	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Maria Caulfield MP** Parliamentary Under Secretary of State (Minister for Patient Safety and Primary Care) Department of Health & Social Care Ministerial Correspondence and Public Enquiries Unit 39 Victoria Street London SW1H 0EU United Kingdom **2.** [redacted] Board of Governors [Chair], British Association for Counselling and Psychotherapy (BACP): 15 St John's Business Park, Lutterworth, Leicestershire LE17 4HB, United Kingdom bacp@bacp.co.uk
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
2	**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
3	**INVESTIGATION and INQUEST** The death of Natalie Melissa Turner on 27.10.20 at her home address was reported to me and I opened an investigation which concluded by way of an inquest held on 20th to 23rd March 2022. I determined that the medical cause of Natalie's death was **1 a Laxative abuse** In box 3 of the Record of Inquest I recorded as follows: **Natalie Turner had for a number of years been abusing laxatives as part of a long - standing eating disorder. She had hidden the true extent of that abuse secret until November 2019. After being admitted to hospital on 05/11/19 in an acute condition, she needed to be provided with parenteral nutrition, and once stabilised she was discharged home on 14/11/19, only to return to hospital on 19/11/19 after ingesting more laxatives. Again stabilised, she returned home on 09/12/19 with a view to receiving care from the Home Treatment Team that was to involve regular**

	assessment, and weekly physical monitoring including blood tests and weight checks. Her condition did not initially raise significant concerns. On 03/01/20 she was discharged from the Home Treatment Team but it was envisaged that she would continue to receive regular physical monitoring. Such monitoring did not happen, in part because of Natalie's reluctance to engage with this, but also because the procedure usually followed at her GP surgery in order to encourage patients to undergo such monitoring was inadvertently not fully followed. This went unrecognised for a number of months. Throughout 2020, Natalie participated in some privately funded counselling sessions. By around April 2020, she had divulged to her Counsellor that she was ingesting laxatives in significant quantities. My mid – June 2020, her Counsellor was concerned for Natalie's welfare but preferring to respect Natalie's privacy she did not feel it appropriate to raise her concerns with medical professionals or Natalie's Husband. This was an opportunity to provide some urgent medical attention. Over subsequent months, Natalie continued to abuse laxatives. By 26/10/20, she was noticeably unwell with vomiting and diahorrea. After her Husband provided here with a drink of water at shortly after 3 am on 27/10/20 when Natalie reported that she remained unwell, she was found unresponsive in her room at around 7.15 am later that morning. A post mortem examination confirmed that she died from the effects of laxative abuse. In box 4 of the Record of Inquest I determined that Natalie died due to: **MISADVENTURE.**
4	**<u>CIRCUMSTANCES OF THE DEATH</u>** In addition to the contents of section 3 above, the following is of note: 1) Natalie had an eating disorder, ultimately diagnosed in November 2019 as Bulimia Nervosa. For many years, she had been ingesting large quantities of laxatives as a means of losing weight / maintaining a low weight. She had managed to keep this a secret from her family. 2) By November 2019, the impact of the laxative abuse left her requiring urgent medical attention in hospital. Her BMI reading was under 14, and laxatives had contributed to significant electrolyte imbalance. Her condition only improved following a period of parenteral nutrition. 3) Once stabilised, and then discharged from hospital, she was to receive treatment in the community. This was to include physical monitoring, and psychological work consisting of cognitive behavioural therapy [for which there was a waiting list and this was unlikely to commence for a number of weeks]. 4) Natalie did not receive the physical monitoring she required, in part because she did not wish to engage with it. A notable aspect of her condition was a clear tendency to do what she could to avoid, or at least restrict, any scrutiny by medical professionals. As far as she was concerned, when she was in hospital medical professionals were able to maintain her weight and / or help her to

