in time, what arrangements with the rest of the NCEDS team had been made for medical cover from the team to ensure Averil's safety and continued support ?
4.22	23.11.12	Correct weight recording ?	VP states in her notes for the session on 23.11.12 that "Averil was very disappointed when she saw her weight loss of 0.4kg to 38.2kg. This entry in VP's notes is 5 days prior to Averil's visit with her sister and father. Both of whom confirmed that Averil appeared to be in very poor health (worse than when originally admitted to S3 in 2011. It is therefore inconceivable in my mind that this weight could have been correct (refer also to Averil's weight on admission to N&N A&E unit on 07.12).			What was Averil's physical condition like on this day ? What is the probability that the recorded weight on this day was incorrect ?
4.23	23.11.12	Exhaustion	VP states in her notes for the session on 23.11.12 that Averil " identified that activity both stops her gaining weight and leaves her feeling even more exhausted and that this exhaustion has a knock - on effect for her concentration at university"	NICE 1.2.2.6 as above		What was Averil's mental state and capacity like on this day (the notes talk about Averil's exhaustion) ?

5. University November 27th 2012 to 7th December (NCEDS)

Averil's sister Imogen and I visited Averil on 28th November in Norwich whilst she was attending UEA. We met in Norwich for a coffee and both Imogen and I were shocked at Averil's appearance and particularly by her mental capacity which was severely reduced. It was apparent that her BMI was clearly lower than when she had been previously admitted to Addenbrooke's S3.

Averil returned to her university accommodation after our visit and Imogen and I strongly agreed that Averil should immediately be re-admitted to hospital (given our prior experience of her admission in 2011). I called Addenbrooke's S3 and left a message to the effect that Averil was very seriously ill and in a worse condition to her prior admission to hospital. Given the nature of my call and the fact that I had not made any calls to S3 previously I envisaged that it would be taken seriously.

The following day, I met with Miranda and Imogen to discuss the events of the previous day. During this meeting we were telephoned by Carol Downe (staff nurse on S3), who confirmed that action had been taken and that we would ***not*** need to worry as the Norfolk team had been contacted. I expressed my concerns again and was informed that the Norfolk team was much improved and that Averil would be looked after.

Table 5 University November 27th 2012 to 7th December (NCEDS)

Ref.	Date		Event	NICE/MARSIPAN guideline reference	Critiical incident Consideration	Related Question(s)
5.1	28/11/2012		Imogen and Nic Hart visit Averil on the 28.11.12 whilst she is at UEA and were shocked by her appearance, her physical and her mental capacity. Slurred words and slow responses and extremely weak physical condition. Averil's physical condition indicated a BMI of 13 or less (reference her prior admission in 2011 to S3).	MARSIPAN Basic Risk Assesment in Anorexia Nervosa. NICE 1.2.26 as above NICE 1.2.4.4 Managing risk. Health care professionals should monitor risk. If there is increased risk, the frequency of monitoring and nature of investigations should be adjusted accordingly.		Given that both Imogen and Nic Hart had prior experience of Averil's AN condition and were still shocked and extremely concerned – how was it conceivable that only 5 days prior VP had spent time with Averil and had not come to the conclusion that Averil required immediate medical attention ?

5.2 **	28.11.12	Emergency Call 1.	Nic Hart calls unit S3 by telephone to speak to Carol Downe (Averil's nurse at S3) and leaves a message with the S3 team which clearly states concerns about Averil's mental and physical condition. In particular stating that Averil was in a "worse condition than when she had been admitted as an emergency patient in 2011, and calling for immediate action" This and subsequent phone call are referred to in Dr. Serfontein's email of the 30.11.12.	NICE 1.2.5.2 Inpatient or day patient should be considered for people with AN whose disorder has not improved with appropriate outpatient treatment.	It was understood that immediate and effective action would be undertaken.	What action was taken in response to this phone call ? What records were maintained regarding this emergency phone call regarding Averil's condition ? Who was called and in particular was the RMO and care co-ordinator made aware that day of the serious nature of Averil's condition ? Were the UEA medical team on the university campus notified of this call ? Who in the NCEDS team was informed of this phone call ?
5.3	29.11.12	S3 Response	Carol Downe returns Nic Hart's call and also speaks to Miranda Hart on 29.11.12 to say that NCEDS has been informed of Averil's deteriorating condition. Carol Downe also allays initial fears by saying that the Norfolk team (NCEDS) has been reformed and is much better than the team that been discussed during the previous "family days" and that Averil would be taken "good care of".		A timely response at this stage would have saved Averil's Life.	The message from S3 has been transferred to NCEDS and received by Dr. Serfontein – what appropriate action did he take to ensure Averil's ***immediate safety*** given the original risk assessment from S3 that Averil was at ***high risk of rapid weight loss and relapse*** ?

