Complaint to NHS England regarding the conduct and care provided by the University of East Anglia Medical Centre 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 University of East Anglia Medical Centre (UEAMC) headed by Dr. Edmonds.

Averil starved to death within ten weeks of commencing university as a direct result of the lack of care and failure to provide adequate medical services by UEAMC.

The UEAMC primary care team was neglectful and negligent in looking after Averil who was assigned to them as a "High risk patient" and failed to follow basic appropriate NICE and MARSIPAN guidelines.

1. 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.

Averil's care coordinator and staff at Addenbrooke's S3 wrote to UEAMC 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. (These checks were listed clearly and included general health as well as blood and physical checks). King's College guidelines were also supplied for the UEAMC to follow in Averil's care plan.

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

…"*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*"

Given that a number of the doctors at the UEAMC had already attended a specialist AN seminar provided by BEAT * (the eating disorder charity), it would be reasonable to expect that they fully appreciated that a high risk AN patient would require special attention, particularly as this was outlined in Averil's discharge report from Addenbrooke's and highlighted by Dr. Sarah Beglin in her letter of the 27th September 2012.

During the ten-week period between commencing university at UEA and her death, the UEAMC saw Averil on a very limited number of occasions and during these visits (which should have been weekly) they failed on many occasions to undertake even the basic health checks that had been required of them. They also failed to communicate with other agencies including the secondary care team, the Norfolk Community Eating Disorder Service (NCEDS) and the

University disability service. These failures in patient safety were critical for Averil's health and as a result she lost weight rapidly and her health quickly deteriorated unchecked by UEAMC.

Even Averil's cleaner at University was concerned about Averil's health, but the checks and help that Averil so badly needed from her primary medical team at University were completely absent.

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.

* information provided by BEAT office in Norwich

2. UEAMC contravention of NHS guidelines on disclosure.

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

A second more detailed complaint is likely to be lodged once we have ascertained further information about Averil's case from UEAMC, which they have so far refused to release.

Despite the NHS guidelines for freedom of information and also "open and honest" dealings with patients and relatives in serious cases such as this, Dr. Edmonds and her team have failed on numerous occasions to provide the information we have requested and in so doing, they have been totally disrespectful to Averil's life. UEAMC have made it very difficult to file a fully detailed complaint. Only with the help of the North Norfolk Clinical Commissioning Service (NNCCG), who have visited UEAMC on our behalf, have we been able to discern some of the information contained within this first complaint. They have also caused the process to become particularly protracted and painful for Averil's family.

3. Catalogue of failures, negligence and neglect by UEAMC.

As part of her care plan and following a full risk assessment on her discharge, the University of East Anglia Medical service was asked specifically (on 31st of July 2012) to check Averil's health to ensure her safety as follows:

A) Weekly basis (four basic health checks):

	1	2	3	4
Weekly check	Weight	Blood pressure	Heart rate	Level of physical strength (SUSS test)

B) Bi-monthly basis (seven basic blood checks):

	5	6	7	8	9	10	11
Bi Monthly	U&E's	LFT's	Bicarbonate	Bone profile	Muscle CK	Magnesium	Phosphate

C) Other recommended checks as MARSIPAN (NICE 1.1.1.4) BMI 15 or less.

	12						
Regular	ECG						

From the information we have so far gained after several months of requests, the following table outlines the failures during the ten weeks that Averil was at University:

The table shows the monitoring provided by UEAMC for each week with the parameters listed as per the checks requested (1-12) in the specific tables above.

Week	1	2	3	4	5	6	7	8	9	10	11	12
24/09	√	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
01/10	√	√	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
08/10	√	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
15/10	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
22/10	√	√	√	√	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
29/10	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
05/11	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
12/11	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
19/11	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
26/11	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
03/12	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X	Fail X
07/12	***											

*** Averil found unconscious in her flat at University

Averil's medical records indicate that only one out of every five of the requested basic health checks were carried out and none of the requested blood checks were carried out by UEAMC. Given the initial comments made by UEAMC in Averil's medical file regarding "*dangerous time*" and "*vulnerable*" this lack of basic health checks is a reckless disregard of basic patient safety.

4. Failure to Communicate with outside agencies

The UEAMC was the primary service for checking Averil's specific health parameters and it is clear that they failed in this undertaking.

They also failed to undertake any meaningful communication with other services to co-ordinate Averil's health care; namely NCEDS, Addenbrooke's (who are mentioned in Averil's records for specific outside reference) or the UEA disability service.

