NPC
49 Marine Avenue

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Response to Regulation 28 Report into the death of [redacted]

From: 49 Marine Avenue GP Surgery (NPC Surgery)
Date: 13th August 2025
To: H.M Senior Coroner, Mr Andrew Hetherington, Northumberland Coroners Office
Response Due: 18th August 2025

Dear Sir,

We acknowledge receipt of the Regulation 28 report concerning the tragic death of [redacted] and extend our sincere condolences to her family. We take this matter very seriously and appreciate the opportunity to reflect on the concerns raised and to outline our learning and planned actions to improve care delivery.

Summary of GP Surgery Involvement:

1. **Monitoring of Weight and Physical Health:** We recognise that from November 2023 there was inadequate face-to-face monitoring of [redacted] weight. As a GP surgery, we rely on multidisciplinary collaboration and clear communication to monitor complex cases. We invited [redacted] for a face-to-face consultation, including weighing, by phoning and then texting directly to her mother; however, [redacted] her family did not contact us to attend for a weight appointment. We regret that despite these efforts we were unable to engage her directly.

2. **Referral to Gastroenterology:** We acknowledge the confusion around referral pathways between consultant services and use of the term "consider referral" and that the requested referral did not occur. We recognise this represents a critical missed opportunity to escalate care. Going forward, we will ensure clearer understanding of referral pathways and strengthen communication with secondary care colleagues to prevent similar delays.

3. **Communication and Information Sharing:** The report highlights concerns regarding the flow of information from other agencies, including the school and mental health services. We concur that a more robust system for sharing relevant clinical and safeguarding information is essential. We are committed to improving multidisciplinary communication, including liaising more proactively with schools, mental health services, and social care teams involved with patients at risk.

Learning and Actions to be Taken:

- **Enhanced Face-to-Face Contact:** The GP surgery already runs a primarily face-to-face appointment system, but we have reminded the team of the importance of this means of access, particularly where weight loss or malnutrition is a concern, to ensure accurate physical assessments. We will continue to reiterate the importance of face to face contacts at our monthly meetings and when any changes to appointment ledgers are considered.

- **Clarification of Referral Pathways:** We are fully committed in working with our secondary care colleagues to ensure that any information that is shared between primary and secondary healthcare pathways and communication is implemented as part of the learning and actions from this case. This will be discussed, for action, at the North East and North Cumbria GP Provider interface group by October 2025. If new pathways are introduced, we will seek to confirm they are operational rather than assume everyone is aware. If there is any uncertainty or ambiguity regarding the request in a letter, we will write back to the Consultant to clarify. If any actions are unable to be carried out for any reason, we will write to the Consultant to inform them and ask if any further action on our part is needed. We are reviewing internal processes to clarify responsibilities and improve timely referrals for specialist input.

- **Improved Multidisciplinary Communication:** We are developing strategies for better information sharing among primary care, secondary care, schools, and mental health services and have met with Northumbria Healthcare Foundation Trust regarding this. Specifically, we are looking into setting up monthly Multidisciplinary Team Meetings (MDTs), to enable sharing of information and timely interventions.

- **New Processes and Policies:** We have developed an *Eating Disorders Management Standard Operating Procedure (SOP)* and a *Safe Management of Under-18s with Eating Disorders Policy.* These cover the management of patients presenting with weight loss (attached). An initial audit has been undertaken to review all under-18s who have an eating disorder at 49 Marine Avenue Surgery and ensured our management is compliant with the new SOP and policy and that we have a robust review and recall system in place.

- **Training and Awareness:** We will provide staff training on the Medical Emergencies in Eating Disorders (MEED) guidelines to increase awareness of clinical red flags and escalation pathways.

- **Patient Engagement:** We acknowledge the challenges in engaging adolescents reluctant to attend appointments. We will review our approach to invite and follow-ups, considering additional support methods, including involvement of family and community services, to improve attendance and monitoring. We have recently reviewed our Safeguarding Policy (March 2025) which includes an Appendix on "Child Not Brought". This includes several safeguards to check a child is brought to an appointment/monitoring and checklists to re-engage and flag concerns if this is ongoing. The policy has been shared with the team.

49 Marine Ave Surgery, as part of

Northumbria Primary Care (NPC)

SOP: Management of Patients Under 18 with Eating Disorders

Author: [redacted] **(Medical Director NPC)**

Date: 01/08/2025

1. Scope and Purpose

This SOP applies to all general practice staff providing initial assessment and ongoing care for patients under 18 presenting with suspected or diagnosed eating disorders (anorexia nervosa, bulimia nervosa, binge eating disorder, OSFED).

2. Overarching Principles

- Management is multidisciplinary and family-inclusive, with early referral to specialist community-based eating disorder teams when indicated.

- Safeguarding, capacity/consent, and physical health monitoring are core, non-delegable responsibilities.

3. Recognition, Screening, and Initial Assessment

- Be alert to eating disorders in young people with low BMI, unexplained weight loss, growth faltering, amenorrhea, repeated vomiting, GI symptoms, psychosocial distress around food/weight, or mental health concerns.

