NHS Resolution

South Regional Safety and Learning Networking Forum

25 November 2025
12:00 – 14:00

@NHSResolution

Advise / Resolve / Learn

Agenda

NHS Resolution

Time	Item	Speaker
12:00	Introduction to the forum	• Chair, Caroline Latham-Parker, Safety and Learning Lead – South, NHS Resolution
12:05	Learning from national and regional VTE claims	• Ingrid Henderson, Associate Safety and Learning Lead – South and London, NHS Resolution
12:10	AIM: reducing VTE in maternity care	• Victoria Wilkins, Associate Safety and Learning Lead – North, NHS Resolution
12:25	Experiences of capturing VTE risk assessments, an improving picture	• Olufunsho Otenaike, PSS, Maidstone and Tunbridge Wells NHS Trust
12:40	Supporting staff affected by a significant adverse event, designing a wellbeing pathway	• Natalie Smith, Associate Director of Healthcare Legal Services, North Bristol NHS Trust
12:55	Case studies, learning points from VTE claims	• David Beattie, Associate, DAC Beachcroft • Edward Duckworth, Senior Associate, Bevan Brittan
13:10	Q&A	• Joanna Lloyd, Partner and Head of NHS Health and Care, Bevan Brittan
13:25	Member led breakout groups facilitated by NHSR	• Caroline Latham-Parker and Kelly Birleson, Midwifery Fellow with Early Notification Team, NHS Resolution • Ingrid Henderson and Victoria Wilkins
13:55	Summary and close	• Ingrid Henderson

Venous thrombosis embolism CNST claims 2015 to 2025

National and regional overview

Safety and Learning team: nhsr.safety@nhs.net

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NHS Resolution – our strategy at a glance

Who we are

We are part of the NHS, operating at arm's length from the Department of Health and Social Care.

Our services

Indemnity and Claims Management: Comprehensive cover and claims management for NHS services.

Advice: Supporting the NHS with concerns about practitioner performance.

Appeals: Offering impartial resolution of primary care contracting disputes.

Safety and Learning: Using the information we hold to support improvement.

Our priorities

Fair resolution

All of our services will focus on fair and timely resolution, keeping patients and healthcare staff out of litigation and other formal processes to minimise distress and cost.

Data and insights

We will contribute our unique data and insights to learn from harm and the response to harm across the health and justice systems.

Maternity and neonatal

We will draw on our unique position and work with our system partners to support maternity and neonatal safety improvements.

Our strategy is driven by our priorities, supported by our people and systems.

Our values

Professional: we are dedicated to providing a professional, high quality service.

Expert: we bring unique skills, knowledge and expertise to everything we do.

Ethical: we are committed to acting with honesty, integrity and fairness.

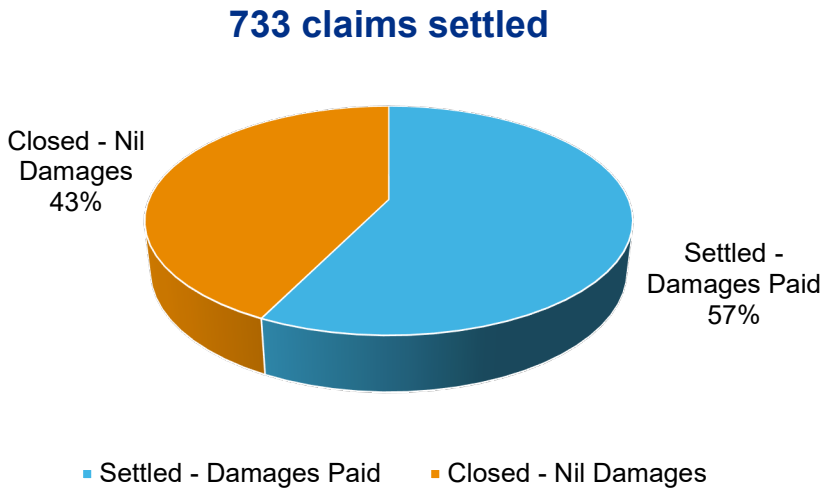
Respectful: we treat people with consideration and respect and encourage supportive, collaborative and inclusive team working.

From 1 April 2015 until 31 March 2025 NHS Resolution documented 733 closed claims relating to VTE injuries across the clinical negligence indemnity schemes nationally. The sum of total damages paid was £27,593,056

1016

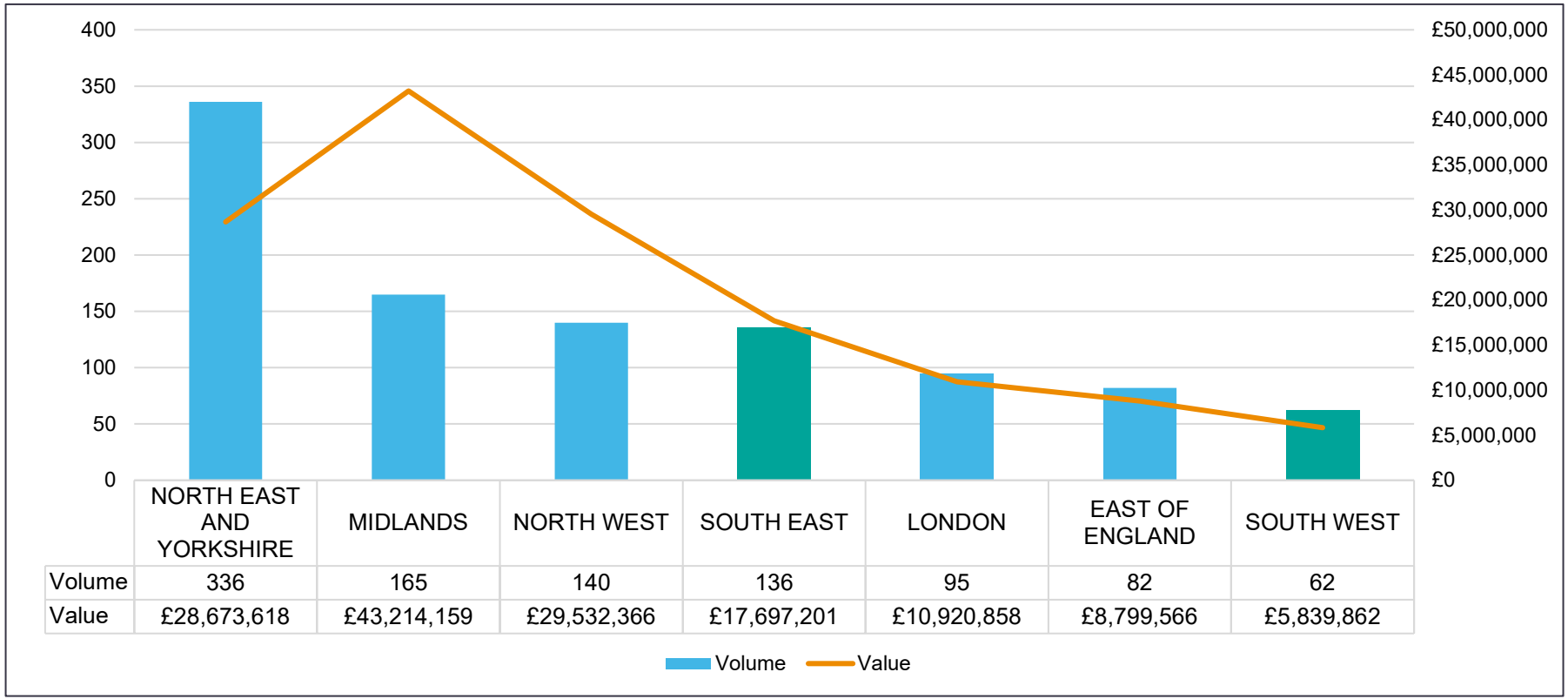
Total volume of claims received between 2015 -2025

