ANDREW HETHERINGTON
H M Senior Coroner for Northumberland

County Hall, Morpeth, Northumberland NE61 2EF
Tel 01670 622600
Email coroners@northumberland.gov.uk

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Northumbria Healthcare NHS Foundation Trust** 2. **49 Marine Avenue Surgery** 3. **Moorbridge School** 4. **North East and North Cumbria Integrated Care Board** 5. **Department of Health**
1	**CORONER** I am Andrew Hetherington, Senior Coroner for Northumberland.
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://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** I commenced an investigation into the death of REDACTED Deceased. The investigation concluded at the end of the inquest on 19 June 2025. The medical cause of death was confirmed as 1a Pulmonary aspiration of stomach contents 1b Gastroparesis 1c Extreme Malnutrition The conclusion of the inquest was a narrative conclusion: Died as a result of the effects of extreme malnourishment. Opportunities to recognise the weight loss

	and escalate care were missed after November 2023. It is not possible to say whether the outcome could have been prevented with earlier escalation.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was aged 17 years of age. She had a diagnosis of Autistic Spectrum Disorder and suffered with anxiety. She complained of symptoms of brain fog, syncope, blurred vision and chronic fatigue which she attributed to COVID 19 or a physical cause. She experienced significant weight loss. She underwent a number of investigations including for an autonomic dysfunction (Postural Orthostatic Tachycardia syndrome) and no formal diagnosis was made. The investigations raised the suspicion of vasovagal response and deconditioning. She admitted to restricting her diet to manage her symptoms. The deceased was seen in the syncope clinic on 20 November 2023. Her weight was recorded as 42.9 kg with a BMI of 16.6. The Consultant Physician was concerned that the deceased was underweight and further investigation of her weight loss was appropriate. On 20 November 2023 referrals were sent to the General Practitioners, Child and Adolescent Mental Health Services and Dietetics to monitor her weight. By the time of her admission to hospital on 30 April 2024 her weight was 26.6 kg. I heard this was 50% of what would be expected as her median weight. From 20 November 2023 her weight had decreased by 16.3 kg. She was admitted to Northumbria Specialist Emergency Care Hospital from home on 30 April 2024 in an advanced state of starvation and with a very low Body Mass Index. The clinicians recognised the imminent risk to life. She agreed to nasogastric feeding and a nasogastric tube was placed on 2 May 2024. On 3 May 2024 she was placed under Section 2 of the Mental Health Act for assessment and treatment. On 5 May 2024 before insertion of a central venous line into the jugular she was placed head down, felt nauseous and went on to vomit. She was rolled over onto her left side and oropharyngeal suction was applied. There was a rapid

	decline in her condition, she became bradycardic and cardiac output was lost. Despite cardiopulmonary resuscitation she died within the critical care unit at Northumbria Specialist Emergency Care Hospital at 10.25 hours on 5 May 2024.
5	**CORONER'S CONCERNS** **To Marine Avenue Surgery and Northumbria Healthcare NHS Foundation Trust** **1.The deceased's weight was not adequately monitored from November 2023.** I am concerned there was no physical or face to face monitoring of the deceased's weight from November 2023. I heard about the importance of physical eye to eye contact and examination on a face-to-face basis so that one can see evidence of the skin, properly see the patient's face and when doing the height and weight asking for the removal some of their clothing to assess muscle mass. **2.There was no referral to gastroenterology** I am concerned there is confusion as to the guidance on Consultant-to-Consultant referrals. The Consultant Physician wrote to the GP saying, "*please monitor weight loss and refer into gastroenterology services for further assessment".* The GP was aware of guidance regarding Consultant-to-Consultant Referrals that had been updated in October 2023 so that Consultants could and should be directly referring patients themselves to another speciality if there was a clinical reason to do so, rather than passing that task back to the GP. The Consultant Physician told me the guidance was not cascaded down to trust level until December 2023 after the Consultant Physician saw the deceased and that the final guidance has not yet been received. **To Northumbria Healthcare NHS Foundation Trust** **3.The deceased was discharged from CAMHS in December 2023 without being seen in person, spoken to or weighed** The second referral to CAMHs was following the Consultant Physician's letter dated 20 November 2023. The request was *"I would be grateful if you could see*

this young girl urgently for advice with regards to oral intake. She has lost weight over a number of months and clinical history as outlined above". The deceased was offered an appointment in keeping with the 4-week national waiting timescale for CYP with an eating disorder.