- Ask screening questions directly: e.g., “Do you think you have an eating problem?” and “Do you worry excessively about your weight?”

- If a gastrointestinal cause for the weight loss is suspected, early referral to secondary care, gastrointestinal services should be considered at the outset or at any other time in the management of the patient if their condition changes and suggests a gastrointestinal problem.

Initial assessment must include:

- Physical health: weight, height, BMI centile, pulse, BP (lying/standing), temperature, signs of dehydration or medical instability (refer to MEED: Medical Emergencies in Eating Disorders guidance).
- Mental health: risk of self-harm or suicidality, psychological distress, depression, anxiety.
- Social/family context: eating patterns, exercise, impact on education/social function.
- Safeguarding: assess risk of abuse/neglect in every case, document and escalate concerns per local protocol.

4. Immediate Risk Assessment

- Immediate hospital admission is required for any child or young person with features of acute physical risk (marked bradycardia, hypotension, hypothermia, syncope, electrolyte disturbance, severely low BMI centile for age, rapid weight loss, or evidence of systemic compromise).
- **Severely low BMI in children/adolescents is typically: BMI for age below the O.4th centile (or less than the 5th centile if no contextual factors are given), or BMI below 70-75% of the median for age/sex and must be interpreted in conjunction with clinical factors and physical health status**
- Refer urgently to specialist eating disorder services if eating disorder is suspected and there is significant impairment or risk.

5. Safeguarding, Consent, and Confidentiality

- Involve children/young people and their families in all decisions, unless harmful or not in best interests.

- Assess and document Gillick competence (under 16): seek valid consent or parental involvement as appropriate. For 16-17s, assume capacity unless evidence to the contrary.

- Respect confidentiality but explain exceptions (risk to self/others). Record legal authority for decisions, especially in contested or overridden treatment.

6. Ongoing Care and Referral

- Every patient should have a care plan for ongoing physical and psychological monitoring, coordination with specialist services, and emergency action.
- Growth and physical health (weight, height, vital signs) should be monitored frequently per specialist or local protocol—seek paediatrician input for faltering growth or medical instability.
- Psychological/medical comorbidities (e.g., diabetes, depression): coordinate MDT management and review regularly.
- People referred to specialist services should begin assessment and treatment within 4 weeks (for children and young people), in line with NHS Access and Waiting Time Standards.

7. Family and Psychoeducation

- Family interventions are first-line: offer evidence-based family therapy (such as anorexia-focused family-based therapy, 32 40 sessions over 12-18 months with additional sessions for parents/carers).

- Provide or refer for psychoeducation to patient and family about risks, nutrition, relapse prevention, impacts on mood, social function, body image, and safety.

8. Referral Pathways and Escalation

- Refer all suspected cases to local community-based eating disorder teams (children/young people) without delay. Follow the NHS England Access and Waiting Time Standard targets.

- In urgent risk, refer to paediatric inpatient care with facilities for specialist refeeding and monitoring—use age-appropriate settings.

- If treatment is refused but deemed essential, follow legal pathways (Mental Health Act, Children Act; seek senior and legal advice).

9. Medicines Management

- Medication is never sole therapy for eating disorders in under-18s; it may be used as adjunctive treatment only under specialist guidance.

- Review all current prescriptions for potential health risks (QT prolongation, risk of dehydration, etc).

10. Documentation

- Record all assessments (including physical and psychological risk), consent discussions, safeguarding steps, referrals, and communications contemporaneously using appropriate coding (e.g., “vulnerable child”, “child protection”).

11. Audit and Quality Assurance

- Review all cases regularly at practice MDT meetings and audit care against NICE NG69 and MEED standards.

- Seek regular updates and training for all staff in safeguarding and eating disorder recognition/management.

Key References

NICE NG69: Eating Disorders—Recognition and Treatment

MEED (Medical Emergencies in Eating Disorders) guidance

Policy for the Safe Management of Under 18s with Eating Disorders

August 2025

Operational Summary

This policy provides a comprehensive, standardised framework for the identification, assessment, referral, and ongoing management of patients under 18 presenting with eating disorders. It includes the use of SystmOne with embedded Ardens Templates, specifies safeguarding responsibilities, and sets out coordinated working with local partners including CNTW, CYPS, Northumberland Foundation Trust, and Newcastle Foundation Trust, in line with current legal and clinical guidance.

1. Introduction

Eating disorders in children and young people are serious mental health conditions associated with significant physical and psychological morbidity. General practice teams have a vital role in early recognition, risk assessment, physical monitoring, safeguarding, and coordination of care with specialist services and multi-agency partners.

2. Purpose

To ensure the prompt, safe, and evidence-based management of under 18s with suspected or diagnosed eating disorders.

To comply with regulatory requirements and NICE NG69 guidance.

To detail processes for safeguarding, assessment, risk stratification, referral, monitoring, and liaison with families and external agencies.

3. Duties

All Staff:

- Identify possible eating disorder presentations.

- Escalate concerns and follow safeguarding pathways.