- 418 claims were settled with damages paid
- 313 claims were settled with no damages paid



*Data correct as of 30.06.25

Regions – VTE CNST claims per year 2015 to 2025 via claims notification date



	NORTH EAST AND YORKSHIRE	MIDLANDS	NORTH WEST	SOUTH EAST	LONDON	EAST OF ENGLAND	SOUTH WEST
Volume	336	165	140	136	95	82	62
Value	£28,673,618	£43,214,159	£29,532,366	£17,697,201	£10,920,858	£8,799,566	£5,839,862

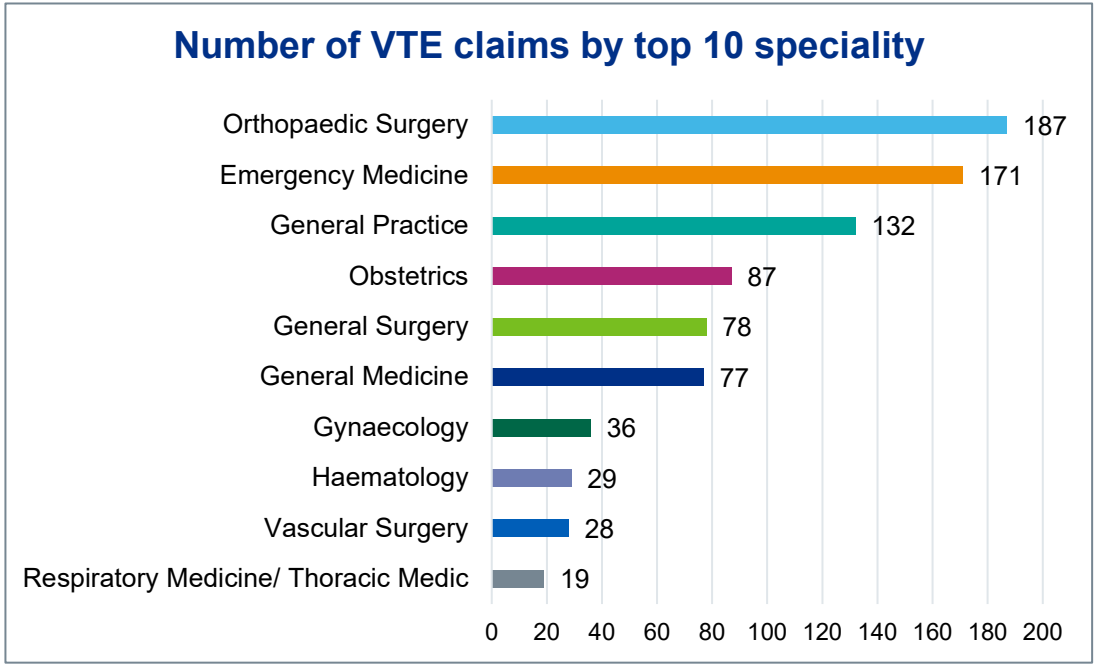
*Data correct as of 30.06.25

Specialities involved in VTE claims

The top specialities involved in VTE claims continue to be

- orthopaedic surgery (18%)
- emergency medicine (17%)
- general practice (13%)

There has been an increase in obstetric claims from 42 in 2022 to 87 in the 2025 data. Obstetrics has now surpassed general surgery.

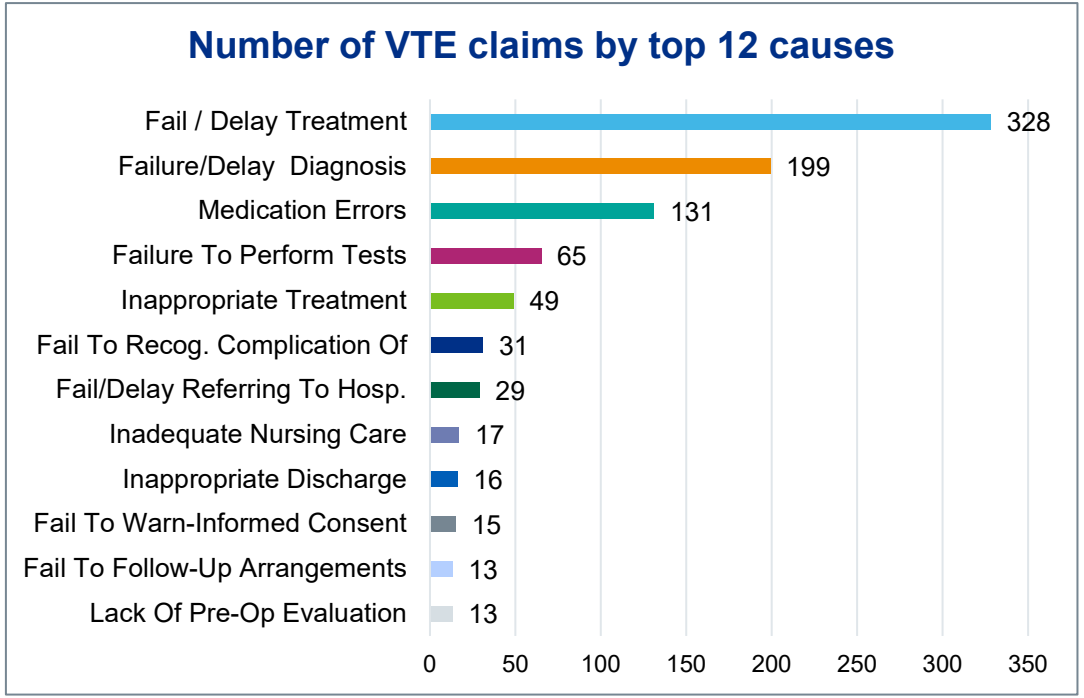


*Data correct as of 30.06.25

Causes reported in VTE claims

Of the claims received, 12.89% were related to a medication error. This is an increase of 2.29% from 2022. The themes seen within the data were the same as those seen in the previous review:

- Failure to prescribe or administer anticoagulant
- Failure to carry out a VTE risk assessment
- Incorrect dose of anticoagulant administered



*Data correct as of 30.06.25

AIM: Reducing VTE (Venous Thrombosis Embolism) in pregnancy

Presented by Victoria Wilkins, Associate Safety and Learning Lead

Background

- Pregnancy elevates venous thromboembolism (VTE) risk by a factor of 4 to 6 compared to the non-pregnant state.
- It is associated with significant morbidity, mortality and psychological distress for families.
- This poses a substantial financial burden onto the NHS.
- National discussions on VTE in maternity have highlighted a potential disconnect between primary and secondary care, prompting action to improve prevention.

