FOR HEALTHCARE LEADERS
HSJ

Tragic death of 19-year-old 'inextricably linked' to four other fatalities

By Rebecca Thomas | 20 May 2019

Coroner probes links between deaths of five patients with eating disorders in same county

Systemic failures in care of first death originally exposed by PHSO in 2017

News follows MPs criticising NHS for slow progress on implementing eating disorders service improvements

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A senior coroner is investigating whether the deaths of five patients with eating disorders in Cambridgeshire are connected by similar systemic care failings, *HSJ* can reveal.

In an email seen by *HSJ*, senior coroner for Cambridgeshire David Hemings told the father of 19-year-old Averil Hart, who died in 2012, that her case was “inextricably linked” to investigations into four other more recent patient deaths in the county.

The email, sent to Ms Hart’s father Nic this month, said: “As you are aware the tragic death of Averil is linked to four other eating disorder deaths that we are investigating…

“The inquest of Averil is inextricably linked/entwined with these other major investigations. I am not sure you are aware but Parliament has also recently announced a major review of eating disorders and health services relating there to.” Averil died in December 2012, after suffering for a number of years with anorexia nervosa.

Averil Hart, who died in December 2012

The inquest into her death is yet to take place. However, in 2017 the Parliamentary and Health Service Ombudsman found systemic failing in Averil's care and that all NHS organisations involved had missed opportunities to identify the deterioration in her condition which could have prevented her death.

Those organisations were Cambridgeshire and Peterborough Foundation Trust, University of East Anglia Medical Centre, Norfolk and Norwich University Hospitals FT and Cambridge University Hospitals FT.

HSJ has, however, not confirmed which specific services or organisations were involved in the treatment of the four new cases.

The news follows MPs on the public administration and constitutional affairs committee criticising NHS and government bodies last week for the slow progress on implementing improvements to NHS eating disorder services at the front line.

As part of its response to Averil's death, the PHSO also published a report, titled *Ignoring the alarms: how NHS eating disorder services are failing patients*. The report made several recommendations for the improvement of adult NHS eating disorder services nationally.

PHSO chief executive Rob Beherns told *HSJ* while the groundwork has been laid for improvements set out in the PHSO report, they were yet to be seen on the front line.

Mr Hart, Averil's father, has been campaigning for more support for people suffering from eating disorders.

Speaking about the lack of progress on the recommendations, he told *HSJ*: "My message is there is absolutely no excuse for there to be no immediate response.

"With Averil and most of the cases we've come across, there's been a failure of basic healthcare. It's not cutting edge technology, it's not specialist, it's things like a lack of communication between secondary and primary care and a basic lack of GPs recognising the illness.

"If we get the basic stuff right than we can cut the morbidity of anorexia, which has one of the highest morbidity rates in mental health."

All trusts were approached for comment.

A CUHFT spokesperson said since Averil's case the trust had made improvements including an electronic medical record system, which means the multidisciplinary management of patients

with anorexia is better defined, and an improved treatment pathway.

Downloads

PHSO's Ignoring the alarms: How NHS eating disorder services are failing patients

Report | PDF, Size 0.15 mb

Report by the Health Service Ombudsman for England of an investigation into a complaint made by Mr Nic Hart

Report | PDF, Size 1 mb

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Source

Coroner's email and PHSO report

Source Date

May 2019 and 2017