- Document assessments and actions fully using SystmOne/Ardens Templates.

GPs/Clinical Leads:

- Undertake full risk/medical assessments.

- Coordinate referrals and ongoing communication with specialist services and safeguarding teams.

- Oversee quality assurance and compliance audits.

Site Lead:

- Ensure staff training and operational resources to assess health status.

- Support audit and version control.

4. Definitions

- **Eating Disorder:** Anorexia nervosa, bulimia nervosa, binge eating disorder, or avoidant/restrictive food intake disorder as defined by DSM-5/NICE NG69.

- **Safeguarding:** Processes to protect young people from neglect, abuse, exploitation, as mandated in the Children Act 1989/2004 and Working Together to Safeguard Children (2018).

- **CNTW/Northumberland FT/Newcastle FT/CYPS/CAMHS:** NHS and local authority specialist services for children and young people's mental health and safeguarding.

- **SystmOne/Ardens Templates:** Electronic clinical templates for recording and standardising history, risk, safeguarding, and referrals in general practice.

5. Process

5.1 Recognition and Initial Assessment

- Identify at-risk patients through history, examination, growth monitoring, and parental/third party concerns.

- Use the Ardens Eating Disorder Template in SystmOne for a structured assessment, including:

- Eating and weight-loss patterns

- Growth chart centiles (WHO/RCPCH standards)

- Physical risk factors (as per MEED "traffic light" tool)

- Mental health and self-harm screening

- If a gastrointestinal cause for the weight loss is suspected, early referral to secondary care, gastrointestinal services should be considered at the outset or at any other time in the management of the patient if their condition changes and suggests a gastrointestinal problem.

5.2 Safeguarding Assessment

- Assess all presentations for potential safeguarding concerns.

- Document and act on issues through the SystmOne Safeguarding Ardens Template.

- Refer immediately to local authority safeguarding or CYPS when indicated, following 'Working Together to Safeguard Children'

5.3 Risk Stratification and Referral

- High-risk presentations (marked weight loss, bradycardia, electrolyte disturbance) require urgent referral to Paediatrics

- For less acute cases, refer for specialist assessment local CYPS / CAMHS Eating Disorders service (CNTW, Northumberland FT, as per locality) via usual local protocols.

5.4 Multi-Agency Working

- Engage with all multi-disciplinary teams including mental health, paediatrics, school health, social care and safeguarding teams. Attend meetings in person if possible. If not deputise and if no-one can attend, ensure that a report is provided to fully inform the meeting about activity in Primary Care.

- All contacts, actions and referrals are to be recorded using communication and referral templates in SystmOne.

5.5 Ongoing Monitoring and Follow-Up

At regular intervals, repeat full risk/physical health assessments should be undertaken in line with NICE guidance. The frequency should be individualized based on risk but generally at least every 1-2 weeks initially, and as often as clinically indicated during weight restoration or if there is any acute risk. Where and by whom this is taking place should be agreed by all agencies, fully documented in the care records and outcomes shared at multidisciplinary team meeting.

For mild to moderate severity (medically stable, no acute risk):

- Physical health monitoring includes:
- Regular weight and height checks
- Pulse, blood pressure (lying and standing), and temperature
- Assessment for physical signs of malnutrition or dehydration
- Blood tests (as indicated for electrolyte imbalance, renal/liver function)
- Frequency: At least every 1-2 weeks initially, with interval extended if stable.

High Severity / Increased Physical Risk (rapid weight loss, acute symptoms, or physical instability):

Monitor more frequently:

- Vital signs (pulse, blood pressure, temperature) often several times a week or daily if needed
- Daily or more frequent weight monitoring where medically indicated (especially inpatient)
- Electrolyte and other relevant blood testing at least weekly or more often as indicated
- ECG monitoring if at risk of cardiac complications (e.g., bradycardia, QTc prolongation) or when taking medications that may affect cardiac function
- Monitor for signs such as fainting, cardiac arrhythmias, or new physical symptoms.

Very High Risk (Medical Crisis/Emergency):

May require continuous inpatient monitoring (e.g., cardiac monitoring), urgent correction of abnormalities, and intensive physical review ongoing as dictated by their status.

- Weight, height, BMI centile, BP, pulse, relevant blood tests
- Mental health, risk of self-harm/suicide

Document in SystmOne using the Ardens Templates and growth chart tools.

5.6 Supporting Families and Providing Information

- Offer information on both local and national support resources (self-help, family support, parent groups).

- Liaise as needed with school nursing and community teams to support education and ongoing care.

5.7 Training and Quality Assurance

- Ensure all staff access regular training in eating disorder management, safeguarding, and the use of SystmOne/Ardens templates.

- Audit practice compliance with this policy annually, reporting findings to the practice leadership team.

6. References

NICE NG69 Eating Disorders: Recognition and Treatment (2017)

Children Act 1989, 2004

Working Together to Safeguard Children (2018)

CQC Regulation 12: Safe Care and Treatment

Royal College of Psychiatrists: Medical Emergencies in Eating Disorders (MEED) Guidance (2022)

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