Complaint to Norwich and Norfolk hospital regarding the lack of appropriate treatment and care which contributed to the death of Averil Hart (aged nineteen).

Our daughter and sister Averil Hart died of a treatable illness at the age of just 19 whilst studying at the University of East Anglia.

We feel that a major contributory factor in Averil's death was the lack of appropriate treatment and care that she received whilst at the Norwich and Norfolk hospital (N&N).

The Norwich and Norfolk hospital failed to follow basic appropriate NICE and MARSIPAN guidelines for AN patients.

Background.

Averil had been admitted to Addenbrooke's hospital as an inpatient suffering from Anorexia Nervosa (AN) in September 2011. After around ten months as an inpatient Averil was deemed well enough to commence University at the University of East Anglia in September 2012.

Staff at Addenbrooke's S3 wrote to the Norfolk Community Eating Disorder Service (NCEDS) before she started at University on two occasions. This correspondence states that Averil is of high risk of relapse and needs regular weekly check-ups to ensure her safety.

On 27th September 2012 a note was made on Averil's medical file:

…"*Averil has a BMI of 15, she is still regarded as fragile, new start at Uni' could be a potentially dangerous time for her … she is vulnerable at the moment*"

Care in the community whilst Averil was at University was virtually non-existent and both the NCEDS service and University of East Anglia Medical Centre failed to monitor or treat Averil and as a consequence her health deteriorated rapidly.

After battling bravely to remain at university, but without the care she so badly needed from her health providers, Averil was found unconscious in her flat and after a 999 call, she was rushed to hospital in Norwich and then transferred to Addenbrooke's where she later died.

Averil arrived at the N&N by emergency ambulance having collapsed at her university flat. She was extremely ill and required immediate treatment specifically to MARSIPAN guidelines.

Under MARSIPAN guidelines it is essential in critical situations for there to be an immediate assessment of mental capacity by qualified psychiatric personnel and appropriate use of the MHA as well as physical assessment.

This assessment of mental capacity was not undertaken as dictated by MARSIPAN and NICE guidelines.

Communication with Averil's family was particularly poor and her family were told that Averil would be "rehydrated" and would be sent home after the weekend. In fact Averil died within just a few days.

Having been without significant nutrition for several days or more and suffering from extreme AN, Averil was expected to feed herself from the ward trolley, rather than by nasogastric methods.

Averil's family sat with her whilst she was expected by N&N staff to feed herself soup and bread. Clearly she was unable to do this and so her condition deteriorated considerably.

Instead of being confined to a wheel chair on one-to-one care, Averil was allowed to move around the ward, using further energy. She was expected to go to the shower and toilet unaided.

Not only was Averil using energy and reserves that she simply didn't have, but she was also gaining no further nutrition. As a result she became critically ill during the next 48 hours.

In this weakened condition and unaided by staff, Averil fell whilst on the ward and sustained a head injury. Another instance of extremely poor care by the N&N.

It soon became clear that without proper and appropriate care at N&N that Averil had deteriorated to an extent where the N&N could not reverse the damage that they had done to Averil in those 48 hours. At our request Averil was transferred to Addenbrooke's where she later died.

This document forms the first part of a major complaint outlining the negligence and neglect in the care of Averil Hart, which lead to her untimely death.

Further detailed complaints are likely to be lodged once we have ascertained further information about Averil's case, which will be subject to a number of FOI requests.

Initial Complaint to the Norwich and Norfolk hospital regarding the lack of appropriate care for Averil Hart.

Although Averil was extremely unwell when she arrived at N&N, it is clear that her treatment at the hospital in the first stages was inappropriate and resulted in her tragic death at the age of nineteen.

1.0 Failure of N&N to ensure an appropriate assessment of Averil's mental capacity as per MARSIPAN guidelines, with no use of the MHA act to ensure Averil's safety.

MARSIPAN states that Medical and ward staff need to be aware that adult patients with AN being admitted to a ward are at very high risk of death unless they are treated correctly.

1.1 Failure to instigate safety procedures to ensure that Averil's nutritional level was maintained at a safe level by Nasogastric or other methods.

1.2 Failure to ensure commencement of appropriate treatment for a patient in a critical condition in a timely way. Averil's family were told that Averil would be sent home after the weekend. Clearly this was an inaccurate and inappropriate assessment of her condition.

1.3 Failure to ensure implementation of the basic *risk assessment* for Averil Hart, leading to the neglect of a high risk, vulnerable patient and preventable death of a young person.

"AN has one of the highest mortalities of any psychiatric condition"

1.4 Failure to assign appropriate staff to a patient in a critical condition. (with knowledge of Averil's condition and capable of dealing with a condition where after several days with no nutrition, glucose levels would be critical).

1.5 Failure to ensure Averil's safety with regard to mobility on the ward.

1.6 Failure to prevent patient mobility in extreme AN, allowing Averil to use critical reserves of energy, which resulted in her condition deteriorating substantially.

1.7 Failure to provide nutrition in an appropriate way (expecting Averil to feed herself from the ward trolley – a virtual impossibility in critical stage AN).

1.8 Failure to prevent Averil from falling and sustaining a head injury.

1.9 Failure to keep Averil's family fully informed of the situation.

2.0 Failure to involve other specialist agencies in a timely manner, with the result that Averil's condition did not have the benefit of specialist AN input at a critical stage, namely on 07.12.12

We believe the lack of care by N&N (particularly the maintenance of Averil's blood chemistry and nutrition and physical care) was instrumental in the rapid deterioration in Averil's health and this was a major contributory factor in her death.

We are seeking the following:

A) A full *external investigation* into the events leading to Averil's death in order to find out *precisely* what went wrong and why.

B) Remedial action to overhaul the standard of care provided to high risk patients in order to increase patient safety.

C) Appropriate *disciplinary action* where the medical standards (GMC guidelines) have fallen below acceptable standards in:

   i) Knowledge and skills,
   ii) Patient Safety and quality
   iii) Communication
   iv) Trust (openness, honesty and integrity)

D) An appropriate statement of apology to Averil and her Family, and Averil's friends at home and university.

Nic Hart, Averil's father

Miranda Campbell, Averil's mother

Imogen Hart, Averil's sister

Zoe Hart, Averil's sister