Contact was made with mum on 24 November and an appointment offered for 13 December 2023. During the call Mum told staff the deceased "*hated CAHMS so might kick off and refuse to come".* Mum cancelled the appointment on 11 December 2023.

CAMHs contacted mum by telephone on 12 December 2023. Mum said that the deceased was not aware that she had been referred to CAMHs, was not willing to attend. Again, there was no exploration as to why that was the case and no direct contact with the deceased.

(a) I am concerned the deceased was discharged from CAMHs on 12 December 2023 without being seen face to face or spoken to directly.

(b) I am concerned there was no scrutiny as to why the deceased was reluctant to engage and not attend appointments.

4.There was no in person assessment by dietetics or escalation of care

The deceased was assessed via telephone on all occasions. I am concerned that whilst telephone assessments expedited contact there was no in person face to face assessment to record weight or to take and record clinical observations.

At assessment on 2 January 2024, the deceased was not aware of her current weight. A weight history from the 20 November 2023 and a 2022 weight were noted. Her BMI was calculated as 17.

On 5 March 2024 the deceased was reviewed by a specialist dietitian again by telephone. The deceased self-reported her weight to be 33kg with a calculated BMI of 13.4.

The Medical Emergencies in Eating Disorders (MEED) guidelines are used to identify at the earliest stage possible the appropriate care and treatment to be provided. It identifies BMI calculators in the green, amber and red.

Red or high risk would be a BMI less than 13.

The next specialist dietitian review took place on 26 April 2024, 2 weeks later than planned again by telephone. The self-reported weight was 31.8kg with a calculated BMI of 12.9

I am concerned that there was no escalation of care or onward referral, and I am concerned about staff's understanding of the Medical Emergencies in Eating Disorders (MEED) guidelines.

To Marine Avenue Surgery, Northumbria Healthcare NHS Foundation Trust and Moorbridge School.

5.The Passage of information/communication

Communication: I heard about the importance of the passage of information. During the course of the inquest a witness was taken to the SEN chronology and an entry dated 1 March 2024 which refers to a conversation with the deceased's mother on 29 February 2024 where she described the deceased having significant problems with her eating habits, losing weight and refusing to eat foods that would be good for her and put weight on her.

I am concerned that this information was not shared to an appropriate body.

To North East and North Cumbria Integrated Care Board and Department of Health

6.One records system - weights, heights and Body Mass Index (BMI)

I heard that patient care records are held on different care record systems within the NHS which are not universally accessible to healthcare organisations, healthcare professionals or patients. I heard good examples of accessible records such as the Great North Care Record (GNCR) and Systm0ne operated by some in Primary Care.

I am concerned there is not one accessible system for weights, heights and BMI.

	To North East and North Cumbria Integrated Care Board and Department of Health **6.Oversight of care in an Outpatient setting** There is a lack of clarity regarding oversight of care in an outpatient setting. The Patient Safety Incident Investigation report identified that there was a lack of oversight of care. The early help assessment team were stepped down in 2022 and they may have been the appropriate team to maintain oversight of care. The SI report comments that the referrals between services were all appropriate but it was unclear who had oversight of all the care and that the investigation team felt that oversight was unclear and that arrangements around risk assessment escalation safeguarding and GP involvement could have been better through improved communication. I heard that in an inpatient setting there are key NHS standards set around what was described as "*the name at the end of the bed"* which healthcare professionals work within. I am concerned that in an outpatient setting there is no specific guidance regarding oversight of care within the NHS. No one department or clinician has overall responsibility or accountability.
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 18 August 2025. 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 following Interested Persons

	• The family of deceased. • Northumbria Healthcare NHS Foundation Trust • The 49 Marine Avenue Surgery • Moorbridge School • North East and North Cumbria Integrated Care Board • Department of Health 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	Date: 23 June 2025 Signed: Andrew Hetherington HM Senior Coroner for Northumberland