5.4 **	30.11.12	NCEDS warned of risk	In an email from Dr Serfontein to Dr. Brabbins regarding the emergency phone call(s) of 28.11.12 "Averil Hart's father visited her yesterday. He has not seen her in a month and was very concerned about her weight loss. He phoned the ward three times yesterday. " ***"I think she needs a medical review"***	Medical review consideration NICE 1.2.2.6 Consideration of inpatient care should be undertaken.		What was the mechanism for getting a rapid medical review ? Did a medical / psychiatric review take place ? If a medical review was undertaken – which members of the NCEDS team undertook the review ? What were the findings of the review ? Who were the findings of the review reported and sent to and were the RMO and care co-ordinator informed ? If no medical review was undertaken what measures did the RMO / Dr. Serfontein take to follow up this omission?
5.5	30.11.12	Review	Medical review process			Was the UEA primary care medical team at the university campus informed that a medical review was underway. Were records requested from the UEA medical centre or other parties to corroborate the weight loss reported by Nic Hart ?

5.6	31.11.12	Communal concern	Averil's health deteriorates and this is noticed by her flatmates and the cleaners in flat 22 at University. Carol Miles, the cleaner of flat 22 at UEA discussed Averil's deteriorating health with her supervisor. Carol Miles later reports to me that she said that "Averil was clearly very unwell, and in my opinion should be in hospital on a drip. She was hardly able to walk up the stairs"		Averil's health becomes a cause of concern for even those without AN expertise.	Why, when so many ordinary members of the public could see that Averil should be hospitalised, could the NCEDS team and the UEA medical centre not respond in a timely and appropriate fashion ?
5.7	30.11.12	Long distance concerns.	Averil corresponded with her Aunt (Melissa Moore) in New Zealand by email. Melissa called me from New Zealand to voice her concerns about Averil's health and mental capacity. She is very worried and states that Averil is definitely not herself and that Averil's email's show signs of lower than usual mental capacity (for example, incorrect grammar, typos etc. that Averil would not normally have allowed). Even from New Zealand concerns are being raised about Averil's well being.			Why, when there was significant concern about Averil's mental state (and her physical health) from as far away as New Zealand did the NCEDS team who were based less than five miles away not respond to the crisis call from the family to assess her risk and carry out an immediate medical review ?

5.8	03.12.12		Averil kept a diary of her life with AN. It runs to seven volumes from the day she started treatment at S3. She is studying English and her diary entries are comprehensive for each day. These are private diaries of which I have read very little other than for the last few entries of the last diary for the purposes of the SI enquiry. Her last diary entries before the 999 call at University, show that her capacity is reducing and that she is very unwell. Her normally fluid and easy to read hand writing reduces to a scrawl as she struggles to stay alive. She writes of the battle to stay at University and it is clear that she is hoping to complete the term and then come home. Sadly an entry regarding her own health shows that on one level she realises just how unwell she really is, but she is unable to call for help. She writes on 3rd December …. "I am going and I am going fast"			The cleaners know that Averil's health is failing, Averil's aunty in New Zealand is concerned. Averil's parents and sisters are at their wits end and worried sick. It is now five days since the emergency phone call to ward S3. Where is the medical help from Averil's specialist team at NCEDS ?

