REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Right Honourable Sajid Javid Secretary of State for Health and Social Care 2. Dr [redacted] Chair of the Faculty of Eating Disorders Royal College of Psychiatrists 3. [redacted] Chief Executive Officer of NHS England 4. [redacted] Chief Executive of the Academy of Medical Royal Colleges 5. Dr [redacted] Chief Executive Northern Care Alliance 6. [redacted] Chief Executive Greater Manchester Mental Health Trust 7. [redacted] Chief Executive of The Priory Group 8. Dr [redacted] Chief Executive of Health Education England 9. [redacted], Bury Clinical Commissioning 10. [redacted], Greater Manchester Health and Social Care Partnership / Integrated Care Board Greater Manchester
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 12th August 2020, I commenced an investigation into the death of Nichola Jane Lomax. The investigation concluded on the 10th December 2021. The medical cause of death was confirmed as 1a) Liver Failure 1b) Anorexia Nervosa 2. Refeeding syndrome and cholecystitis. I recorded a narrative conclusion that Nichola died as a result of the physical complications of the mental disorder anorexia nervosa, contributed to by neglect. I found on the balance of probabilities if appropriate care and refeeding had been provided to Nichola it is more likely than not she would have survived. A significant number of failings were identified.
4	**CIRCUMSTANCES OF DEATH** Nichola had an eighteen year history of an eating disorder. She had been an inpatient in 2011 and 2016. Since 2017 she had disengaged with services, with the exception of her GP. Until June 2018 there was regular weighing of Nichola by her GP but this then ceased (it is not known why as she continued to engage with them for other matters). At the beginning of 2020 Nichola felt unwell and on three occasions attended via ambulance at A&E at Fairfield General Hospital "FGH". She attended on the 13th January, 23rd March and the 28th April 2020. On each of these occasions she is treated for low potassium. In January her weight was

noted to be 31.6kg (BMI 11.6) although it is not known if she was actually weighed and therefore if this was accurate. There was no recorded weight in March or April.

The Northern Care Alliance ("NCA") accepted that on each of these three occasions Nichola should have been admitted to hospital as she was a high risk for refeeding syndrome. In addition, it was accepted by the NCA that it had not disseminated or trained staff in respect of MARSIPAN (Management of Really Sick patients with Anorexia Nervosa) guidance.

In addition during these admissions no discharge follow up was suggested for her GP and there was no referral of Nichola to any specialist services. No consideration was given to the involvement of Psychiatry with Nichola.

On the 1st June Nichola attended her GP practice having been found by a family member unable to walk and "*like she could die at any minute*". From this stage onwards the Advanced Clinical Practitioner at the GP practice did everything she could do to help Nichola. She immediately recognised the life-threatening condition. She weighed Nichola, her weight was 26.7kg and her BMI 10. In all likelihood this was the first accurately recorded weight since 2018.

She immediately sent NIchola to A&E at FGH and referred her to the Community Eating Disorder service ("CEDS") which for Bury is under Greater Manchester Mental Health Trust ("GMMH").

CEDS made a referral for inpatient admission to the Specialist Eating Disorder Unit at The Priory as they recognised her need for inpatient admission. However CEDS did not accept Nichola as their patient as they do not accept anyone with a BMI less than 14.

At FGH Nichola was admitted until the 3rd June to treat her electrolyte imbalance. She was not admitted to address her risk of refeeding. There was no recognition that this was Nichola's fourth attendance at A&E since January. During this admission there was poor nursing input and poor recording in the nursing notes. There was no nutrition or fluid charts and no monitoring of her daily intake or any purging behaviours. There was poor dietetic input and no attempt to obtain any advice from a specialist eating disorder dietitian. There was a failure to follow the basic dietetic input which was given and no prescribing of supplemental drinks. There was a lack of clarity as to the treatment plan for Nichola other than to stabilise her electrolyte imbalance.

There was a confused picture and understanding as to whether NG feeding was actively going to be considered. This led to an incoherent referral to psychiatry for them to assess her capacity for discharge.

At this stage the court found Nichola was willing to stay in hospital, in fact she was asking to stay in, she was engaging with treatment in that she was eating orally, there was no evidence any medic was wanting to treat Nichola by way of NG feeding and there was no evidence anyone had discussed in an appropriate way, NG feeding with Nichola and no evidence she had refused the same.

