REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Gillian Keegan MP

Minister of State (Minister for Care and Mental Health)

Department of Health & Social Care

CORONER

I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**

CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

The death of **Louise Cooper** on 16/05/20 at her home address was reported to me and I opened an investigation, which concluded by way of an inquest held on 17th December 2021.

I determined that the medical cause of Ms. Cooper's death was **1 a Severe Malnourishment**

In box 3 of the Record of Inquest I recorded as follows:

Louise Cooper had been diagnosed with Anorexia Nervosa for many years. She has received care for this condition during a number of in-patient admissions, the last of which ended in July 2019. Over subsequent months she continued to receive care from an eating disorder service until she was discharged on 2 January 2020. Louise knew that the Clinical Psychologist with whom she had worked for a number of years was due to go on maternity leave. She did not wish to work with any other members of the Eating Disorder Service [EDS] team. When discharged her Body Mass Index [BMI] is estimated to have been at a significantly low level of 12.5. She was discharged on the understanding that she would receive ongoing monitoring from her General Practitioner. The GP surgery was notified about the discharge but due to an administrative issue the need for Louise to be monitored was not appreciated. She did not receive the necessary monitoring. During the weeks preceding Louise's death, her health went into further decline. This was in part contributed to by the Coronavirus pandemic in March 2020 which left her more isolated. Having last exchanged text messages with Louise on the 15th May 2020, a friend attended her home address at approximately 12:30pm on the 16th May 2020 to deliver some shopping as previously

arranged. Unable to obtain a reply he forced entry and he found Louise to be deceased on her bed in the rear bedroom. A subsequent post mortem examination confirmed she had died from the consequences of severe malnourishment.

The conclusion of the Coroner was a Narrative Conclusion as follows:

Having been discharged from an eating disorder service on 2nd January 2020, Louise Cooper's condition had not been monitored by medical professionals by the time she died on 16th May 2020 as a result of complications of her previously diagnosed anorexia nervosa.

CIRCUMSTANCES OF THE DEATH

In addition to the contents of section 3 above, the following is of note:

- Louise was known to have suffered with anorexia nervosa for many years. During the weeks preceding Louise's death, those close to her report a decline in her health.

- It is reported that she stated to friends that the nationwide lockdown due to the Covid-19 Pandemic had removed all of the mechanisms that she had for coping with her condition. A Trust review would later find that as Louise was self-isolating due to Covid - 19, this may have impacted upon her mental and physical wellbeing due to reduced social contacts.

- Louise did not received the monitoring she was expected to receive during 2020. The court found that had she received that monitoring as envisaged, there was a good chance she would not have died when she did, but was unable to say that she would have survived

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

- Louise was known to have suffered with anorexia nervosa for many years and during that time her treatment had included a number of in-patient admissions at times when her extremely low weight became concerning. Neither Louise nor her Father felt that these admissions were in fact helping her to improve.

- Louise had for some time also received treatment from an eating disorder service. Her treatment had included supported eating whereby once per week a

professional would sit with her whilst she ate a meal. She responded positively to this. Indeed, it is of note that when her Father attended our court not long after her death, he commented that had Louise been able to have a professional with her once per day whilst she ate, then the outcome for her may have been different and the costs of providing such a service would have been far less than the significant costs of admitting her for periods of treatment in a hospitals. He described her regular hospital admissions as a "revolving door" which was not helping her.

- The Consultant Clinical Psychologist responsible for her care at the eating disorder service had tried to commission an increase in the level of supported eating for Louise but unsuccessfully. She told the court Louise needed this support at least once per day.

- There will be many patients such as Louise who appear to make minimal if any improvement in a hospital setting but who may benefit – according to the clinicians treating them – from sustained supported eating. If that option is not available, these patients may be left with no realistic chance of any meaningful improvement.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report. Given the approaching holiday period I have extended this period to **Friday, 28th February 2022**. I, the coroner, may extend the period further.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

- [redacted] [Friend / Executor]
- Lancashire & South Cumbria NHS Foundation Trust
- Poplar House Surgery
- Blackpool Clinical Commission Group / Fylde & Wyre Clinical Commissioning Group

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

21/12/2021

Signature____ 

Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**