5.9 **	05.11.12	Emergency call 2	Carol Miles the cleaner at UEA flat 22, meets Averil in her flat and is extremely concerned about her health and well being. She speaks to her supervisor who calls for medical assistance for Averil. The call is thought to have been routed via the deans office. Averil is visited by a member of UEA "health or student services" team who sees Averil and does nothing further. This visit does not appear to have been recorded or imparted to other appropriate medical services			It is now nine days since the emergency phone call to ward S3 What has NCEDS done to save Averil's life ? Who from NCEDS or the UEA medical team has seen Averil ? What assessment was made by the visiting member of staff of Averil's physical and mental state ? Was this person competent to make this assessment ? What was communicated concerning this visit and to whom ? Why have NCEDS not followed up on Averil's care plan, particulary when the high risk of relapse has been highlighted from day one ?

5.10	07.11.12	Emergency call 3	Carol Miles attends flat 22 where she is cleaning the student rooms. The time is mid morning and she finds Averil unconscious in the kitchen. She immediately calls for medical assistance and an Ambulance from the nearby Norfolk and Norwich university hospital is called to attend. Averil is taken the N&N hospital where she is placed on a drip with Glucose infusion and is found to be in a very bad physical condition. NCEDS is informed by Miranda Hart of Averil's admission to N&N. It is now 11 days since the emergency phone call to ward S3.	NICE 1.2.2.6 as above		What response was made by NCEDS once they had been informed that Averil had been admitted to N&N ? Who in the NCEDS team was aware on the 07.12.12 that Averil had been admitted to N&N ? What immediate action in accordance with Averil's care plan was implemented (MARSIPAN response) ?
5.11	07.11.12	NCEDS	Averil is now in hospital at the N&N. Dr. Brabbins emails Dr. Serfontein at 14:13 after Averil's admission to N&N. Dr. Brabbins writes "I thought I would let you know that Averil Hart cancelled this morning's appointment last night" "we received a call from Averil's mum" to say that she had been admitted to N&N hospital. "*Dad may try and contact you which is why I thought I'd best bring you up to date*."			Why was the medical review not carried out as soon as the emergency call was received nine days previously ? Why does Dr. Brabbins email to bring Dr. Serfontein up to date at this late stage, referring to my calls / visit as the reason for the email rather than for the purposes of getting a member of the NCEDS team to see Averil at the N&N hospital straight away to ensure that the correct treatment is provided ?

6. Norfolk and Norwich University hospital

Averil is found unconscious by cleaners at University of East Anglia this two days after they reported that they were concerned about Averil's well being and general health to the university.

It is now over ten days since serious concerns were raised about Averil's health and a call made directly to unit S3 at Addenbrooke's to alert them of the situation.

As far as the medical notes provided to me indicate, no-one from NCEDS or UEA medical team had seen or attended to Averil during all of this time and the result is that there has been a catastrophic deterioration in Averil's health to a critical point at which time she is found unconscious.

The risk analysis in Averil's discharge care plan proves to be correct. Averil was at high risk of "Relapse" and high risk of "sudden weight loss".

Averil is admitted to Norfolk and Norwich University hospital and a call is made to me to attend immediately. I anticipate that the hospital will call NCEDS or Addenbrooke's S3 to inform them of the situation, and that a member of the NCEDS team will attend, providing specialist knowledge concerning the treatment of advanced Anorexia Nervosa and to discuss stabilising Averil's condition with a specialist physician.

I also expect NCEDS to discuss with the N&N, the standard issues concerning a seriously ill patient with Anorexia such as detention under the MHA, specialist nursing care, passing of a nasogastric tube as well as under feeding and re-feeding syndrome.

Sadly, nobody from the specialist team arrives and there appears to be no record of any visit until early the following week, during which time treatment at the N&N hospital proceeds with adverse consequences.

The Acute ward appears to be totally unprepared for the correct treatment of an AN sufferer and the guidelines in MARSIPAN are not adhered to.

The result is that Averil is allowed to wander around the ward and has a serious fall and a cut to her forehead. She is expected to feed herself from the ward trolley and there is no move to either detain Averil under the mental health act (if required) or provide nasogastric feeding to prevent further decline in her health.

During my visits over the weekend I see a deterioration in Averil's condition as she takes no (or minimal) nutrition and I seek to have her transferred to Addenbrooke's for more specialist care at a unit that has a greater understanding of her condition and is better placed to treat her.

