Complaint to CPFT regarding the conduct and care provided by the care coordinator at Addenbrooke's S3, resulting in the death of Averil Hart (aged nineteen).

Our daughter and sister Averil Miranda Hart died of a treatable illness at the age of just 19 whilst studying at the University of East Anglia and whilst in the "care" of the Norfolk Community Eating Disorder Service (NCEDS).

Averil starved to death within ten weeks of commencing university. We feel that a major contributory factor in Averil's death was the lack of transitional care she received.

The care coordinator at Addenbrooke's S3 was neglectful and negligent in ensuring adequate and appropriate transitional care to Averil, who was understood by all clinicians to be a "High risk patient".

The care coordinator failed in numerous ways to follow basic appropriate NICE and MARSIPAN guidelines.

Background.

Averil had been admitted to Addenbrooke's hospital as an inpatient suffering from Anorexia Nervosa (AN) in September 2011. After around ten months as an inpatient Averil was deemed well enough to commence University at the University of East Anglia in September 2012.

Staff at Addenbrooke's S3 wrote to NCEDS before she started at University on two occasions. This correspondence states that Averil is of high risk of relapse and needs regular weekly check-ups to ensure her safety.

On 27th September 2012 a note was made on Averil's medical file:

…"*Averil has a BMI of 15, she is still regarded as fragile, new start at Uni' could be a potentially dangerous time for her … she is vulnerable at the moment*"

It is well understood and documented that periods of transition, both in life events and between services are high risk for AN patients. Despite this, the care coordinator at Addenbrooke's S3, Dr. Beglin, failed to ensure the provision of proper transitional care as outlined in MARSIPAN. (A basic guide for care of AN sufferers).

These failures in patient safety were critical for Averil's health and as a result she lost weight and her health deteriorated.

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We feel that the assessment of Averil's heath and ability to maintain herself at University was flawed as shown by the tragic results. It is clear from the course

of events that Averil was extremely vulnerable at the stage of discharge from Addenbrooke's S3.

After a long period in hospital, Averil was ill equipped without professional medical help to survive in the community at University. In particular she required "care coordination" within the community to bring together the various services in order that she could continue her recovery.

The handover of the care coordinator role from Addenbrooke's to NCEDS was delayed and mishandled on numerous accounts. The transitional care did not involve the family, this despite Dr. Beglin being fully aware of the family dynamics, having spent time with Averil and her family at previous "family days".

By not involving the family in meetings during the transition of Averil's care to NCEDS and not communicating the new setup and structure, Dr. Beglin dramatically increased the risk to Averil's life.

Once it was clear that Averil was extremely unwell and in need of urgent medical attention, we called Addenbrooke's S3 to get help for Averil. This help was delayed and did not arrive in time. No other point of contact had been relayed to family members.

There are clear procedures in the MARSIPAN guidelines relating to the handover of the care from one service to another. If these procedures had been followed the family would have been able to relay their concerns about Averil's health more quickly and with the appropriate clinicians.

After battling bravely to remain at university, but without the care she so badly needed from her health providers, Averil was found unconscious in her flat and after a 999 call, she was rushed to hospital in Norwich and then transferred to Addenbrooke's where she later died.

This document forms the first part of a major complaint outlining the negligence and neglect in the care of Averil Hart, which lead to her untimely death.

Further detailed complaints are likely to be lodged once we have ascertained further information about Averil's case, which has been subject to a number of FOI requests.

<u>Initial Complaint to CPFT regarding the lack of transitional care for Averil Hart,</u>

Averil's S3 care coordinator failed to ensure Averil's safety during transition.

This lack of transitional care and patient safety was responsible for a deterioration in Averil's health which resulted in her tragic death only ten weeks after starting university at the age of nineteen.

1.0 Failure of the Addenbrooke's care coordinator Dr. Beglin to undertake standard MARSIPAN handover guidelines when Averil left Addenbrooke's such as;

1.1 "Properly conducted and *recorded*" handover meeting.

1.2 Failure to ensure a meeting of the RMO with Averil to make an initial assessment for the new service provision.

1.3 Failure to ensure commencement of treatment for a high risk patient in a timely fashion with delays of three weeks (Dr. Tatham's apology for delays in commencing therapy and treatment), leading to health deterioration.

2.0 Failure to ensure implementation of the basic *risk assessment* for Averil Hart, leading to the neglect of a high risk, vulnerable patient and preventable death of a young person suffering from a treatable illness.

"AN has one of the highest mortalities of any psychiatric condition"

(NICE guidelines NICE 1.1.1.4, 1.2.4.5,6.4.1.3.2)

3.0 Failure to provide adequate *patient safet*y during transition and adhere to a structured care plan leading to the death of a high risk patient, at a well known (MARSIPAN) high risk transitional period in her life.

4.0 Failure during the period of transition to verify with the primary care team that the weekly patient *health checks* were carried out as prescribed in Averil Hart's discharge plan from Addenbrooke's hospital, leading to the death of a high-risk patient. (Bloods, BP, Heart rate, SUSS test and physical condition).

5.0 Failure to involve Averil's family in the transition from one service to another as specified in the basic MARSIPAN guidelines.

6.0 Failure to take into account family dynamics and failure to provide the family with contact details of key NCEDS staff, which inevitably proved disastrous in an emergency situation.

7.0 Failure to document properly the appointment and handover to a new care coordinator. The SI report comments on the poor quality of the record keeping.

8.0 Failure to communicate the appointment of a new care co-ordinator with Averil's family.

Failure of the care coordinator to liaise with the rest of the NCEDS team to bring together the clinical and psychological assessment of Averil's ongoing overall health during transition.

9.0 Failure to consider fully and act upon previous case histories that were well known such as the fatality in 2008 and two other well known cases which were discussed at length at family days.

10.0 Failure to ensure an accurate assessment of patient "mental capacity" during transition either by clinical assessment of communication with outside agencies undertaking such assessments with appropriate referral to inpatient services (as MARSIPAN).

11.0 Failure to *record* accurately changes in the Care plan. There are no appropriate complete entries in Averil's health records authorizing a change in her Care Plan. The SI report clearly states that the records maintained were "below the standards expected".

We believe the lack of transitional care by Averil's care coordinator at S3 was instrumental in the rapid deterioration in Averil's health, which ultimately lead to her death following further failures by NCEDS.

We are seeking the following:

A) A full *external investigation* into the events leading to Averil's death in order to find out *precisely* what went wrong and why.

B) Remedial action to overhaul the standard of care provided to high risk patients in order to increase patient safety.

C) Appropriate *disciplinary action* where the medical standards (GMC guidelines) have fallen below acceptable standards in:

i) Knowledge and skills,
ii) Patient Safety and quality
iii) Communication
iv) Trust (openness, honesty and integrity)

D) An appropriate statement of apology to Averil and her Family, and Averil's friends at home and university.

Nic Hart, Averil's father

Miranda Campbell, Averil's mother

Imogen Hart, Averil's sister

Zoe Hart, Averil's sister