THEME EATING DISORDER

Learnings from serious case Review 2020-2022 BHF

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The details from the case are from the coroner's review

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- This case highlights the complexity of eating disorder patients seen in primary care.

- Learning from such cases is to be shared following a coroner review

Summary of Evidence
Bariatric Surgery 2015 – History

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- Pt X had a history of Mental Health and food related issues dating back to 2010. Pt X was assessed and had bariatric surgery in 2015 as Pt X was overweight (101kg) with a BMI of 44.1

- Pt X had reported trying a number of diets but nothing had enabled them to lose weight and was in the category of being morbidly obese prior to surgery

- Pt X attended a Weight Loss Surgery Seminar

- Booked for gastric bypass surgery 2015

Bariatric Surgery

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- No psychological support was available for these patients before or after this surgery
- Pt X attended 5 Month review after surgery . The weight was 35kg and c/o occasional nausea
- Further post surgical review November 2015 Pt X Did Not Attend

Mental Health Assessment 2018

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- Pt X had mental health difficulties over a number of years
- Pt X was seen by a Mental Health Professional in October 2018
- Pt X disputed that they were limiting their food intake in the appointment with the Mental Health Nurse
- Pt X denied restriction of diet

Mental Health Assessment 2018

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- The Registered Mental Health Nurse was not concerned about Pt's Mental Health in terms of a risk of harming themselves or others
- The RMHN did not consider an eating disorder within the scope of issues they were considering at the time.
- Pt X was referred to IAPT
- Review showed Pt X never attended IAPT Appt

Primary Care and Overall Health

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- Pt X had a very complex health picture
- A collision between mental and physical Health conditions
- Pt X omitted information to health professionals

Primary Care and Overall Health

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- The Majority of Pt X's care fell to the General Practice
- General Practice is by nature not specialised and clinicians are required to refer into other services when support is needed
- Coroner made no criticism of General Practice for failing to expertly managing a complex picture and complex conditions such as Pt X
- However, they referenced a disparate view of the staff dealing with Pt X

Primary Care and Overall Health

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- The ACP with MH qualifications also who was seeing the patient had a working diagnosis that Pt X had an eating disorder

- The ACP did record in PT's record weight and calorie intake but the evidence received was that this was entered as free text in the record
- The ACP did not record her perception that Pt X may have an eating disorder

- The GP formed a view that the weight loss was due to a physical cause and did not consider an eating disorder

Dietician Review

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- The dietetics referral did not go through a risk -based triage process in dietetics. There was no process at that time.
- It was over one month after the GP referred PT X to the dietician, before they were given an appt
- Pt X had attended the appointment with their mother and was open in the discussion about their relationship with food being a difficult one
- Pt X also confirmed that they were terrified of returning to original weight if they did not control their food intake.

Hospital Investigations / Admission

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- Pt X was Referred by GP into what is known as the two week wait pathway for Gastrointestinal Investigations. They did not make any appt

- Pt X condition became critical 19 July 2019 admitted to hospital High Dependency Unit and treated for dehydration, electrolyte disturbance, acute liver injury and a critically low BMI, transferred to the Gastroenterology ward

- Pt was referred and seen by the mental health teams 22 July 2019 having received a referral on 19 July 2019 from Barnsley Hospital. Pt X was too unwell to be assessed by the Mental Health Team.

Medical Cause of Death

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On the basis of the documentation in hospital the Dr completing death cert has read and a belief that Pt X had been diagnosed with or at least there was a working diagnosis of Anorexia Nervosa.

- On reflection the Dr amended Medical cause of death to delete anorexia Nervosa and record instead:
  - 1a. Hypovolaemic shock due to acute upper gastrointestinal bleeding
  - 1b. Stress ulceration due to critical illness
  - 2. Previous laparoscopic bariatric surgery, acute liver injury, multiple electrolyte abnormalities due to malnutrition of unknown case and gastroenteritis

Case Review

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- Dietician letter follow up was not acted upon
- Communication and discussion was key in the team
- Referral to dietician by GP documenting the patient's weight
- Failure to see Pt X had not attended IAPT appts 7 months after referral
- Failure to consider the whole picture
- Dietician referral and wait too long
- Dietician missed conversation documentation
- Lack of significant concern reflected to GP in dietcians letter

Learnings from the case

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- By the time Pt X is admitted to hospital her condition is grave
- Pt X needed Mental Health support but her condition was too poorly to receive this.

Final Conclusion - Coroner

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- Having considered all of the above the coroner was unable to conclude whether any of these missed opportunities, had they been different; would have led to a different outcome for Pt X
- Pt X did appear to engage with appointments that were attended. All those who saw Pt X confirm that Pt X was engaged with not just the appointment but also the following treatment plans
- There is a history of Pt X not attending appointments or follow ups however the reason for this non-attendance has not been set out in evidence
- I cannot allow myself to speculate as to what might have happened had Pt X been provided with different services and therefore whilst I have identified missed opportunities to offer Pt X the best possible care. I cannot stretch that finding to determine that this contributed to Pt X Death