Table 6. Norfolk and Norwich University hospital

Ref.	Date		Event	NICE/MARSIPAN guideline reference	Critical incident Consideration	Related Question(s)
6.0	07.12.12	Weight at hospital admission	Averil is admitted and weighed on entry to N&N hospital at 30 Kg or less.	NICE 1.2.4.6 Involvement of a physician with expertise in the treatment of medically at risk patients with AN should be considered MARSIPAN recommendation 1. Medical and psychiatric ward staff need to be aware that adult patients with AN being admitted to a medical ward are often at high risk	It is difficult to understand how someone could lose over 8 kilos or 17 pounds in the fourteen days since VP recorded a weight at Averil's session 6 appointment. This is a loss of over 21% of her body weight.	How does the weight recorded at the N&N hospital relate to the weight monitoring, mental state and care that she had been receiving from NCEDS in the prior weeks ? Why have NCEDS allowed Averil's weight to decline to such a low BMI without intervention ?
6.1	07.12.12	Correct treatment	After several weeks of starvation and latterly dehydration, Averil is very weak and hypoglycaemic. Averil is placed on a glucose drip, but receives no other nutrition to speak of.	MARSIPAN states that patients attending acute wards are at very high risk of death unless they are treated correctly.		Was a nasogastric feeding tube proposed as soon as Averil was admitted to N&N hospital ? (even if this required the use of the MHA).

6.2 **	07.12.12	Weight and initial treatment at N&N hospital	On arrival at N&N hospital Averil's mental state, capacity and physical condition are very poor. Averil clearly requires urgent specialist gastroenterology and eating disorders medical attention and nursing. I sit with Averil as she is given a cup of soup from the ward trolley and she struggles to eat a few spoonfuls of soup and clearly has difficulty swallowing. I am told by the admissions doctor on the ward that Averil requires re-hydrating and will be able to go home after the weekend. This information leaves me struggling to comprehend what is happening as things go from bad to worse. There appears to be no specialist help and the acute ward seem not to understand the very serious nature of Averil's condition.	Ref MARSIPAN guidelines on Nasogastric feeding,re-feeding and Underfeeding syndromes. MARSIPAN recommendation 8 Key tasks: Safely re-feed the patient Avoid re-feeding ***Avoid underfeeding syndrome*** Arrange transfer to a SEDU Manage, with the help of psychiatric staff, behavioural problems Manage family concerns	Weeks later reading MARSIPAN and case histories of other sufferers of AN who have died having been taken to acute wards, I begin to see that this lack of appropriate care is a sad reality of acute wards that do not understand the illness and what is required to save the lives of AN sufferers.	Why is Averil not attended on the acute ward by NCEDS directly she arrives to establish a proper care regime as outlined in MARSIPAN ? Why was a psychiatric assessment not undertaken on admission to see if Averil should have been detained under the MHA ? Should a nasogastric tube have been passed straight away to prevent further deterioration in Averil's health to prevent underfeeding syndrome ?

6.3 **	07.12.12	Specialist	Averil is admitted to N&N and requires specialist treatment.	As recommended in MARSIPAN "Partnership between physician and psychiatrist"		Was a Gastroenterology specialist with experience of AN available at N&N or is there a locally agreed protocol that the staff were aware of for contacting him or her ? What Partnership (if any) pre-existed between NCEDS psychiatrist and an eating disorders nutrition physician If the acute ward at N&N did not have anyone with sufficient experience of re-feeding or under feeding syndrome or the care of really sick patients with AN, did they contact Addenbrooke's hospital or other agency to get advice on treatment ?
6.4 **	07.12.12-10.12.12	Still No Attendance by NCEDS	It appears that no-one from the NCEDS specialist team attends Averil for three further days. This allows her condition to yet further deteriorate whilst she is treated outside the strict guidelines laid down in MARSIPAN.			When were NCEDS notified that Averil had been admitted to N&N ? Why did it take so long for someone with specialist knowledge of AN to attend the N&N hospital, especially when the NCEDS headquarters are in central Norwich which is 4 miles away or less than fifteen minutes drive away? Who in the NCEDS team knew that Averil had been admitted to N&N on the 7th December ? What are the emergency procedures for NCEDS to visit the patients on their "at risk" list. Who was on call for NCEDS for the weekend of the 8th and 9th of December ? If there were no on-call arrangements for NCEDS who was the liaison psychiatrist and did they have specialist knowledge of AN ? Did NCEDS liaise with the N&N psychiatric liaison team or on-call psychiatric team ?