Objective

To identify contributory factors in the occurrence and management of VTE in maternity by analysing NHS Resolution claims data, with a view to promote consistency and excellence in risk assessment and prophylaxis throughout the duration of maternity care.

Methodology

- A retrospective thematic analysis of NHS Resolution claims related to VTE
- Inclusion criteria (Total 51 claims):
  - Settled maternity claims with damages paid
  - All VTE during pregnancy up until 6 weeks postnatal
  - Incidents occurring between April 2016 - March 2025
- Themes from 43 open claims were identified but not analysed

Results

- 1 in 2 suffered with a **Pulmonary Embolism (PE)**
- 3 in 4 developed a VTE in the **postnatal period**, most commonly between 11-42 days.
- 3 in 5 delivered **vaginally**

Results - diagnosis

- **1 in 2** presented more than once before a diagnosis was made
- For those who presented more than once, the average time from presentation to diagnosis was **9 days**
- The longest time from presentation to diagnosis was **102 days***
- **2 in 5** presented to **Urgent Care or Emergency Departments** between 24 weeks to 10 days postnatal
- **3 in 5** presented to a **GP** > 11 days postnatal

Results - risk assessment

- Of the claims with no VTE risk assessment it was apparent from the letter of claim that risk factors were present
- **3 in 4** women had a completed VTE risk assessment, however only **1 in 3** were completed **correctly**
- **3 in 4** women had a **change** in risk factors from booking
- This led to VTE prophylaxis not being prescribed in several cases where it was required (58%)

Results - risk assessment

NHS Resolution

Booking	Antenatal	Postnatal
• Maternal Age • BMI 30-40 • Parity • Family History • Smoker	• Hospital Admission • Current Systemic infection • Immobility	• Caesarean Section • Parity • Maternal Age • BMI • VTE in antenatal period

Illustrative case story – postnatal

NHS Resolution

Situation:

- Presented four days post forceps delivery to emergency department with shortness of breath and chest pain
- Discharged home after one dose of treatment for assumed pulmonary embolism (PE). No diagnostic testing performed.
- Five days later patient collapsed and was admitted.
- Diagnosis was confirmed pulmonary embolism and respiratory infection
- Patient deteriorated and required admission to ITU
- Patient went on to develop pulmonary oedema and cardiomyopathy

Background:

- G5 P3 – 1 singleton, 1 set of twins
- Deemed low risk pregnancy
- Late booker
- Previous LETZ procedures
- BMI of 35
- Smoker
- Maternal age 34 at booking – turned 35 during pregnancy

Assessment:

Breach of duty:

- Wrong pathway of care from booking
- Antenatal VTE assessment incorrect
- Postnatal VTE assessment incorrect
- No prophylaxis given

Recommendations:

Causation:

- Correct VTE assessment was required in the antenatal and postnatal periods which would have triggered the prescribing of prophylaxis which should have prevented the initial PE on a balance of probabilities

Illustrative case story – Surgical admission for non-obstetric procedure

NHS Resolution

Situation:

- Patient, 25+3 weeks pregnant, had an accident whilst gardening and scraped leg on a piece of rotten wood with rusty nails protruding
- Patient attended emergency department 2 days later with grazing, cuts and weeping wounds
- Cellulitis diagnosed and antibiotics required IV
- Wound unclean therefore decision made for surgical wash out and for admission
- Patient went on to develop a PE whilst an inpatient
- Patient was seen daily for FH monitoring whilst an inpatient but remained under surgical care

Background:

- G2 P1 – previous SVD
- Maternal age 37
- No prior medical conditions

Assessment:

Breach of duty:

- VTE assessment not completed as an inpatient or after surgery
- When symptoms arose, although a VTE assessment carried out, this was not maternity specific.

Recommendations:

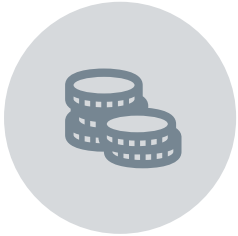
Causation:

- Correct VTE assessment was required on admission, prior to surgery and after surgery.
- A maternity VTE assessment and re-assessment would have triggered the prescribing of prophylaxis which should have prevented the PE on a balance of probabilities

The cost of claims

NHS Resolution

The total cost of closed with damages paid claims was £3.5m



The average cost of a claim was £68,793

Other associated costs included increased medication needs for longer duration, increased inpatient stays, longer term ongoing follow up care

Other 'costs' to the patient are detriments to physical, emotional and mental health in the short, medium and long term

Limitations

- Assumptions made when:
  - Spontaneous vaginal delivery when no other type of delivery is noted
  - Low risk when no risk factors have been noted
- Compliance to prophylaxis remains unknown throughout pregnancy and the postnatal period.
- Retrospective – basing on available documentation
- Health inequalities were not analysed with this data

The influence of health inequalities on receiving care and making a claim

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Ethnicity – multifactorial

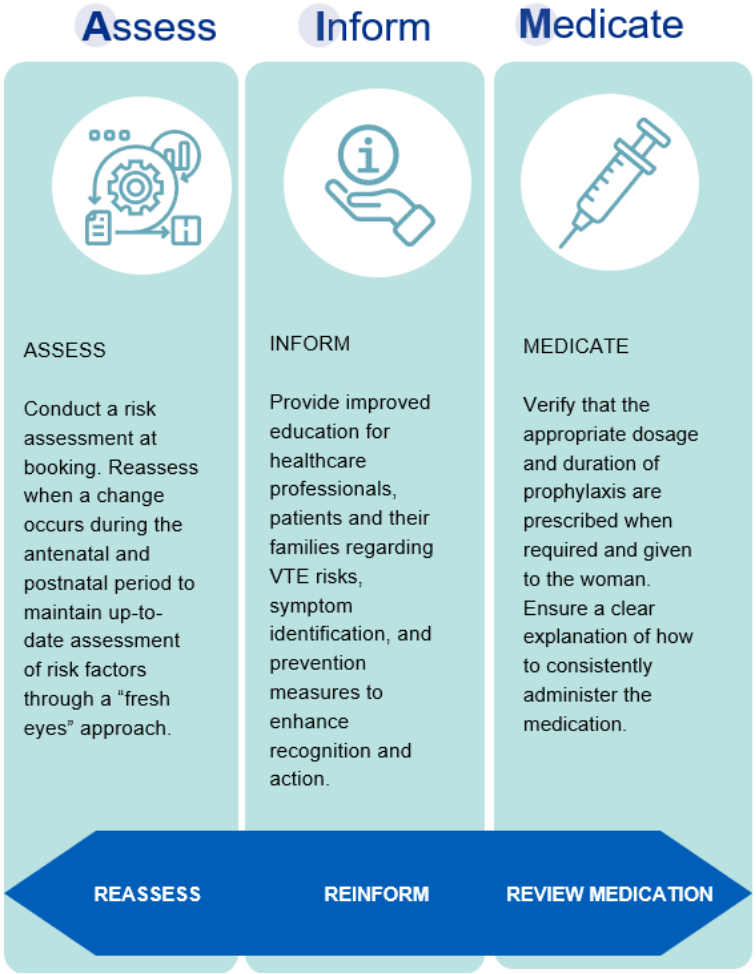
Social and economic deprivation – ability to attend appointments/hospital

