National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Ms Alison Mutch
HM Senior Coroner Manchester South
1 Mount Tabor Street
Stockport
SK1 3AG

[redacted]

[redacted]

02 April 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Rhys Lennon Hill who died on 9 February 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 15 January 2024 concerning the death of Rhys Lennon Hill on 9 February 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Rhys' family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Rhys' care have been listened to and reflected upon.

I apologise for the delay in responding to your Report, and for any anguish this may have caused to Rhys' friends and family. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

This response focuses on the issues raised in your Report within the remit of NHS England national policy and programmes. Concern numbers one to seven in your Report fall under the remit of Lancashire Teaching Hospitals NHS Foundation Trust. I note that you have also addressed your Report to the Trust, who are the appropriate organisation to respond. NHS England has requested to be sighted on this and will carefully consider their response to the coroner. My regional Quality colleagues within the North West have been engaging with Lancashire and South Cumbria Integrated Care Board (ICB) to seek assurance for the local concerns raised.

Concern number eight in your report raises concerns that there is a difference in approach on the use of prophylaxis for a surgical bariatric patient and a neurosurgical patient. You raised the concern that where there is a bariatric patient who has also undergone neurosurgery there is a lack of clarity on how to reduce the chances of venous thromboembolism (VTE) occurring. As your Report notes, the National Institute for Health and Care Excellence (NICE) produce the relevant clinical guidelines [NG89] for reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism and the Quality Standard for Venous thromboembolism in adults [QS201]. You may also therefore wish to refer your concerns to NICE.

The NG89 guidelines include a section on risk assessment (section 1.1) which states the importance, in the case of surgical patients of balancing 'the person's **individual risk** of VTE against their risk of bleeding when deciding whether to offer pharmacological thromboprophylaxis to surgical and trauma patients.'

The NICE guidance also states that mechanical VTE prophylaxis should be offered to 'people undergoing elective spinal surgery' (section 1.12), comprising either anti-embolism stockings or intermittent pneumatic compression. Pharmacological VTE prophylaxis should be used 'for people undergoing elective spinal surgery whose risk of VTE outweighs their risk of bleeding, taking into account individual patient and surgical factors (major or complex surgery) and according to clinical judgement.'

NHS England is in the process of undertaking some work to review the characteristics of individuals who get thrombosis. It is intended that this will look at the medication people are on and whether they have certain comorbidities. It is possible that the outcomes of this could influence further work around thrombosis risk factors.

NICE also produce guidance on medicines optimisation [NG5] which includes a section on medicines reconciliation: 1 Recommendations | Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes | Guidance | NICE (section 1.3).

As noted above, NHS England has engaged with Lancashire and South Cumbria ICB on the other concerns raised in your Report and are aware that Lancashire Teaching Hospitals undertook a Serious Incident Review into the care delivered to Rhys. We refer you to the Trust's response, but NHS England is advised that:

- The Trust did undertake VTE assessments, prescribing both mechanical and pharmacological prophylaxis.
- There is evidence that education was provided to the patient on the importance of the medication scheduled.
- That the patient declined to wear the anti-embolic stockings prescribed.
- That the Trust have taken actions to improve holistic care and adopt learning from the care delivered to Rhys which includes a review of VTE guidance on assessment pre-discharge, VTE advice leaflet to be provided in pre-admission packs and to ensure that a Senior Nurse acts as a link from daily nurse safety huddles to the daily ward round.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

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

Yours sincerely,

National Medical Director