6.5 **	07.12.12	NCEDS	As recorded in the notes Dr. Serfontein emails Louise Brabbins and says "I phoned N&N. They cannot give me information about her on the phone" Dr. Serfontein asks her "if you could review Averil on Monday" 10th December	***MARSIPAN recommendation 1.*** Medical and psychiatric ward staff need to be aware that adult patients with AN being admitted to a medical ward are often at ***high risk***		It is now 11 days since the emergency call to ward S3. Given that an emergency call was made on the 28th Novemeber and Averil is now in hospital it seems inconceivable that alarm bells would not be ringing with Dr. Serfontein and yet he does not see fit to get his team to the N&N straight away (Friday 7th December) in order to provide specialist assistance to the N&N acute ward …….. Why ? If Dr. Serfontein has "no information" about Averil from his phone conversation on Friday 7th December, did it not seem imperative to find out what is going on straight away ? Was Dr. Serfontein, Averil's care co-ordinator or other specialist member of NCEDS in the Norwich office on the day in question, less than five miles from N&N and who could have attended for this emergency ?

6.6 **	07.12.12	Psychiatric nurse / Doctor	On arriving at the N&N hospital I endeavour to see Averil. The duty doctor and registrar appear to lack any medical experience of AN and advise me that Averil may not wish to see me. It appears that they have not been able to establish that Averil's mental capacity is severely reduced and that a psychiatrist or doctor is required urgently to assess Averil's mental state, which I can see is severely affected. It seems that the AN component is very strong and when I finally get to see Averil, she tells me that that the "voices are getting stronger" and that she is battling hard with the illness. Averil's voice is weak and I begin to worry that her admission is not going well.	MARSIPAN notes re: practical considerations of special psychiatric nursing care.		Where is the immediate psychiatric care that is required to assess Averil's condition, capacity to consent to treatment and consideration of possible detention under the mental health act (with the immediate consideration of nasogastric feeding) ? Why was one-to-one treatment outlined in MARSIPAN not provided with a specialist psychiatric nurse rather than general care that was often inappropriate ?

6.7 **	07.12.12 – 10.12.12	Averil falls whilst at N&N hospital	Despite her incredibly weak condition, Averil is allowed to walk around the ward. With classic AN behaviour, this leads to increased energy consumption at a critical time. Averil falls and receives an injury to her head leaving a wound which is treated by the ward staff. At this critical BMI In ward S3 at Addenbrooke's, patients are refrained from movement to conserve energy and are nursed strictly on a one-to-one basis in a wheelchair.	See MARSIPAN case histories of sufferers of AN who have died having been taken to acute wards with lack of appropriate care		Why was Averil not kept either in bed or in a wheelchair to conserve her energy at this critical stage, with one-to-one specialist nursing to ensure her safety ? Why was a critically ill patient allowed to fall and injure herself ?

6.8 **	09-10.12.12	NCEDS involvement ?	I visit Averil when allowed by the visiting times on the N&N acute ward and I become ever more concerned about the treatment, care and her condition. On the morning of Monday 10th December after many phone calls I am able to get Dr. Serfontein's phone contact and call him to try and get Averil moved to a more capable and specialist ward at Addenbrooke's. He emails Sharon Winter at S3 also asking how "did he get hold of my number" ? According to the notes Dr. Serfontein also emails Dr. Shapleske to say that NCEDS needs a bed for Averil. He states, "she is not eating well on the ward and is active" This information from Dr. Serfontein indicates to me that he is out of touch with the situation. Averil is critically ill, but allowed to be "active and without nutrition".			If early intervention and proper treatment at the N&N under MARSIPAN guidelines could have saved Averil's condition from deteriorating further why was a transfer to Addenbrooke's not considered earlier by either the N&N acute ward or NCEDS ?