Language – ability to understand information and provision of information in appropriate language

Working pregnant people – ability to attend appointments/hospital

Vulnerabilities – learning disabilities, migrants/asylum seekers, safeguarding concerns, teenagers- multifactorial

Rural communities – ability to attend appointments/hospital



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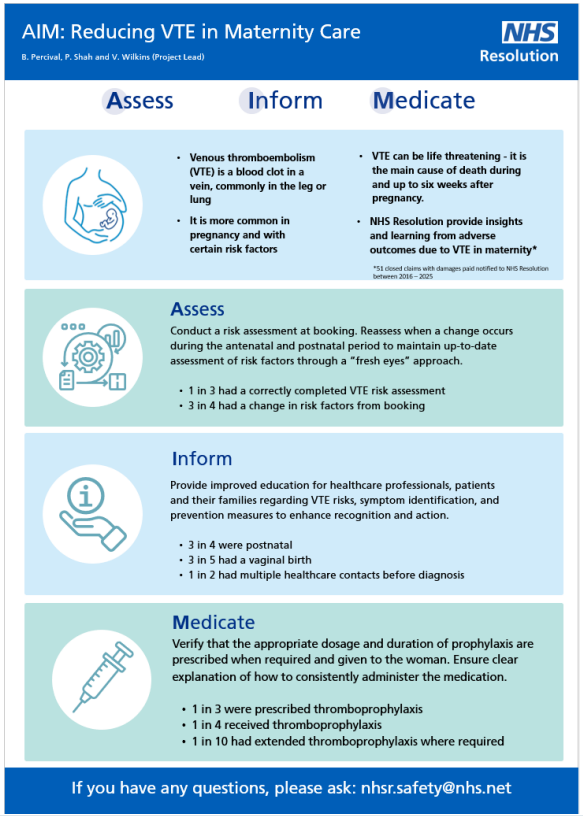
Information poster for clinicians

NHS Resolution

Inform

INFORM

Provide improved education for healthcare professionals, patients and their families regarding VTE risks, symptom identification, and prevention measures to enhance recognition and action.



Information poster for patients and families

NHS Resolution

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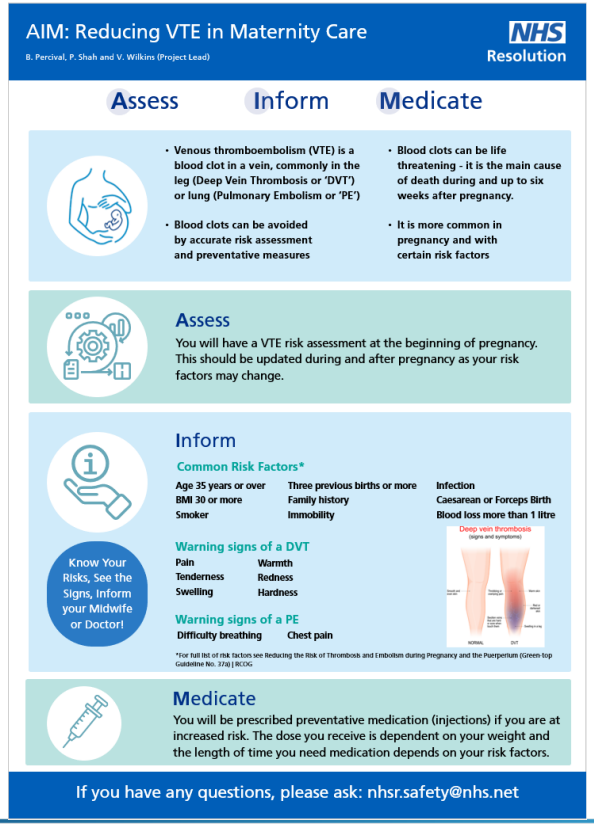
Provide improved education for healthcare professionals, patients and their families regarding VTE risks, symptom identification, and prevention measures to enhance recognition and action.



Key messages

VTE assessment is essential in pregnancy and the postnatal period

Risk should be reassessed with every change, using the correct maternity VTE assessment tool

This will allow for the correct prophylaxis at the right dosage for the right amount of time

Thank you for listening

Safety and Learning team
nhsr.safety@nhs.net
020 7811 2700

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Project Lead - Victoria Wilkins
Associate Safety and Learning Lead (North)

Victoria.Wilkins3@nhs.net

MTW

NHS
Maidstone and
Tunbridge Wells
NHS Trust

Experiences of capturing VTE risk assessments, an improving picture

Regional Safety and Learning Networking Forum

Olufunsho Adetutu Otenaike

VTE Patient Safety Lead

Maidstone and Tunbridge Wells NHS Trust

November 2025

Introduction

VTE prevention is a key patient safety priority.

Accurate and timely risk assessment reduces harm.

Transition aimed to improve compliance, data visibility, and learning.

Background

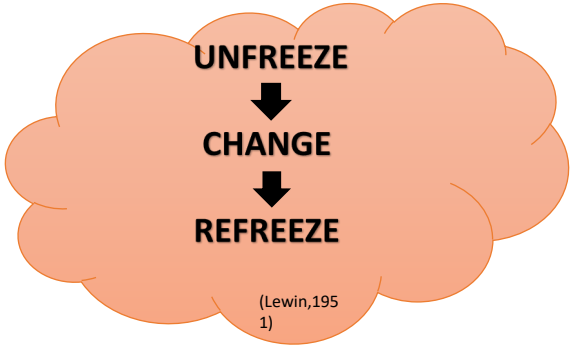
Previously used paper forms Trust-wide.

Issues with tracking, compliance, and audit data.

Shift to digital documentation for accuracy and accessibility.

Part of wider Trust digital transformation strategy.

Aim



Implement electronic* VTE risk assessments.

Improve completion and compliance rates.

Enable real-time monitoring and governance reporting.

Align with national VTE prevention standards.

*Allscripts Sunrise - electronic patient record (EPR) system

Timeline

Planning Phase (2019): Stakeholder engagement, IT development, data gathering, workflow design.

Phase 2 (2021): Testing & initial rollout; VTE forms removed due to EPMA* readiness and UAT** defect.

Full Rollout (2022): Trust-wide implementation with Electronic Prescription system (EPMA).

Post-Implementation: Ongoing monitoring and improvement.

