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Regulator admits multiple failings in investigation of young woman's death

By Rebecca Thomas | 9 January 2020

Parliamentary Health Service Ombudsman admits to multiple failings in its investigation into death of Averil Hart

Report found the investigation took too long and was allocated "insufficient" resource

Comes as coroners in Cambridgeshire look at possible links between failures in Ms Hart's care and that of four other women

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Multiple failings have been found in the health ombudsman's investigation into the death of a young woman with anorexia.

The Parliamentary Health Service Ombudsman has admitted to multiple failings in how it handled a three-and-a-half year investigation into the systemic failings by NHS providers in Cambridgeshire and Norfolk which led to the death of Averil Hart in 2012.

The findings come as a senior coroner in Cambridgeshire investigates whether there are links between the failures in Averil's care and that of four other women with an eating disorder who were under the care of the same services.

The PHSO's failings have been revealed in an internal review, published today, which ruled the regulator's investigation took too long and should've been completed in half the time.

It also found "insufficient" resource was allocated to the Averil's investigation, despite staff requesting it, which led to significant delays.

According to the PHSO, Averil's investigation had come at a time when the regulator was required to make a 24 per cent cut in its annual budget.

In total, five caseworkers worked on Averil's investigation over the three and a half years, which the report said sometimes led to information being lost.

However, the report did identify improvements which have been made since, including the appointment of advisory panel to "support and challenge its work". This panel includes James Titcombe and Dr Bill Kirkup.

Averil's father, Nic Hart, told *HSJ*: "It has taken me five years to get to this point, where virtually I wake up every day thinking about the failures in Averil's care and the failings of this investigation. This isn't something that goes away and means my own life has been put on hold.

"In my opinion there have been avoidable deaths as a result of the time it has taken… because changes could've been made by Cambridgeshire and Peterborough."

He also said while the PHSO's review of its investigation "paints a picture of chaos", it had failed to point out the poor quality of the investigation.

In a statement published with its report the PHSO said: "This report makes clear there were a number of failings in the way we handled Mr Hart's complaint. We have apologised to Mr Hart for the fact that the investigation took much longer than it should have, and for the difficulties and stress this caused him and his family."

Source

PHSO report

Source Date

9 January 2019