SECRETARY OF STATE
MINISTRY OF DEFENCE
FLOOR 5, ZONE D, MAIN BUILDING
WHITEHALL LONDON SW1A 2HB

[redacted]

[redacted] 28 January 2022

Dear Nigel,

REGULATION 28 REPORT: DEATH OF VICTORIA HARRILD-JONES

Thank you for your Regulation 28 Report dated 17 November 2021 following the Inquest into the very sad death of Mrs Victoria Harrild-Jones on 27 December 2019'. Mrs Harrild-Jones, who had accompanied her husband on posting to British Forces Cyprus, suffered a post-operative complication of elective abdominal surgery. I very much share your desire to prevent any recurrence and I am grateful to you for bringing your findings to my attention.

I set out below steps already taken on the issues you have raised, where further action is planned and the limits of where action can be taken by Defence to assure or regulate healthcare provision in overseas nations that host UK Service personnel and dependants. In Defence we take matters surrounding the health and wellbeing of serving individuals and their dependants extremely seriously. The Surgeon General has personally reviewed this case to identify where there is organisational learning from a clinical perspective.

Matter of Concern 1: If the bariatric surgery had been undertaken in the UK, Mrs Harrild-Jones would have been prescribed anticoagulation medication for at least 2 weeks postoperatively.

This concern reflects the fact that anticoagulation medication (known as Low Molecular Weight Heparin, or LMWH), used to prevent venous thrombosis (VTE) and subsequent embolism, was not continued after Mrs Harrild-Jones' discharge from hospital. She received twice-daily doses of LMWH for three days until her discharge on 21 December 2019. This guidance differs from the evidence provided to the court. Had UK standards been followed, NICE best practice

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identifies she should have received LMWH for a further four days. In this respect the administration of LMWH post-discharge fell short of UK NICE guidelines by a period of four days. A theoretical safety net would be for the general practitioner to review the care immediately after discharge. In this case, however, Mrs Harrild-Jones had made a private arrangement for surgery, outside the awareness of the military medical practice, and no hospital discharge summary was forwarded. The practice was alerted to the surgery having happened at the point of attendance to the first 112 call on 22 December 2019. The principal protection for the patient, and the organisation, is through prohibiting certain elective operations overseas and referring Service personnel and dependant patients to the NHS. This protection was in place for Mrs Harrild-Jones: the circumstances are described in the following section.

The UK national best practice to prevent VTE is embodied within the National Institute for Health and Care Excellence (NICE) Guideline on 'Venous Thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism'. There is only one situation where LMWH prophylaxis greater than seven days from admission is routinely recommended by NICE, which is for major cancer surgery involving the abdomen (para 1.14.4) when evidence shows a reduction in VTE with prophylaxis if extended for 28 days.

The Defence Medical Services takes as its benchmark the University Hospital Birmingham (UHB), with which it is strategically partnered, and which hosts the Royal Centre for Defence Medicine. UHB abides by the 7-day period for VTE pharmacological prophylaxis for bariatric surgery, assuming no contraindications.

The supporting literature to the national guidelines confirms that LMWH will *reduce* the risk of VTE, but it does not *remove* the risk, particularly in cases such as Mrs Harrild-Jones, who faced a number of compound health risks. Full compliance with UK NICE guidelines would not have completely removed the risk of VTE, although it would have contributed to reducing the likelihood. Accordingly, MOD have taken steps, where they are in our control, to mitigate the risk of future occurrence to as low as practicable.

In Mrs *Harrild Jones'* case, the post-mortem examination concludes the cause of death to be "Embolism of the pulmonary artery, on the basis of peritonitis". Earlier intervention for her peritonitis is seen as an important opportunity to have affected the adverse outcome in this case and to prevent future deaths in similar circumstances. Recognition by the military general practitioner on the day after discharge that a fever and abdominal pain after bowel surgery *might* represent early peritonitis from an anastomosis leak, should have precipitated a telephone consultation with the responsible operating surgeon — or an immediate referral back to the Ygia Polyclinic. The Defence general practitioner has reflected on his clinical judgment and shared this with the Court. He has instituted local policy change in Cyprus to ensure future communication with the operating surgeon when there is a post-operative complication; and to ensure that all 112 calls receive a routine telephone follow up by the duty doctor the next day. **Where applicable, these practice changes will be replicated across Defence Primary Healthcare Overseas through central policy guidance**.

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Matter of Concern 2: Military personnel (and their dependants) who receive inpatient secondary care from local providers whilst deployed overseas, may be provided treatment following their discharge that is not compliant with NICE guidance and which falls below the standard expected in the UK.

Defence recognises that this is a risk for Service personnel and their families when deployed overseas. NICE Guidelines are UK-specific and each developed overseas health system will have its own guidelines and governance processes, which may differ from the UK approach.