*EPMA - Electronic Prescribing and Medicines Administration
** UAT - User Acceptance Testing

Lessons Learned – Challenges

- COVID-19 (2020–2021): Staff redeployed, limited capacity.
- Technical integration issues with EPR & EPMA.
- Challenging timeframes for rollout and training.
- Change resistance and digital adoption fatigue.
- Temporary compliance dip during transition.
- Dual systems caused duplication and confusion.

Lessons Learned – Successes

Improved data quality and accessibility

- for all needing access to data

Real-time visibility of VTE assessments

- higher completion rates, fewer hospital-acquired VTE/ anticoagulation related cases

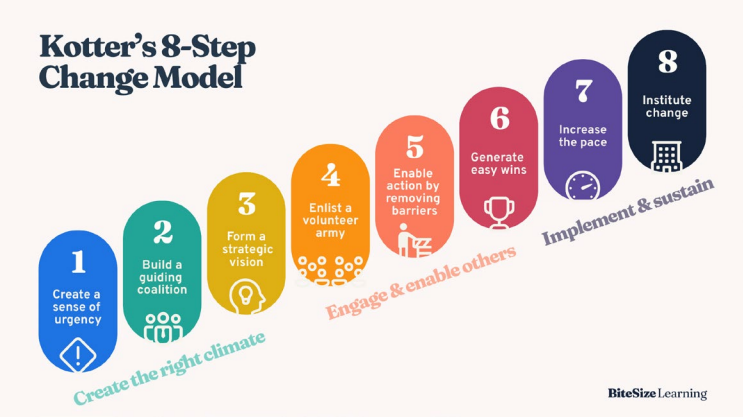
Better governance reporting and incident learning

- reliable audit trails

Staff confidence increased after training

- positive staff feedback on usability

Change management



- Transition required both digital and cultural change.
- Early engagement and communication were vital.
- Digital systems enable proactive safety learning.
- Collaboration across teams was key to success.

Next Steps

Continuous monitoring and quality checks

Further usability improvements

Integrate VTE data into Trust dashboards

Embed VTE training in induction programmes

Share learning regionally for wider improvement

Thank you

CONTACT:

OLUFUNSHO.OTENAIKE@NHS.NET

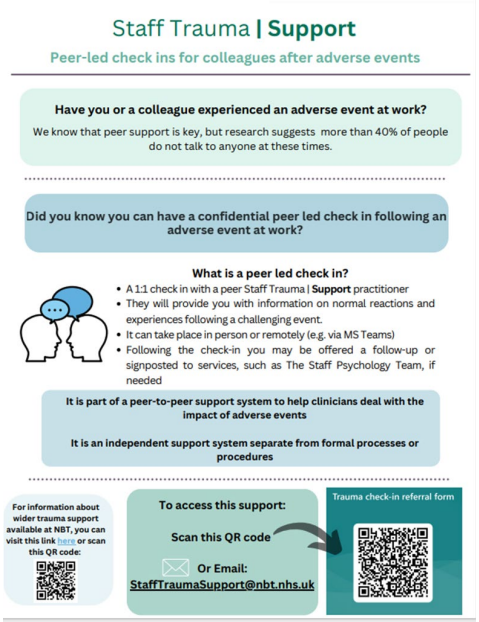
MAIDSTONE AND TUNBRIDGE WELLS NHS HOSPITAL

Supporting staff affected by a significant adverse event

Natalie Smith - Associate Director of Healthcare Legal Services, North Bristol NHS Trust

NBT's Wellbeing Pathway

As part of NBT's Staff Trauma Support a Wellbeing Pathway has been developed to help provide support to staff – collaborative work Staff Trauma, peer support wellbeing lead and Healthcare Legal



NBT's Wellbeing Pathway

Adverse Event

NBT Staff Trauma | Support

Support available for you after an adverse event at work

NHS North Bristol NHS Trust | Staff Psychology Team

Resilience is between us not just within us

Essential throughout any significant adverse event:

Support from colleagues, line manager, educational supervisor (for doctors in training) and team.

When?	What support is available?
When an adverse event happens.	• Support from your team • If you select notify specialist team 'Staff Trauma Support' when completing a Datix, the Staff Trauma Support psychologists will contact you via email to check if you are okay • Run/attend a peer-led PITSTOP (hot debrief) • Access a confidential 1.1 check in with a Staff Trauma Support Peer Practitioner
In the weeks after the event.	• Support from your team • Access a 1.1 follow up with a Staff Trauma Support Peer Practitioner, where needed • Arrange a psychology-facilitated debrief
4-6 weeks after the event.	• We would typically expect things to settle over this period of time. However, if you feel the event is continuing to impact your wellbeing, please do make a 1.1 referral to the Staff Psychology Team via our page on LINK or by emailing StaffPsychologyTeam@nbt.nhs.uk.
If the adverse event is likely to lead to a serious patient safety investigation/inquest.	• For senior and junior doctors, contact Janet Angus for a peer check in (Janet.Angus@nbt.nhs.uk) • For all staff, contact the Staff Trauma Support team for support before, during, and after the investigation/inquest

To access this support, please contact StaffTraumaSupport@nbt.nhs.uk

The Staff Trauma Support team also provides training (e.g., on trauma awareness, and running PITSTOPs/hot debriefs) as well as consultation for leaders/managers.

NBT's Wellbeing Pathway

Patient Safety Learning Response Review

In the event that a Patient Safety Learning Response Review is commenced

Essential throughout any significant adverse event:

Support from colleagues, line manager, educational supervisor (for doctors in training) and team.

Responsive Support

When?	What?
Onset of Patient Safety Learning Response Review	1. Divisional Governance Team or Clinical Director/Head of nursing/Deputies contact Staff Trauma | **Support** to advise of patient safety learning response review and provide list of affected colleagues. Staff Trauma | **Support** to provide support options for staff members/team as needed. 2. Signposting as agreed/appropriate e.g., to line manager/educational supervisor, additional support with the Staff Psychology Team, Occupational Health etc.

NBT's Wellbeing Pathway

Inquests

In the event of a Coroner's Investigation and/or Inquest

Essential throughout any significant adverse event:

Support from colleagues, line manager, educational supervisor (for doctors in training) and team.

Responsive Support

Notice of Coroner's Investigation

1. Trust Healthcare Legal Service's Team to contact Staff Trauma | Support, clinical/professional leads with monthly updates about upcoming inquests
2. Trust Healthcare Legal Service's Team to send **Looking after your wellbeing when involved with an inquest** leaflet to all involved

Email: StaffTraumaSupport@nbt.nhs.uk

NBT's Wellbeing Pathway

Inquests

In the event of a Coroner's Investigation and/or Inquest

		When?	What?
Essential throughout any significant adverse event: Support from colleagues, line manager, educational supervisor (for doctors in training) and team.	**Responsive Support** **Specialist Support**	2-4 Weeks prior to full Inquest hearing	1. Healthcare Legal Services contact Staff Trauma| **Support** to confirm names of staff members who will be in attendance and share any concerns. 2. Offer 1:1 check in conversation (general and doctor-specific) with option for psychology support if needed 3. **Psychology Team Guidance for Coroner's Court Before, During and After Leaflet** given during this appointment
	Responsive Support **Specialist Support**	After Inquest	1. Staff Trauma| **Support** to check in with all staff members who attended Coroner's Court 2. Offer of psychology support if needed (including trauma-focused interventions) 3. Service leads to liaise with Staff Trauma| **Support** as needed regarding any learning in terms of wellbeing support

Wellbeing support around attending inquests is available for all NBT staff affected at the time of the incident, including those who have left the trust or rotated out, e.g., doctors in training. Staff leading review processes can also access support through the Staff Trauma| **Support**.

