Great Western Hospitals NHS
NHS Foundation Trust

Private and confidential

Marlborough Road
Swindon
SN3 6BB

Ian Singleton, Esq
His Majesty's Area Coroner for Wiltshire

[redacted]

[redacted]

15/11/2023

Dear Mr Singleton

Re: Coroner's Regulation 28 Report

We write in response to the Regulation 28 Prevention of Future Deaths Report, raising concerns about the circumstances which led to the death of the late Mr Adam Stuyvesant.

I was very sorry to hear of the sad death of Mr Stuyvesant. I was also concerned to learn of your matters of concern which are repeated here:

1) The wearing of a black boot can lead to lower limb immobility and the possibility of a restriction in the "calf pump function" which can lead to deep vein thrombosis.
2) The Deep Vein Thrombosis (DVT) risk assessment in use in the Emergency Department at the Great Western Hospital made no provision to take account of immobilisation when considering whether anti- clotting medication should be prescribed.
3) That without taking account the immobility, as part of the DVT risk assessment, further patients may not be prescribed anti-clotting medication and as a result develop DVT, resulting in death from pulmonary embolus.

In December 2022 a patient safety review into Adam's case was presented at the Incident Review Meeting, as a result an action plan was generated with a focus to improve the performance of the DVT risk assessments and provide assurance around the issuing of patient information via written communication (patient information leaflet).

To enhance this the Emergency Department reassessed the recommendations from the 2018-19 Royal College of Emergency Medicine (RCEM) national quality improvement project (QIP) on Venous Thromboembolism (VTE) risk management, the department has also reviewed and taken appropriate action in line with the recommendations suggested at the end of the inquest.

The Trust guideline for Venous Thromboembolic event follows both RCEM and National Institute of Clinical Excellence (NICE) guidance. There has been a strict emphasis on these guidelines to be followed by all the clinicians who deal with the patients requiring a black orthopaedic boot for trauma.

The Trust has reviewed the assessment again following the regulation 28 and are confident that the current VTE risk assessment is fit for purpose. As part of the review our local VTE risk assessment was compared to the Plymouth Scoring system, a nationally recognised standard, to assess whether the appropriate treatment is being given to patients and we confirm it is in line with this standard. To guide staff, the Trust's policy was reviewed and updated to indicate that patients who receive a black boot to assist with mobility but have significant reductions in their mobility will require a VTE assessment.

VTE education and training is now a part of the local induction process for all junior doctors when they commence working in the emergency department.

There has been an increased focus on the patient information leaflets and the VTE risk assessment checklist in the department for patients with a black boot and these have since been relocated to the area where the black boots are stored. This is to emphasise the importance of completing the correct documentation for VTE risk assessments for patient requiring a black boot. There has also been a MEMO reminder sent to all Emergency Department staff reminding them that they need to complete risk assessments for any patients who are wearing lower limb casts or black boot.

Information leaflets regarding mobility of a patient wearing a black boot has been revised. We have communicated to all staff within the Emergency Department the requirement to ensure that both verbal and written patient information is provided and recorded as complete within the health care records.

We will continue to monitor the effectiveness of the changes by way of spot check audits within the department, these results will be shared at Divisional Governance meetings and appropriate actions taken as required.

Finally, I would like to reiterate my sincerest condolences to Mr Stuyvesant’s family and apologise for the distress this process may have caused.

Yours sincerely

Chief Executive

Copy to: CQC