6.9			I am phoned by the ward nurse/sister at N&N to tell me that Averil is being transferred as a medical emergency to Addenbrookes. The ward nurse/sister finds my number on Averil's phone.			Should this transfer have taken place earlier on Friday 7th December ? Was there an unacceptable delay ? Why was the only method of contacting the family via Averil's phone contact list ? Why were the family contact details not requested by N&N on admission on the 07.12.12

7. Addenbrooke's University hospital

Averil is transferred by ambulance from N&N hospital to Addenbrooke's on the morning of 11th December 2012.

She texts us with a picture she takes in the Ambulance with her lucky mascot and a message "I am terrified, but I can do this".

The family are alerted that Averil is being transferred and their visit to see Averil is re-directed so that they arrive just after the ambulance and go straight to the GI ward where she is being treated.

The day progresses with regular monitoring of Averil's condition. Taking blood samples is painful and difficult. Averil's family are all able to be with her. Dr. Serfontein arrives and talks to Averil about the MHA and nasogastric feeding.

Dr. Jeremy Woodward visits Averil and gives direction for her treatment.

I stay with Averil until late that evening. Her physical condition has noticeably declined and she is unable to hold up her head or move her limbs as her muscle capacity is severely diminished, she requires pillows and help to stay upright in bed and to be comfortable.

I spend my last hours with Averil whilst she is conscious.

I hold her, we talk and laugh at times and just sit together. I help her to the toilet and clean and care for her. It will be an abiding memory of the purest time together when there are just the two of us and we need and love each other.

A one to one nurse is sent to be with Averil, but she is a bank nurse with very little understanding of Averil's condition.

I stay with Averil until she wishes to sleep and sends me home.

The next day I see Averil and she is unconscious.

Dr. Woodward, informs us that there has been a catastrophic event in the night and that Averil has not responded well and that there may have been mental and physical damage. Apparently she had refused a dextrose infusion during the night when her blood sugars dipped. For some reason she was not on a glucose drip.

The family arrive and we all stay with Averil to be with her, we call her boyfriend Alex, who rushes from London and her Aunts and Uncles and cousins also come to see Averil.

The family stay with Averil and all of us spend time by her bedside, holding her. Initially Averil knows that we are there and she responds to us with smiles although she is unconscious. However, during the night of the 12th December she goes to a deeper place and we know and hear directly from Dr Woodward that Averil will not survive. We are heartbroken.

Averil dies on the 15th December 2012. We have lost a wonderful and brave daughter and sister and our lives will never be the same, but they will be the better for having known Averil.

Table 7. Addenbrooke's University hospital

Ref.	Date		Event	NICE/MARSIPAN guideline reference	Critical incident Consideration	Related Question(s)
7.0 **	10-11.12.12	Nursing	Averil is cared for in the GI ward N2 on the day of her arrival. In the evening of the 11th December a bank nurse is allocated to care for Averil through the night. The bank nurse normally worked on the geriatric ward. She had no experience of AN. During the night Averil's vital signs deteriorated and her blood glucose, heart rate and BP fell. Averil may have refused a dextrose infusion, she has a major catastrophic event (the details of which are not entirely clear) and becomes unconscious.	NICE 1.2.4.11 Feeding against the will of the patient requires expertise and should only be done in the context of the MHA. MARSIPAN Policies and protocols to agree specialist nursing (table 8).		It is now 15 days since the emergency call to ward S3. Why when Dr. Serfontein visits Averil does he not detain her under the MHA and why was nasogastric feeding not commenced ? What assessment did Dr. Serfontein make of Averil's mental state and capacity ad how did he record this ? Why does Dr. Woodward not ensure that Averil's blood glucose is maintained overnight with a glucose drip ? Why is a bank nurse allocated who clearly has no experience or training with AN patients ? What is meant by Dr. Woodward 's comments in Dr. Serfontein's notes that .... "Averil had low glucose during the night that was not corrected and maintained as per his recommendation "? Was this lack of care to maintain Averil's glucose level responsible for the major catastrophic event in the early hours of the 12th December ?