For those no longer at NBT, signposting to local services can be provided following this support if needed (e.g., for psychological interventions). Our Leads for Senior and Junior Doctors are the initial contact offering check ins for doctors; Staff Psychology Team for all other staff.

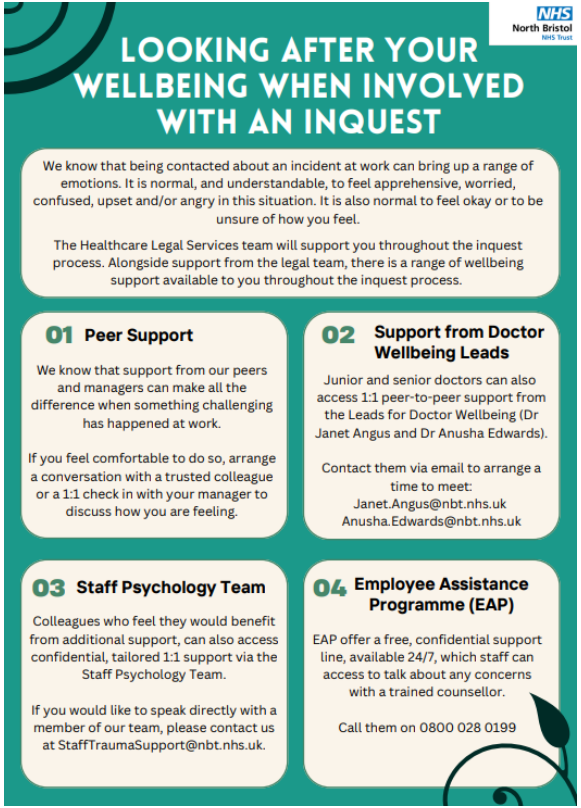
Staff leading review processes can also access support through the Staff Trauma| **Support.**

Email: StaffTraumaSupport@nbt.nhs.uk

NBT's Wellbeing Pathway

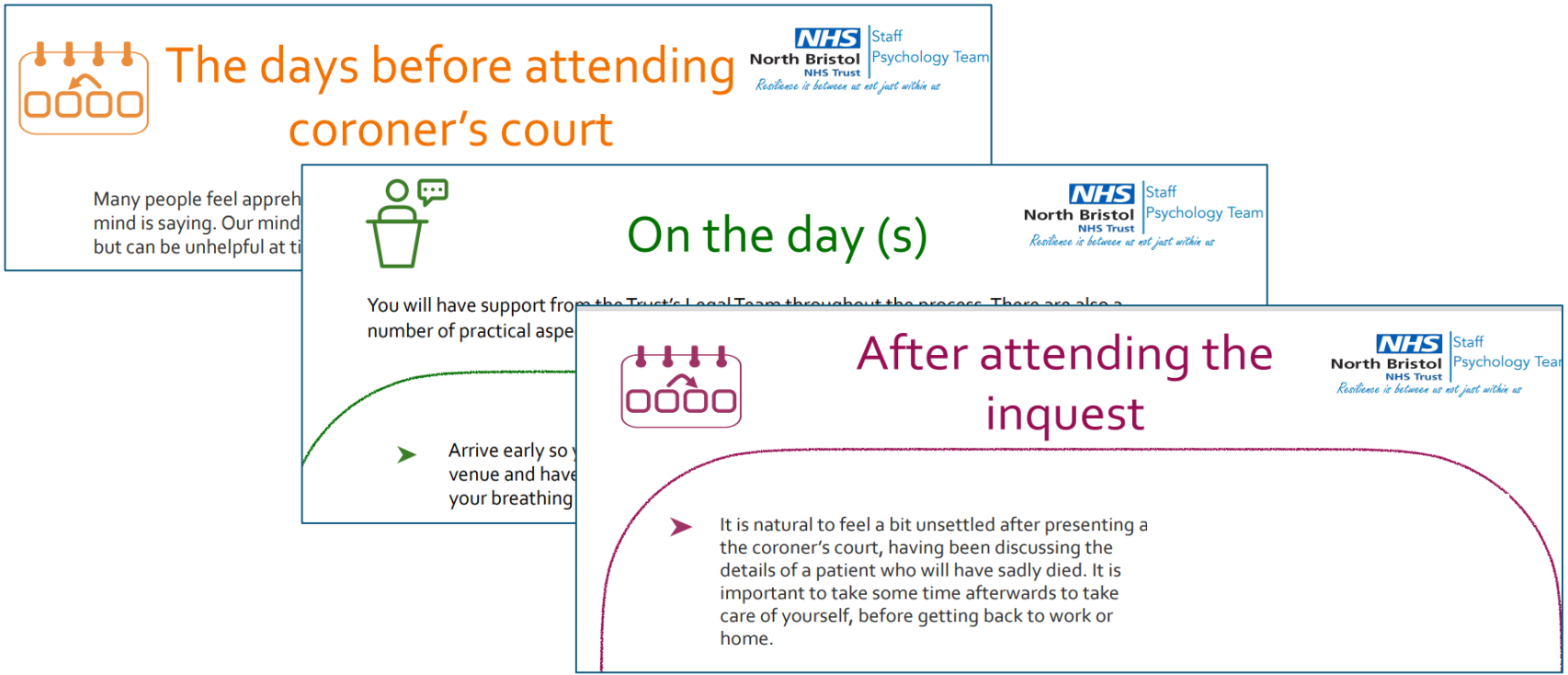
Inquest Guidance Note

This guidance note is provided to all staff members who are approached to provide an inquest statement.



NBT's Wellbeing Pathway

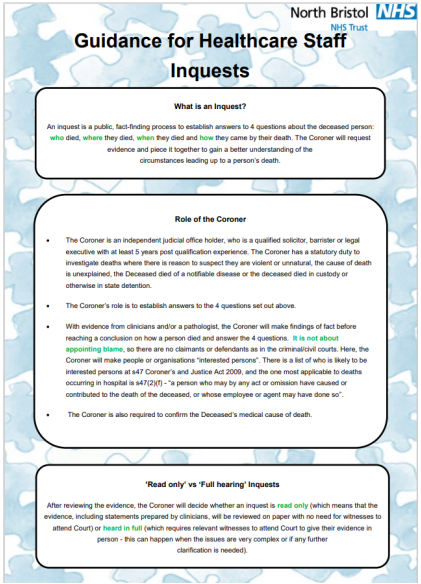
Staff Psychology Leaflets – Inquests



Other innovative work relating to inquests - NBT's Inquest Toolkit

NBT has developed a range of resources for healthcare staff to rely on as they prepare for the inquest process, these include:

Inquest Guidance Note



North Bristol NHS Trust

Guidance for Healthcare Staff

Inquests

What is an Inquest?