We requested information from UEAMC concerning their communications with other agencies involved in Averil's care. Despite several requests, no information was forthcoming from UEAMC directly. However, with the intervention of NNCCG, we have ascertained the following:

Communications with outside agencies following health checks:

Week /c	NCEDS secondary care	UEA Disability	Other agencies
24/09/2012	NIL	NIL	NIL
01/10/2012	NIL	NIL	NIL
08/10/2012	NIL	NIL	NIL
15/10/2012	NIL	NIL	NIL
22/10/2012	NIL	NIL	√ *
29/10/2012	NIL	NIL	NIL
05/11/2012	NIL	NIL	NIL
12/11/2012	NIL	NIL	NIL
19/11/2012	NIL	NIL	NIL
26/11/2012	NIL	NIL	NIL
03/12/2012	NIL	NIL	NIL
07/12/2012	***		

* 23/10 Communication regarding a fridge

*** Averil found unconscious in her flat at University

5. Failure to respond to Averil's family in an "open and honest manner"

Following Averil's death, it became clear that the UEAMC had not followed the care plan and patient safety regime that had been specified in Averil's discharge plan from Addenbrooke's, further more their lack of communication with outside agencies had resulted in a significant increase in the risk to Averil's life.

NHS guidelines are clear in specifying that in serious cases where a patient has died, that the NHS organisation concerned must communicate with family in an open and honest manner.

As a family we wrote to the practice on numerous occasions to understand the causes of the tragedy. It soon became apparent that the UEAMC were being evasive and were particularly slow in responding to our correspondence, often totally ignoring the content of our letters or simply refusing to answer correspondence.

Furthermore the authors of SI report by CPFT (Cambridge and Peterborough Foundation Trust) noted the lack of disclosure of UEAMC in their investigation into the care that Averil received.

As a family we feel that Dr. Edmonds, the head of the UEAMC, has been particularly obstructive with regard to an "open and honest approach".

We spoke to NNCCG about this lack of openness and they agreed to visit the UEAMC. After their visit we were informed that the UEAMC had been advised by their medical defense union to remain "cautious in replying to our questions and not to provide potentially litigious information to us".

A summary of UEAMC communications with us is provided in the table:

	Date of letter to UEAMC	Date of response	Questions answered
1	03/01/2013	05/04/2013	Nil – holiday(s)
2	02/04/2013	11/04/2013	Partial
3	26/05/2013	31/05/2013	Nil
4	10/06/2013	14/06/2013	Nil
5	12/06/2013	No reply	Nil
6	21/06/2013	No reply	Nil
7	26/06/2013	01/07/2013	Records sent to NNCCG
8	04/07/2013	No reply	Nil
9	15/07/2013	No reply	Nil

Letters 5,6,8 and 9 requesting detailed information on Averil's care have been totally ignored by UEAMC.

6. Initial Complaint to NHS England,

The University of East Anglia Medical Centre are responsible for the lack of care provided to Averil Miranda Hart. This lack of care and patient safety was responsible for the tragic death of Averil at the age of nineteen who died of Anorexia Nervosa only ten weeks after starting university.

6.1. Failure to follow the basic *risk assessment* for Averil Hart, leading to the neglect of a high risk 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)

6.2. Failure to provide adequate *patient safety* and adhere to the Care Plan provided by Addenbrooke's leading to the death of a high risk patient, who the UEAMC had already designated as being in a "*dangerous*" transitional period in her life.

6.3. Failure to undertake the simple weekly patient *health checks* as prescribed in Averil Hart's discharge plan from Addenbrooke's hospital, leading to the death of a high-risk patient.

6.4. Failure to assign a Doctor with appropriate *experience and training* to Averil's care.

6.5. Failure to follow simple MARSIPAN & NICE guidelines for AN sufferers.

Failure to ensure an accurate and ongoing assessment of patient "physical health" either by clinical assessment of communication with outside agencies undertaking such assessments with appropriate referral to inpatient services :

MARSIPAN 6. " The role of the primary care team is to *monitor* such (AN) patients and refer them early".

6.6. Failure to *communicate* with outside related agencies (NICE guidelines) which lead others to believe that care was being provided (as prescribed) when effectively no or less than minimal care was being given.

6.7 Failure to *communicate changes* in care plan activity to outside agencies.

6.8. Failure to provide *emergency care* (caused by lack of communication and proper liaison / working methods) with the University disability service and University student's dean's office, as would be reasonable to expect from a university medical service.

6.9. Failure to *assess* incoming communication from a patient within the context of their illness and take appropriate action.

UEAMC have cited as an excuse for the lack of care they provided for Averil, an email that they received from her. Given that Anorexia Nervosa is a psychiatric disorder with one of the highest mortality rates of any mental health illness, it is inconceivable that an email from a mental health patient should be cause for any cessation or reduction of care without proper health checks and a referral to specialist health professionals. See 6.8

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

6.11 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.

6.12. Failure to provide *open and honest* responses and communication with Averil Hart's family, following Averil's death. Failure to respond in full to ten letters from the Hart family.

Failure to provide a copy of the internal inquiry at UEAMC when requested.

We hold the University of East Anglia Medical Centre (UEAMC) responsible for the death of our daughter Averil Hart by neglecting her basic human right to an appropriate level of health care at the University.

We are seeking the following:

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

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

C) Appropriate *disciplinary action* where the medical standards (GMC guidelines) at UEAMC 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