No attempts were made to discuss her case with the Priory and she was discharged on the 3rd June.

The CEDS and GP were concerned about her discharge, CEDS wrote a letter for Nichola to take with her to the hospital. She was once again asked to attend A&E went back to FGH on the 5th June 2020. On this occasion she was admitted until the 11th June 2020. During this admission the court found there a number of failings:-

- a lack of close monitoring of her nutritional intake and purging behaviours,
- there was no prescribing of supplemental drinks,
- there was no adherence to the Trusts refeeding policy,
- there was a lack of specialist dietetic advice which should have been escalated to management if there were difficulties obtaining the same,
- There was an unclear treatment plan in terms of whether Nichola required NG feeding
- Inappropriate and unclear requests were made of psychiatry

On the 11th June there was a discussion between the medical doctor and the Priory. This conversation was totally unacceptable. At the conclusion of the call both Consultants had an irreconcilable understanding as to the result and advice each were providing. The Priory understood from this conversation that Nichola no longer required inpatient admission to their service. This was not correct. The Trust were indicating Nichola was medically stable and no longer

	required admission in FGH. In addition the Priory believed Nichola was being discharged under the care of the community mental health team with a 7 day follow up. This was not the case. In the meantime the medical doctor believed Nichola was under the CEDS service due to the letter which had been provided by them in support of her admission on this occasion. As a result of this poor communication Nichola was discharged from FGH and the Priory cancelled her inpatient referral. There was then a delay in making a re-referral to the Priory. This should have occurred on or around the 16th June when CEDS become aware that Nichola had been removed from the waiting list. A second referral was not sent by them until the 3rd July. This led to a delay in a bed for Nichola. Despite all the specialists indicating Nichola's case was one of the two most extreme cases they had seen in over 15 years of practice, at no stage was her case escalated to NHS England to try and obtain a bed out of area Between the 11th June and the 22nd July Nichola was monitored by the advanced clinical practitioner within the GP practice. She attended regularly for weighing and bloods. Despite this her condition deteriorated and she was admitted to hospital on the 27th July (as it was hoped an inpatient bed was going to be available on the 29th July). She deteriorated further and died on the 3rd August 2020.
5	**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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows:- 1) Inadequate Training of doctors and other medical professionals re eating disorders **For National / NCA / Royal College of Psychiatrists** Over 30 members of the medical profession saw Nichola during her three admissions to FGH in 2020. Of those, only one had knowledge of MARSIPAN and his understanding of MARSIPAN was extremely limited. This is not a question of lack of familiarity by professionals, it reflects a complete absence of any understanding that MARSPAN exists and indeed how to implement it in respect of the emergency treatment of an anorexic patient. Previous Regulation 28 reports suggests this remains an ongoing concern nationally and MARSIPAN is not being disseminated to practitioners on the ground. Whilst MARSIPAN can be accessed via a link in the NICE guidance on Eating Disorders. My concern is that Acute Trusts may not have sufficient regard to Guidance issued by Royal College of Psychiatry which is relevant to the medical care which they provide. 2) Accessing Specialist Advice **For National, NCA/GMMH/PRIORY** None of the practitioners in Nichola's case knew how to access specialist eating disorder advice including medical or dietetic advice. There are no pathways to assist acute clinicians in how to access this specialist advice. To this day the clinicians told the Court they would not know where to go other than to try and contact the Priory. The Court heard from the Priory they are not commissioned to provide advice. 3) Referral Criteria for the Priory and Community Eating Disorder Service **For GMMH, PRIORY, BURY CLINICAL COMMISSIONING, ICB** In Greater Manchester the Community Eating Disorder Service (CEDS) do not accept patients who have a BMI of less than 14. The court heard this is in part due to the structure and commissioning of the service. Adherence to this criteria had the following implications for Nichola's care: • As the only service who can refer to the Priory, CEDS become aware of Nichola. CEDS involvement created the impression that they were providing care to her. This created a confused picture as to who was co-ordinating her care.