7.1	112-15.12.12		Averil is cared for in the ITU and N2 wards for three days and three nights with some of the best nursing care she had ever received and her family and friends are with her. Averil dies on the 15th December 2012 a few days before her twentieth birthday as her song for the day is played. "Accentuate the positive" by Rumer.			
7.2	31.12.12	Notes Addition	Dr. Serfontein makes an additional note in Averil's medical records more than two weeks after she dies. He states "She (Jo Brooks gastro registrar at N&N) said she was impressed with NCEDS input – we had been very helpful and responded very quickly by seeing Averil on Monday morning following her admission, I saw her on the 10th December"	MARSIPAN recommendation 9 "Health commissioners should be aware of the usually inadequate local provision for MARSIPAN patients Ensure that robust plans are in place including adequately trained and resourced medical, nursing and dietetic staff on the acute services and specialist eating disorder staff in the mental health services.		It is now 35 days since the emergency call to ward S3. What is the purpose of this late entry in the notes by Dr. Serfontein ? How many times (when and where) did Dr. Serfontein visit Averil before she was admitted to hospital as an emergency case and whilst there was a possibility of changing the course of events which lead to her death ? Given the lack of insight shown in this late entry in Averil's medical notes ….. Was the NCEDS team that was overseeing Averil's care plan "fit for purpose"? Is the safety of patients in the community still at risk with the current NCEDS setup ?

Table 8: Systems Questions for the SI for AVERIL HART

	Context GMC/NICE/MARSIPAN Reference	Questions
8.0	The family had learnt of at least two 'near miss' incidents involving out patients at Family days when Averil was an IP on S3	Had there been any previous SI's in the local area in the previous 5 years? What was the outcome of these? If there had been any SI's, what were the conclusions in terms of lessons learnt and what measures had been put in place to avoid future harm to patients?
8.1	MARSIPAN: 'Transfer between services'	Is there a clear transition policy for patients transferring from S3 IP to NCEDS OP care at a time recognised of high vulnerability? Are responsibilities for apportioning any shared aspects of care e.g. investigations/physical examination for patients with Anorexia Nervosa agreed locally between primary and secondary care? Have any GPs/GP committees raised concern about this issue with the NCEDS team?
8.2	MARSIPAN: 'Staffing levels' Dr Serfontein indicated to Nic Hart on 10th December that he and his team felt 'thinly spread' professionally and this was echoed by Dr Shapleske in a further meeting in 2013. GMC: Leadership and Management for Doctors GMC: Accountability for Multi-disciplinary and Multi-Agency Mental Health Teams GMC Good Medical Practice – Raising concern about patient safety	Was the NCEDS team adequately staffed and with staff who were competent to undertake psychological / clinical assessments and provide treatment and risk assessments in a timely manner? Did the team have clear working arrangements for covering staff holidays/leave for high risk patients? Were there any issues raised by the RMO or medical staff about NCEDS team members' responsibilities, supervision or lines or accountability? Were RMO responsibilities clear for monitoring patients within the team? Had Medical staff working in the current or previous NCEDS team raised concerns about staffing levels or patient safety with management in the past 5 years?

8.3	MARSIPAN: 'Policies and protocols to agree in advance' e.g 'All local health commissioners should demand that a MARSIPAN group with at least a physician, a psychiatrist, a dietician and a nurse as well as management be set up in their area to advise on services required in medical units.'	Were any of the following protocols agreed and in place during the time of Averil's care? > A local MARSIPAN group. > Criteria for medical as opposed to psychiatric admission > Special nursing: qualifications and supervision of one-to-one nurses > Mental Health Act: criteria for its use, identification of responsible clinician (psychiatrist) and responsible manager > Specialist eating disorder unit (SEDU) consultation and referral > Issues around funding (e.g. special nursing or SEDU referral) which may require an approach to the primary care trust > Liaison psychiatry services: training role, involvement of consultants and trainees with patients admitted and consultation with eating disorder specialists.
8.4	Liaison with UEA and primary and secondary care	What systems operate in the University to assess young people who have become critically unwell whilst resident at UEA ? If University staff are asked to make assessments of young people's health, how are they deemed to be competent ?