	necessarily gain some weight, and she was rendered unable to continue with taking laxatives whilst in a hospital setting. This apprehension about contact with medical professionals was not limited to hospitals because she clearly sought to minimise contact with GPs in the primary care setting too, because attending a consultation with a GP could in her eyes lead to a return to hospital.
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 could occur unless action is taken. In the circumstances it is my statutory duty to send the report: There are two **MATTERS OF CONCERN** are as follows. – 1. The first issue I raise with **Parliamentary Under Secretary of State (Minister for Patient Safety and Primary Care), Department of Health & Social Care.** • The inquest received some helpful evidence from a GP, Dr [redacted], of the Ash Tree House Surgery, Kirkham. In court, I acknowledged the response of that surgery to Natalie's death which I have found to be thorough, open and constructive, and a genuine attempt to minimise the prospect of a recurrence in the future. Dr [redacted] explained that notwithstanding her considerable experience as a GP, General Practitioners do not receive specific guidance in relation to eating disorders, which are often very complex in nature. • It seemed to me that GPs can often find themselves in a difficult position when deciding how to approach dealing with a patient who has an eating disorder, but the situation is all the more challenging when the patient is unwilling to engage with medical professionals and accept treatment which is clearly necessary. Many of these patients ostensibly have capacity to make their own decisions, yet given the nature of their eating disorders may go on to make decisions that are not in their own interests. What the GP can and should do is often unclear. • The number of patients affected is not insignificant: indeed, the inquest heard that this one local surgery had recently identified thirteen of their patients were facing challenges relating to an eating disorder. GPs can resort to the current mental health legislation, **MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) guidance,** and **NICE (Eating Disorders Recognition and Treatment) guidance** which offers some assistance, but it seems to me that in the absence of guidance which focuses on eating disorder patients and what can be done when a patient is not engaging with treatment, GPs are often left unsure about how to help these patients, and in the absence of some guidance on this issue patients may go without treatment and with potentially fatal consequences.

- In response to Natalie's death, the Lancashire & South Cumbria NHS Foundation Trust has also responded in a constructive manner and have demonstrated a clear plan to avoid a repetition. This response has included the creation of new posts within the Trust who local GPs will be able to access for guidance and these include **a** Consultant Dietician and a Consultant Nurse, and hopefully local GPs make use of this new assistance, but this is not always the case elsewhere in the country.

2. The second issue I raise with **the British Association for Counselling and Psychotherapy (BACP):**

   - The inquest heard from a BACP Accredited Counsellor, with whom Natalie shared some 63 counselling privately funded counselling sessions between January and October 2020.

   - BACP guidance includes a set of core principles which ought to guide counsellors, and the guidance makes clear that in exceptional circumstances the need to safeguard clients from serious harm "may require practitioners to override a commitment to make a client's wishes and confidentiality the primary concern". The guidance makes clear that a breach of confidentiality may be justified.

   - The Counsellor had developed a good therapeutic relationship with Natalie, but in my judgement she felt unduly constrained by the wishing to avoid breaching Natalie's confidence, despite she herself having formed the view given what Natalie was disclosing to her about the extent of her ongoing laxative abuse she was at risk of self harm and of dying. These circumstances were exceptional, it is hard to think of a clearer example where to disclose her concerns to others would have been justified but she preferred not to because she did not feel she could betray her confidence. This was despite having regular discussions with her supervisor, and knowing that Natalie was not accessing the medical monitoring that she needed from her GP.

   - The Counsellor explained in court that she personally has not knowingly counselled an eating disorder patient before. The potential complexities of these conditions were not fully appreciated.

   - Patients with eating disorders will commonly prefer to avoid contact with mainstream medical care and treatment, and their families. It follows that such patients may be attracted to discussing their condition privately with a private counsellor.

   - Although the therapeutic relationship between counsellor and patient is fundamentally important, as the BCAP guidance makes clear there are occasions when a breach of confidentiality is justifiable. Counsellors who begin a course of therapy with an eating disorder patient need to

	appreciate that refraining from breaching confidentiality may well mean the patient goes without necessary and potentially life-saving care and treatment. Even if patients try to reassure counsellors that they are seeking medical help elsewhere, such claims may well not be credible because these patients may be claiming they are being treated as a distraction. • The Counsellor informed the court she did not have the benefit of guidance on eating disorders. More information may have highlighted the particular risks eating disorder patients may pose, particular as regards whether to breach confidentiality or not. In the absence of such guidance, I am concerned that there is a risk that vulnerable patients – who may in fact benefit from a disclosure by their counsellor – will miss out on necessary and potentially life – saving treatment. • Whilst acknowledging that on the BACP website [www.bacp.co.uk], within a section headed "Events & resources", there is a series of articles which explore some of the issues eating disorders may pose for counsellors, the Counsellor who gave evidence at Natalie's inquest did not appear to be familiar with these articles. This arguably reinforces the need for this subject to be raised with counsellors in a more targeted way.
6	**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.
7	**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, 10th June 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • [redacted] [Natalie's Husband] • Lancashire & South Cumbria NHS Foundation Trust • Ash Tree House Surgery, Kirkham, Lancashire • Blackpool Clinical Commission Group / Fylde & Wyre Clinical Commissioning Group • [redacted], Medical Director and Director of Education Standards, General Medical Council

	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.
9	25/03/2022 Signature____ AAWilson ____________________ Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**