- This meant that monitoring of Nichola was undertaken by the GP practice who were not specialists and had limited knowledge of eating disorders. It would have been more clinically appropriate for CEDS to have taken on this role and the court heard that in many other areas of the country the CEDS accept patients with BMIs lower than 14 and have responsibility for the monitoring and co-ordination of the patients care.

The Court heard evidence from a number of practitioners as to their understanding of the referral criteria for Nichola to be admitted to The Priory. The clear impression given by The Priory was that Nichola would not be accepted until 1) a bed became available but also 2) her BMI increased to somewhere around 12/13. The Court was told that the rationale for this is that a patient with a BMI below 13 is at high risk of refeeding according to MARSIPAN and more likely to require an acute hospital admission.

This impression meant that hospital clinicians and the GP understood that Nichola would not be accepted by the Priory until her weight had increased. However the court heard that the Priory can take someone with a BMI of less than 13 if medically stable and the benefits of specialist care outweigh the risks of refeeding. Given the impression created by the Priory no attempt was made to obtain an emergency bed for Nichola who was medically stable for some time after the 11th June.

4) Lack of Critical Services

For BURY CCG / ICB /GMHSCP

The Court heard evidence that despite FGH having a 24/7 Emergency Department, adherence had not been paid to NICE guidance which recommends the establishment of an Acute Liaison Psychiatry service. In this case the court heard that such a service would have provided continuity of care and psychiatric input. The only available psychiatry input at Fairfield hospital for the acute staff is either within the A&E department where there are psychiatric nurses or using the on-call psychiatrist, this post being on call for all psychiatry matters within the whole of Bury. There is no specific liaison psychiatric service for the Acute Hospital. .

The evidence was that there is no Consultant Psychiatrist allocated to the CEDS in Bury or the 6 other boroughs of Manchester. However even though the CEDS is provided by the same mental health trust, it is only the city of Manchester that does have an allocated Consultant Psychiatrist.

5) Community Monitoring of patients with an Eating Disorder

For BURY CCG / NATIONAL / ICB/ GMHSCP

There is a lack of clarity as to whether there is any formally commissioned provision for the monitoring of moderate to high risk Eating Disorder patients within the community. The Court heard from GMHSCP that this was the responsibility of primary care however it was unclear whether this was known by those working in primary care and whether this service had ever been commissioned.

6) Nursing Input and Recording

For NCA

Notwithstanding that the NCA made admissions in relation to the clinical care provided to Nichola, the Serious Incident Review did not consider the nursing input. Evidence during the course of the Inquest showed the nursing input to be poor and lacking in basic care. There were no nutrition / fluid charts on her first admission in June. There was a lack of close monitoring of her food and purging behaviours which would have been essential information to provide to the Doctors involved in setting her treatment plan. There was a poor documentation and incorrect completion of documentation which highlighted her malnutrition but then recorded conflicting information.

7) Delay in Re-Referral

For GMMH/PRIORY

Due to a misunderstanding following the telephone discussion between the Priory and FGH on 11th June Nichola was clearly removed from the Priory waiting list. This led to confusion for the GP practice who did not know why she had been removed. There was then a delay by the CEDS in re-referring Nichola which on balance likely led to a delay in a bed being available. This should not have occurred and more worryingly had not been noted as there had been no incident review of this case by either the Priory or the CEDS.

7) Lack of Recognition of the need to Investigate

For National Medical Examiner

	It was of concern to the court that the only reason Nichola's death was referred to HM Coroner was her initial medical cause of death had incorrectly included paracetamol toxicity. It was not until the court investigated this case, that there was any recognition by any of the agencies that there had been failings in the care of Nichola. If this death had not been reported to the Coroner, none of the above failings or the need for learning would have been identified. The court is extremely concerned that there is the real potential for the under reporting of such cases and a lack of appropriate investigation to ensure learning is captured so as to prevent future deaths. This is important given the court heard eating disorders have the highest mortality rate of any mental disorder.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively have the power to take such action.**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 14th February 2022. I, the Coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely:- Farleys Solicitors – representatives for the family of NICHOLA LOMAX Pennine Care NHS Trust – Interested Person 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 from. 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.
9	Date: 17th December 2021. Signed: Joanne Keasley.