NHS England & NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

Ms Caroline Topping
Assistant Coroner for Surrey
HM Coroner's Court
Station Approach
Woking
GU22 7AP

c/o [redacted]

16th March 2021

Dear Ms Topping,

Re: Regulation 28 Report to Prevent Future Deaths – Peter James Michael Unsworth, date of death 29th July 2018.

Thank you for your Prevention of Future Deaths Report issued under Regulation 28 of the Coroners' (Investigations) Act 2013 (the "report") dated 1 December 2020 concerning the death of Peter James Michael Unsworth on 29th July 2018. Firstly, I would like to express my deep condolences to Mr Unsworth's family.

The regulation 28 report concludes Mr Unsworth's death was a result of 1a Pulmonary Thrombo-Embolism and 1b Deep Vein Thrombosis.

Following the inquest, you raised concerns in your report to NHS England and NHS Improvement regarding:

1. The advice provided by the Consultant Haematologist related to a very complex medical situation. It was not recorded in writing. The Consultant Orthopaedic surgeon did not record it in the patient's records nor email his understanding of the advice to the Consultant Haematologist for confirmation of what he understood the advice to be.
2. The Consultant Haematologist did not confirm her advice in writing or make any record of the advice given.
3. As a consequence, there may have been a misunderstanding of the basis on which the advice was sought and/or given, and of the import of the advice.

The Trust carried out an internal investigation and recommended adopting a 'read back' approach to the provision of verbal clinical advice or information to check understanding of any advice. The Trust takes the Situation, Background, Assessment, Recommendation (SBAR) approach to communication which is a structured framework for communication that enables information to be transferred accurately between individuals. In addition, Human Factors training events are held

regularly as part of the postgraduate education programme. These events focus on improving documentation and communication between team members.

For your second concern, the Trust has reiterated to all staff and clinicians the need to document verbal advice or information contemporaneously within the patient's notes in line with GMC Good Medical Practice 19, 21 and continues to audit medical records to monitor this and other aspects of record keeping to reinforce good practice. As an organisation, the documentation of specialist advice had been embedded in the curriculum for Junior Doctors and is emphasised at regular Trust events.

Going forward the documenting of specialist advice will be further strengthened by the introduction of Electronic Patient Records which will allow clinicians to input information into health records in real time. It is anticipated that this system will go live within the Trust in December 2021.

Thank you for bringing this important patient safety issue to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

Medical Director for Professional Leadership and Clinical Effectiveness
Lead Medical Director for Covid-19 Medical Workforce Cell
NHS England and Improvement