REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health and Social Care** **2. The Department of Health and Social Care**
1	**CORONER** I am Catherine Wood, assistant coroner, for the coroner area of North East Kent.
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.
3	**INVESTIGATION and INQUEST** On the 5th February 2020 an inquest was opened into the death of Hayley Smith. At the inquest, which was heard with a jury and lasted eight days we heard from many of those involved in Hayley's short life. The jury concluded on 9th March 2022 with a narrative conclusion "The deceased died from complications of Anorexia Nervosa."
4	**CIRCUMSTANCES OF THE DEATH** (1) Hayley Smith developed severe and enduring Anorexia Nervosa at around the age of nine or ten and was resistant to treatment including several hospital admissions both voluntary, and at times compulsory treatment under the Mental Health Act. (2) Between 2015 and 2018 she was repeatedly admitted to the Priory hospital in Hayes but following each discharge her weight fell rapidly and she required readmission. She was discharged for a final time in October 2018 and subsequently admitted to the Bethlem hospital a couple of weeks later in the November. She was a resident of Kent and throughout her care the local Eating Disorder service were involved in her care (Kent and Medway Eating Disorder service managed by North East London Foundation Trust.) (3) By May 2019 it had become clear to the treating clinicians that Hayley had not gained weight and was managing to falsify her weight. Her illness was pervasive and her metabolism severely affected with a seizure in July 2019 likely as a consequence of hypoglycaemia and her liver function deteriorated showing signs of raised transaminases as a consequence of her malnutrition. She was subject to regular blood tests and her leave was restricted when her results were abnormal leading to some improvements. She was referred for a Hepatology opinion and investigations at Kings. (4) As she was unlikely to be able to cope in the community steps were taken to find a suitable rehabilitation placement, the nearest being Ipswich some considerable distance away from her family and any support network she had. There were no local units where Hayley could have been treated which may have led to improved communication and more involvement and support from her family. We heard evidence from Professor [redacted] Consultant Psychiatrist from the Bethlem hospital and Dr. [redacted] an independent Consultant Psychiatrist that her final placement was one of only two units in the country offering rehabilitation treatment for those suffering from Anorexia Nervosa.

(5) As she had been so resistant to treatment she was discharged with a Community Treatment Order (CTO) in place. On 22 December 2019 she travelled back to Kent to spend Christmas with her family.

(6) On 23rd December 2019 she had not eaten, became confused and unwell, and an ambulance was called. The correct emergency treatment was provided but Hayley responded quickly and regained consciousness and refused further treatment or admission to hospital. On 24th December she became unwell again and this time was taken to Queen Elizabeth the Queen Mother hospital where she again refused treatment and discharged herself against medical advice. The responsible medical officer from the Kent Eating disorder team gave evidence that had the team known of either of these episodes they would have taken steps to admit her and treat her.

(7) On Christmas Day 2019 she collapsed for a final time and this time, had an out of hospital cardiac arrest, and was admitted to Queen Elizabeth the Queen Mother hospital and transferred to Intensive care where she was diagnosed as suffering from hypoxic brain damage as a result of her cardiac arrest due to severe hypoglycaemia as a consequence of her Anorexia Nervosa. She died on 29th December 2019 at the age of twenty-seven.

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 report to you.

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

(1) Evidence given at the inquest revealed that there were seven different organisations involved in Hayley's care all of whom had different systems for recording their clinical notes:
   I. South London and the Maudsley NHS Foundation Trust (SLAM)
   II. North East London NHS Foundation Trust (NELFT locally known as the Kent and Medway Eating Disorders Team)
   III. The White House
   IV. Kings College NHS Foundation Trust (Kings)
   V. General Practitioner (GP)
   VI. East Kent Hospitals NHS Trust (EKHT for Queen Elizabeth the Queen Mother)
   VII. South East Coast Ambulance Service

(2) The evidence given at the inquest revealed that each of the organisations were reliant on being copied into correspondence or on specific information being shared by others. The White House were not sent copies of clinical correspondence and at the time did not have access to GP records although since Hayley's death do now have access to GP records. The mental health team at NELFT were responsible for managing Hayley's CTO despite the fact that she was placed out of their geographical area but were not aware she had been seen by either the ambulance service or by Queen Elizabeth the Queen Mother hospital.

(3) The evidence at the inquest revealed that communication between those involved in her short life was inadequate and, as each ran separate clinical records systems, they could not access crucial information which could have made a difference ultimately meaning Hayley may not have died when she did. It is highly likely that had the paramedic at South East Coast Ambulance Trust who attended Hayley on 23rd December or the emergency department nurse who saw her at Queen Elizabeth the Queen Mother hospital on 24th December

	2019 been aware that Hayley was on a CTO they or her treating mental health team would have been able to take steps which would have saved her life. (4) Evidence was given at the inquest that locally some steps have been taken to try to share key data between acute hospitals but there have been significant hurdles which have impeded the process namely, the different information technology systems used, licensing issues for the software, Data Protection requirements, confidentiality and consent issues as well as training and funding. (5) Hayley died following an out of hospital cardiac arrest on Christmas day 2019. If information been shared between different health care organisations particularly crucial information about Hayley's CTO it is highly likely she would still be alive today.
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, namely by 24th May 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 the family, The White House, North East London NHS Foundation Trust, South London and the Maudsley NHS Foundation Trust, Kings College NHS Foundation Trust, East Kent hospitals NHS Trust and Hayley's General Practitioner at the time. 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	**28 March 2022**  **Catherine Wood** **Assistant Coroner** **North East Kent**