NHS
North Middlesex
University Hospital
NHS Trust

**Legal Services Department**
North Middlesex University Hospital
Sterling Way
London
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30 September 2019

**VIA EMAIL & POST**
Mr Andrew Walker
Senior Coroner
Northern District of Greater London
North London Coroner's Court
29 Wood Street
Barnet EN5 4BE

Dear Mr Walker

**Prevention of Future Death Report – Joseph Charles**

We write following receipt of the Regulation 28 report issued following the conclusion of the inquest into the death of the above named. Whilst we understand that the lack of national guidelines for the prevention of DVT and pulmonary embolus following upper limb surgery is a matter for the Department of Health to address, the Trust decided to undertake a review of our local policy and procedures.

We can confirm that there were no failures in the care and treatment that Mr Charles received either during or following his right elbow surgery. However, we felt it was important to ensure that, in the absence of any national guidelines, our local guidelines for prevention of DVT following upper limb surgery are robust, and improvements to ensure safety netting are made wherever possible. As a result of this review, the following actions have been carried out:

**Review of the Trust's Venous Thromboembolism (VTE) prevention policy**
It was agreed there is no need to amend or change the present guidance, which is consistent with national guidelines for lower limb surgery and specifically mentions any major surgery over 90 minutes, which would include the elbow replacement surgery which Mr. Charles had. However, there is now an opportunity to strengthen education, training and awareness of this policy is amongst the surgical team. [redacted] Consultant Haematologist, is to conduct an education and awareness event at the next Orthopaedic Governance Meeting on Tuesday 1 October 2019, and in addition there will be an audit meeting to publicise the policy and guidelines updates on Tuesday 3 December 2019.

**All inpatient and day case surgery patients to be risk assessed on discharge**
In addition to the Risk Assessment for VTE, which is carried out for all patients on admission, a further risk assessment is now undertaken on surgical patients prior to discharge. This has been implemented with immediate effect. The orthopaedic team are also working with the Information Technology (IT) department in order to introduce an additional step to the electronic discharge procedure, whereby there will be a requirement to complete the VTE risk assessment summary

box in order to be able to discharge the patient. This is intended to be an additional prompt to ensure the VTE risk assessment is carried out on discharge as well as admission. The IT team is due to implement this change to the system by the end of October 2019.

**Publishing a VTE risk assessment template/flyer in Orthopaedics**
Discussions are currently being held by the hospital's Thrombosis Group regarding the publishing of a new leaflet, which is due for Trust-wide implementation by 31 January 2020. Following approval this leaflet will be incorporated into the Orthopaedics Handbook, which is due to be revised by 28 February 2020.

**Review of the VTE risk assessment in theatres**
Although appropriate risk assessments are undertaken prior to routine surgery, our investigation revealed that the required medication(VTE prophylaxix in this case) had not always been prescribed. As such, an extra domain has been added to our local pre-operative checklist to ensure that the anaesthetists will write up thromboprophylaxis on the anaesthetic drug chart during surgery. This change in process will be discussed with the Head of Anaesthetics by 31 October 2019.

Yours sincerely

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Maria Kane
**Chief Executive**