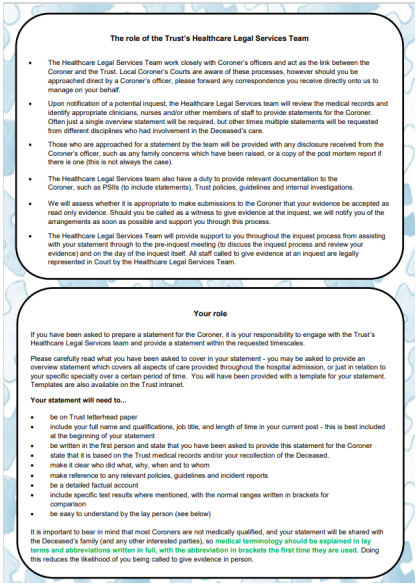
An inquest is a public, fact-finding process to establish answers to 4 questions about the deceased person: who died, where they died, when they died and how they came by their death. The Coroner will request evidence and piece it together to gain a better understanding of the circumstances leading up to a person's death.

Role of the Coroner

- The Coroner is an independent judicial office holder, who is a qualified solicitor, barrister or legal executive with at least 5 years post qualification experience. The Coroner has a statutory duty to investigate deaths where there is reason to suspect they are violent or unnatural, the cause of death is unexplained, the Deceased died of a notifiable disease or the deceased died in custody or otherwise in state detention.
- The Coroner's role is to establish answers to the 4 questions set out above.
- With evidence from clinicians and/or a pathologist, the Coroner will make findings of fact before reaching a conclusion on how a person died and answer the 4 questions. It is not about appointing blame, so there are no claimants or defendants as in the criminal/civil courts. Here, the Coroner will make people or organisations "interested persons". There is a list of who is likely to be interested persons at s47 Coroner's and Justice Act 2009, and the one most applicable to deaths occurring in hospital is s47(2)(f) - "a person who may by any act or omission have caused or contributed to the death of the deceased, or whose employee or agent may have done so".
- The Coroner is also required to confirm the Deceased's medical cause of death.

'Read only' vs 'Full hearing' Inquests

After reviewing the evidence, the Coroner will decide whether an inquest is read only (which means that the evidence, including statements prepared by clinicians, will be reviewed on paper with no need for witnesses to attend Court) or heard in full (which requires relevant witnesses to attend Court to give their evidence in person - this can happen when the issues are very complex or if any further clarification is needed).



The role of the Trust's Healthcare Legal Services Team

- The Healthcare Legal Services Team work closely with Coroner's officers and act as the link between the Coroner and the Trust. Local Coroner's Courts are aware of these processes, however should you be approached direct by a Coroner's officer, please forward any correspondence you receive directly onto us to manage on your behalf.
- Upon notification of a potential inquest, the Healthcare Legal Services team will review the medical records and identify appropriate clinicians, nurses and/or other members of staff to provide statements for the Coroner. Often just a single overview statement will be required, but other times multiple statements will be requested from different disciplines who had involvement in the Deceased's care.
- Those who are approached for a statement by the team will be provided with any disclosure received from the Coroner's officer, such as any family concerns which have been raised, or a copy of the post mortem report if there is one (this is not always the case).
- The Healthcare Legal Services team also have a duty to provide relevant documentation to the Coroner, such as PSIIs (to include statements), Trust policies, guidelines and internal investigations.
- We will assess whether it is appropriate to make submissions to the Coroner that your evidence be accepted as read only evidence. Should you be called as a witness to give evidence at the inquest, we will notify you of the arrangements as soon as possible and support you through this process.
- The Healthcare Legal Services Team will provide support to you throughout the inquest process from assisting with your statement through to the pre-inquest meeting (to discuss the inquest process and review your evidence) and on the day of the inquest itself. All staff called to give evidence at an inquest are legally represented in Court by the Healthcare Legal Services Team.

Your role

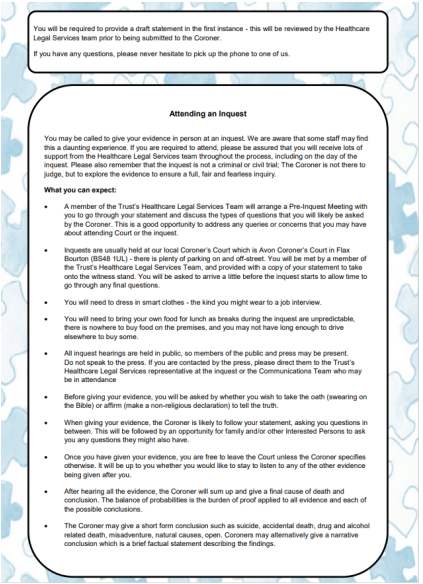
If you have been asked to prepare a statement for the Coroner, it is your responsibility to engage with the Trust's Healthcare Legal Services team and provide a statement within the requested timescales.

Please carefully read what you have been asked to cover in your statement - you may be asked to provide an overview statement which covers all aspects of care provided throughout the hospital admission, or just in relation to your specific specialty over a certain period of time. You will have been provided with a template for your statement. Templates are also available on the Trust intranet.

Your statement will need to...

- be on Trust letterhead paper
- include your full name and qualifications, job title, and length of time in your current post - this is best included at the beginning of your statement
- be written in the first person and state that you have been asked to provide this statement for the Coroner
- state that it is based on the Trust medical records and/or your recollection of the Deceased.
- make it clear who did what, why, when and to whom
- make reference to any relevant policies, guidelines and incident reports
- be a detailed factual account
- include specific test results where mentioned, with the normal ranges written in brackets for comparison
- be easy to understand by the lay person (see below)

It is important to bear in mind that most Coroners are not medically qualified, and your statement will be shared with the Deceased's family (and any other interested parties), so medical terminology should be explained in lay terms and abbreviations written in full, with the abbreviation in brackets the first time they are used. Doing this reduces the likelihood of you being called to give evidence in person.



You will be required to provide a draft statement in the first instance - this will be reviewed by the Healthcare Legal Services team prior to being submitted to the Coroner.

If you have any questions, please never hesitate to pick up the phone to one of us.

Attending an Inquest

You may be called to give your evidence in person at an inquest. We are aware that some staff may find this a daunting experience. If you are required to attend, please be assured that you will receive lots of support from the Healthcare Legal Services team throughout the process, including on the day of the inquest. Please also remember that the inquest is not a criminal or civil trial; The Coroner is not there to judge, but to explore the evidence to ensure a full, fair and fearless inquiry.