9. Summary of critical incident concerns

Averil's life could and should have been safe in the hands of the Norfolk community eating disorder service. The care plan that had been laid down when Averil was discharged from S3 clearly specified that her BMI and basic health parameters were to be monitored on a weekly basis and this together with a proper risk assessment and regular reviews by her RMO should have insured her safety.

As it was the NCED service did not appear to follow the care plan and even changed the care plan in crucial areas like monitoring.

NCEDS allowed Averil's BMI to fall to critical levels whilst she struggled to stay at University and worse the NCEDS service did not appear to respond in a timely fashion when emergency calls were made on the 28th November or in the following week until Averil was finally admitted to Norfolk and Norwich hospital.

At the Norfolk and Norwich hospital the care appeared to be outside many of the guidelines laid out in MARSIPAN and NICE and there appeared to be little liaison in the first days with NCEDS to assist in Averil's treatment.

At Addenbrooke's hospital the incident on the night of the 11/12th December and treatment during that night leaves many questions unanswered.

Table 9. Summary Critical incident concerns (NCEDS, N&N and Addenbrooke's).

Note: These critical incident concerns are shown in each of the previous tables with an "**" against the relevant events and related questions.

Ref.	Date		Event	NICE/MARSIPAN guideline reference	Critical incident Consideration	Related references and questions
9.1	04.10.12	Late	NCEDS commences Averil's care plan three weeks late and with little or no communication with Averil's family.	Table 4.9		See questions raised in table 4.9

9.2	10-11.12.12	UEA Medical centre	Despite a written request by both Dr. Spencer and Sarah Beglin for UEA medical centre to weigh Averil weekly and take her vital health paramaters this does not appear to have been undertaken or monitored by NCEDS	Table 4.3 Table 4.6 Table 4.11		See questions raised in table 4.3 See questions raised in table 4.6 See questions raised in table 4.11
9.3	26.10.12	Changes	Vikki Powell informs Averil (26.10.12) that she doesn't need to be weighed by the GP / UEA Medical centre	Table 4.12		See questions raised in table 4.12
9.4	23.11.12		Vikki Powell records a weight for Averil that appears to be highly questionable given other evidence from the family's visit a few days later.	Table 4.22		See questions raised in table 4.19
9.5	28.11.12	Call 1	There is no meaningful response to N.Hart's emergency calls to ward S3 and nobody from NCEDS appears to see Averil until she is admitted to hospital ten days later	Table 5.2 Table 5.4		See questions raised in table 5.2 See questions raised in table 5.4
9.5	30.11.12	Cover	No clinical cover is provided for VP at the usual weekly session with Averil which may have picked up on her mental state and poor physical condition	Table 4.20		See questions raised in table 4.20
9.6	05.12.12	Call 2	Carol Miles' the cleaner call to the university for emergency medical treatment on Wednesday 5th of December results in minimal and ineffective response.	Table 5.9		See questions raised in table 5.9

9.7	07.12.12	MARSIPAN at N&N	N&N appear to provide incorrect treatment and nursing care (MARSIPAN guidelines) for Averil and she is allowed to move about and incurs a fall. There is no apparent involvement by NCEDS on the day or for two subsequent days after Averil's hospital admission. It is not apparent that immediate detainment under the MHA and nastrogastric feeding was considered with Averil's family to prevent underfeeding.	Table 6.2 Table 6.3 Table 6.6 Table 6.7 Table 6.4 Table 6.5		See questions raised in table 6.2, 6.3, 6.6, 6.6 See questions raised in table 6.4, 6.5
9.8		N&N	If insufficient expertise to treat advanced Anorexia was available at the N&N hospital a transfer to a more appropriate service may have been considered directly on arrival	Table 6		See questions raised in table 6
9.9		Addenbrooke's	At Addenbrooke's hospital it appears that there was no immediate action to detain under the MHA or pass a nasogastric tube and critically then to maintain blood glucose levels as directed by Jeremy Woodward (this resulting in a major catastrophic event on the night of the 11/12.12.12).	Table 7		See questions raised in table 7