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Ms Victoria Davies
Area Coroner for the coroner area of Cheshire
Cheshire Coroner's Service
Museum Street
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Sent via email only to: [redacted]

Your ref: [redacted]
Our ref: [redacted]

Dear Ms Davies,

I write in response to your regulation 28 report of 23 April 2024 regarding the very sad death of Ms Nuliyati Busunje. I would like to express my sincere condolences to Ms Busunje's family.

We have reflected on the circumstances surrounding to Ms Busunje's death and the concerns raised in your report.

With regard to the assessment of VTE risk in people with psychiatric disorders admitted to hospital, in the NICE guideline on venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism we recommend that clinicians should use 'a tool published by a national UK body, professional network or peer-reviewed journal' to assess VTE risk, however we do not recommend a particular risk assessment tool as there is not enough evidence to support the use of one over another and during development of the guideline, the committee made a research recommendation in this area, reflecting the uncertainty in the evidence for one risk tool over another.

The Department of Health's national risk assessment for VTE, highlighted in recommendation 1.9.1, has been widely used in the NHS to assess a person's risk of VTE since 2010, however it has not been validated or tested against other tools to evaluate its diagnostic accuracy or effectiveness at correctly identifying people at risk of VTE.

As such, we explain that the tool is commonly used to develop a treatment plan for psychiatric patients. However, clinicians can and should choose a different tool if it better fits the clinical circumstances of the patient.

Concerns regarding the risk assessment tool referenced in NG89 would need to be directed to the Department of Health and Social Care.

We agree that people with psychiatric disorders may be at risk of developing venous thromboembolism, particularly when acutely unwell and admitted to hospital, and that that risk assessment should not stop once significantly reduced mobility has been ruled out as other risk factors may be present.

The committee recognised that the risk of VTE in these patients may be due to the presence of several risk factors including reduced mobility due to psychiatric illness or sedation, but also dehydration due to poor oral intake, or comorbid physical illness, and this should be included in the risk assessment. The committee also noted that as with other populations, prophylaxis decisions for

psychiatric inpatients should be clearly documented and they should be reassessed throughout their stay as it likely that their clinical condition could change unexpectedly.

We believe that our recommendations for assessment and review cover the clinical circumstances outlined in your report. In NG89 we recommend that all people admitted to an acute psychiatric ward should be assessed for risk of VTE at consultant review or if their clinical condition changes (recommendation 1.9.2). Further, we recommend that clinicians should consider pharmacological VTE prophylaxis for people admitted to an acute psychiatric ward whose risk of VTE outweighs their risk of bleeding and that this should be continued until the person is no longer at risk (recommendations 1.9.3 and 1.9.5).

We note the observations of the consultant physician regarding a growing body of research which indicates that psychiatric patients on a ward are at higher risk of DVT. As discussed above, the risks pertaining to this population were discussed by the committee and is reflected in our recommendations. We are aware of a recent retrospective study which showed no difference in the VTE rates following psychiatric inpatient admission compared to unselected acute medical admission.

The signs and symptoms of a pulmonary embolus (PE) are discussed in the Clinical Knowledge Summary on Pulmonary Embolus. This notes that the signs and symptoms of pulmonary embolism are non-specific, but symptoms typically have a sudden onset, and that PE may be completely asymptomatic and be discovered incidentally when assessing for another condition. The recommendations on when to suspect PE is based on clinical features of PE described in the NICE and European Society of Cardiology (ESC) guidelines [NICE, 2023; Konstantinides, 2020] and the BMJ Best Practice guide [BMJ Best Practice, 2022].

NICE recommends considering using the Pulmonary embolism rule-out criteria (PERC) rule if clinical suspicion of PE is low, based on the overall clinical impression, and if other diagnoses are feasible. However, given the non-specific nature of presenting symptoms, clinicians need to have a high level of suspicion in people with risk factors for PE.

Again, I offer my sincerest condolences to Ms Busunje's family.

Yours sincerely,

[redacted]

[redacted]
Chief Executive