In the six months following removal of the gastric band, Mrs Harrild-Jones received regular contact with healthcare professionals to attempt dietary, exercise and self-help group measures. Authority was refused for a further bariatric elective procedure to be undertaken in Cyprus, with DCA stating this must be done in the UK. Specifically, direction was given to review the requirement for further elective surgery 3-6 months after the band was removed and to make a referral at that point. She was referred to NHS in Bristol on 29 August 2019; a multidisciplinary consultation was arranged in Bristol for 4 February 2020. However, Mrs Harrild-Jones referred herself for private surgery at the Ygia Polyclinic, outside the advice and knowledge of the military medical centre.

This case will be raised for awareness at the strategic Partnership Board between NHS and Defence Medical Services in order to highlight the challenges when referring patients into the NHS from overseas.

There are mitigations in place to manage the risks associated with personnel receiving inpatient secondary care from local providers whilst deployed overseas. Within Cyprus, the secondary health care contract includes the requirement to follow UK guidelines (NICE; NHS England) for those procedures that are approved, unless they contravene Cypriot MoH guidelines. The contracted service provider in Cyprus has been the Ygia Polyclinic since 2012. A new contract, based on an enhanced statement of requirement, has recently been awarded to the American Medical Centre (AMC) in Nicosia, Cyprus, and will come into effect from 1 April 2022, providing specified in-patient and out-patient services to the entitled population. **Within the new contract, Defence GPs will confirm that a proposed care pathway meets NICE guidelines**. Where there is doubt Defence GPs will **seek the opinion of the relevant Defence Consultant Advisor** (senior consultant specialist in the relevant clinical discipline).

Further mitigation is provided by Defence policy, which outlines eligibility on medical grounds to deploy overseas and restrict overseas elective surgery in local provider facilities to those procedures that have been assured and agreed in advance.[1] This includes prohibiting elective bariatric surgery. As often as possible Service personnel and their dependants are returned to the UK for

[1] 2021DIN01-079, Annex A, updated June 2021

planned treatment. The provider of contracted secondary healthcare is subject to performance and quality monitoring, including professional liaison visits by Defence Consultant Advisers. To match the new contract with the AMC, Defence Primary Healthcare will **improve the standardisation of information to patients who request secondary healthcare in Cyprus.**

In identifying how future risk may be reduced of treatment overseas falling below NHS standards, **the principal safeguard** is to ensure that Service personnel and their dependants do not submit themselves for *elective* procedures within third party countries, when those procedures have not been approved by Defence. Appropriate policy exists, but it will only be fully effective if it is optimally communicated and understood.

Service personnel and families are screened prior to deployment to overseas bases for suitability to ensure their healthcare needs can be met.[2] This process was undertaken for Mrs Harrild-Jones and two doctors independently assessed that her existing needs could be met (assessments in Bulford and by telephone to Cyprus). Information is sent by the Families Section; however, there is no specific verbal briefing for families. The **feasibility and suitability of a briefing to families will be explored**, regarding healthcare provision overseas, to complement the written information provided.

Contextual training is provided for a Defence GP in an overseas, remote or austere practice: this is then complemented by local understanding at the handover and on induction by local practice staff. The Defence Professor of General Practice has committed to add this case and reflective discussion to the **mandatory course for all Defence GP trainees, one week of which is held in Cyprus each June**.

Defence recognises that providing comprehensive military secondary healthcare facilities in the overseas operating bases is not feasible. We seek to mitigate such risks, although these cannot be eliminated completely.

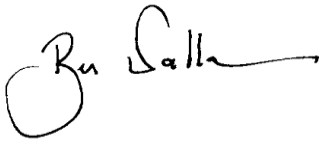
The potential deficit in assurance *in Cyprus* is addressed through a combination of the rigorous contract with the secondary healthcare provider, together with professional liaison visits (PLVs) conducted by Defence Consultant Advisers and reporting to Commander Medical BFC. While PLVs are not currently underpinned by formal policy, they are supported by an 'Advisory Visit Report Template' and questionnaire within an Advisors' briefing pack, in order to facilitate consistency. There is a well populated plan of continuing PLVs to Cyprus up to 6 months ahead.

This **assurance process is currently under formal review** through a newly established DMS Overseas Assurance Working Group, in order to create the supporting policy and common framework that is transferable to all operational areas. This will nest within the broader Defence Authority Assurance Working Group. Work is also ongoing by the Director Overseas Bases to **develop fixed visit programmes** to support a more enduring solution.

[2] JSP 770, *Tri-Service Operational and Non-Operational Welfare Policy*, v13.0 dated Apr 2019 (para 1.2A.16).

Thank you for writing to me about this important matter. I hope that my response has confirmed that the Ministry of Defence has learned and will continue to learn lessons from the tragic death of Mrs Harrild-Jones. I hope too that her husband, [redacted], her daughter and her wider family will draw some comfort from the knowledge that your report has prompted action.

Yours sincerely,



THE RT HON BEN WALLACE MP