Surrey and Borders Partnership NHS
NHS Foundation Trust

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18 September 2014

Dr Karen Henderson
Assistant Coroner in Surrey

Dear Dr Henderson

Inquest into the death of Clare Cooper – REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Further to the conclusion of the inquest into Miss Cooper's death on 11th July 2014, you wrote to Surrey and Borders Partnership NHS Foundation Trust in accordance with the Regulation 28 report to prevent future deaths, stating that during the course of the inquest the evidence revealed matters giving rise to concern. We would like to take this opportunity to offer our sincere condolences to Miss Cooper's family for their loss.

The areas of concern you raised that relate to our Trust and our responses are detailed below:

Lack of evidence of a robust assessment of presenting signs and symptoms with a presumption of a psychological/psychiatric problem without considering or excluding an organic cause

We have revised our referral form in order to try and improve the quality of information that GPs provide when referring patients. The form asks for more detail from the GP including that they consider and exclude organic causes of weight loss prior to making a referral to the Eating Disorders Service. The form also highlights the need for the GP to provide further details of the nature of the eating problem, results of blood investigations, physical examination and past medical history so that all information is available prior to assessment by the Eating Disorders Service. It is hoped that as well as assisting the Service in prioritising the referral, identifying if a medical assessment is necessary and optimising the assessment process, the details required in the revised form will also act as a prompt for the GP to consider the possibility of organic disease in those presenting with eating difficulties.

Lack of understanding of the underlying causes of hyponatremia (consistently or intermittently low) and the level below which will require further investigation, and the investigations that should be carried out, particularly in circumstances when there is no obvious cause of the low sodium.

We acknowledge the importance of increasing knowledge and awareness within the Eating Disorder Service about possible causes of hyponatremia and when to seek further investigations. We will be addressing this need through the Trust-wide eating disorders academic meeting during which there will be a teaching session for all clinical staff specifically about presenting symptoms and signs of Addisons disease including psychological manifestations, causes of hyponatremia and circumstances/levels below which further investigation should actioned.

Insufficiently robust EDS proforma used to triage patients for an eating disorder: lack of prompts and a need to emphasize and exclude possible organic causes, however rare. The lack of a documented list of potential diagnoses to be assessed and excluded at triage, including organic causes. A need to facilitate communication from the referral agents to the eating disorder service.

The triage assessment form was introduced a number of years ago as a screening assessment to establish if the patient met the criteria for having an eating disorder that our service could help with, rather than being developed as a comprehensive assessment form. This enables us to see people quickly and avoid waiting lists. If the person is found to be suitable for our service, they are then offered a fuller assessment.

We have however reviewed our triage form to ensure that all information including physical investigations is recorded in one form. The changes made include:

1. Box to record blood investigation results
2. Box to record findings of physical examination
3. 3.Box to record details of physical symptoms and past medical history with prompts.

The form also has an addendum reminding staff to be alert to the possibility of organic causes of illness when assessing new referrals. It provides a list of examples of possible conditions that may present with weight loss/eating problems. We are of the view that this revised form will prompt our staff to make contact with the GP where required to request organic causes to be ruled out. It is our expectation that in cases where any symptoms are atypical, that they would be discussed with the medical staff in the team and appropriate action would be taken.

Lack of hospital notes available for the pathologist undertaking the post mortem to facilitate a greater opportunity for clinical –pathological correlation in deaths which are unascertained and a higher level of suspicion to explore rare causes of unexpected death, especially in the young.

We are sorry that there was an issue with making notes available to the pathologist to facilitate a review to determine any clinical –pathological correlation. We work really

closely with all interested parties to share clinical records including the Coroner and the pathologists. In this incident we shared records with the family (including the professional witness) and our Medical Records Team was in constant communication with them about access to records, but we are unable to find any information about any delays or issues with making these records available to the pathologist. We have shared this concern with our Medical Records Team and we will continue to support them in ensuring that all key records are made available in a timely manner to the pathologist in the future.

Our Board has been made aware of your letter and we would like to offer our sincere condolences again to the Cooper family for their loss. We hope that the steps we have taken as outlined above assure you and Miss Cooper's family that we have learnt and continue to learn from Miss Cooper's death. Please do not hesitate to contact me or [redacted] Director of Quality (DoN) if you require any further information.

Yours sincerely

Fiona Edwards
Chief Executive

cc

[redacted] – Director of Quality (DoN)
[redacted] – Medical Director
[redacted] - Director of Children & Young People Services
[redacted] - Director Risk & Safety (DDoN)