What you can expect:

- A member of the Trust's Healthcare Legal Services Team will arrange a Pre-Inquest Meeting with you to go through your statement and discuss the types of questions that you will likely be asked by the Coroner. This is a good opportunity to address any queries or concerns that you may have about attending Court or the inquest.
- Inquests are usually held at our local Coroner's Court which is Avon Coroner's Court in Flax Bourton (BS48 1UL) - there is plenty of parking on and off-street. You will be met by a member of the Trust's Healthcare Legal Services Team, and provided with a copy of your statement to take onto the witness stand. You will be asked to arrive a little before the inquest starts to allow time to go through any final questions.
- You will need to dress in smart clothes - the kind you might wear to a job interview.
- You will need to bring your own food for lunch as breaks during the inquest are unpredictable, there is nowhere to buy food on the premises, and you may not have long enough to drive elsewhere to buy some.
- All inquest hearings are held in public, so members of the public and press may be present. Do not speak to the press. If you are contacted by the press, please direct them to the Trust's Healthcare Legal Services representative at the inquest or the Communications Team who may be in attendance
- Before giving your evidence, you will be asked by whether you wish to take the oath (swearing on the Bible) or affirm (make a non-religious declaration) to tell the truth.
- When giving your evidence, the Coroner is likely to follow your statement, asking you questions in between. This will be followed by an opportunity for family and/or other Interested Persons to ask you any questions they might also have.
- Once you have given your evidence, you are free to leave the Court unless the Coroner specifies otherwise. It will be up to you whether you would like to stay to listen to any of the other evidence being given after you.
- After hearing all the evidence, the Coroner will sum up and give a final cause of death and conclusion. The balance of probabilities is the burden of proof applied to all evidence and each of the possible conclusions.
- The Coroner may give a short form conclusion such as suicide, accidental death, drug and alcohol related death, misadventure, natural causes, open. Coroners may alternatively give a narrative conclusion which is a brief factual statement describing the findings.

NBT's Inquest Toolkit

2

Mock Inquest Video

NBT's Inquest Toolkit

Factual and Nursing Overview Templates

INQUEST INTO THE DEATH OF XXXX [INSERT NAME OF DECEASED]

STATEMENT OF XXXXX [INSERT NAME]

I, [name and title] of [insert name of department] at North Bristol NHS Trust, will say as follows:-

1. Insert your job title, how long you have been in this position, commencement of employment at North Bristol NHS Trust and professional qualifications.
2. I make this statement in relation to the death of [insert name of deceased] at [insert place and date of death]. Insert details as to what period and care this statement is referring to, explain whether the statement is made with reference to the medical records and/or your recollection of the deceased. If you have no recollection of the deceased please state this.
3. Provide a brief summary of background medical history based on the medical records.
4. Provide a factual account of your involvement in the care and treatment of the deceased / overview account of the care and treatment provided in chronological order during the admission/s from X to X [insert dates]. Ensure your statement is based on the medical records and your recollection (if applicable) and includes reference to any relevant guidelines, policies and risk assessments.
5. Be candid around any key issues with care and/or treatment, e.g if any guidelines, policies, risk assessments, standard practice not followed, explain factually what did not happen and if known, explain why this was the case. Also explain what impact, if any, this had.
6. Ensure the statement only covers areas within your expertise. Also ensure the statement covers NBT care only, rather than care relating to other Trusts.
7. If within your expertise, explain whether you agree or disagree with the proposed cause of death and give reasons for your views.
8. Ensure paragraphs are numbered throughout the statement and use sub-headings where appropriate e.g. suggestions include background medical history, key care – surgery/fall on X date, care from X to X date.
9. I believe the contents of this statement are true to the best of my knowledge and belief.

Name:-

Signature:-

Date:-

INQUEST INTO THE DEATH OF XXXX [INSERT NAME OF DECEASED]

STATEMENT OF XXXXX [INSERT NAME]

I, [name and title] of [insert name of department] at North Bristol NHS Trust, will say as follows:-

1. Insert your job title, how long you have been in this position, commencement of employment at North Bristol NHS Trust and professional qualifications.
2. I make this statement in relation to the death of [insert name of deceased] at [insert place and date of death]. This statement is a nursing overview covering the period X to X [insert dates] whilst [Name of deceased] was on [Ward details]. Explain whether the statement is made with reference to the medical records and/or your recollection of the deceased. If you have no recollection of the deceased please state this. Explain why you have been asked to provide this nursing overview report.
3. Provide an overview account of the nursing care and treatment provided in chronological order during the admission/s from X to X [insert dates]. Ensure your statement is based on the medical records, your recollection (if applicable), discussions with nursing staff (if applicable) and includes reference to any relevant guidelines, policies and risk assessments.
4. Ensure the statement covers in detail falls risk assessments undertaken, including the date, outcome and how the outcome was reached for any assessments. Ensure the statement covers any measures to mitigate falls in place both pre and post each falls risk assessment and fall, if the deceased had multiple falls.
5. Ensure the statement details if enhanced care was considered (if appropriate) and if not appropriate, explains reasons why.
6. Ensure the statement covers in detail intentional rounding undertaken both pre and post any falls.
7. Be candid around any key issues with nursing care and/or treatment, e.g if any guidelines, policies, risk assessments, standard practice not followed, explain factually what did not happen and if known, explain why this was the case. Also explain what impact, if any, this had.
8. Ensure the statement only covers areas within your expertise. Also ensure the statement covers NBT care only, rather than care relating to other Trusts.
9. Ensure paragraphs are numbered throughout the statement and use sub-headings where appropriate e.g. suggestions include background falls history, key fall – fall on X date, care from X to X date.
10. I believe the contents of this statement are true to the best of my knowledge and belief.

Name:-

Signature:-

Date:-

DAC BEACHCROFT

VTE Case Studies

David Beattie
Associate
DAC Beachcroft LLP

VTE Case Studies

Orthopaedic care in the community

Background

C had an elective orthopaedic joint replacement as an inpatient. Surgery successful and PE risks in *inpatient* stage managed appropriately:

- Pre-op patient information booklet provided warning of the risk of DVT and PE,
- DVT / PE listed as risk in his consent form
- Post-operative TED stockings and anticoagulants given whilst in hospital

Initial recovery went well:

- 1 day post op – in a chair, pain fee. Discharged with aspirin and TED stockings. Information given about TED stockings and DVT red flags
- 1 day post discharge – recovering well, no new problems on call
- 4 days post op - calves were measured and evenly sized. Advice given to mobilise, use a cold compress, use a hot water bottle for cold feet and keep leg elevated.

Issues arose after:

- 10 days post op – appointment missed
- 11 days post op HCA visits and notes a swollen leg, with different circumferential measurements and a significant increase since the previous measurement.
- Swelling was the only symptom. There were issues with records: No detail of whether C had worn their stockings, and whether they were still taking aspirin. There was a dispute over whether C reported pain or not. No further action was taken.

12 days post op C suffered a PE.

VTE Case Studies

Orthopaedic care in the community

What went well?

- Good provision of information re: DVT and PE risks, verbally and through information leaflets before discharge from hospital
- Post op TED stockings and anticoagulants all appropriately prescribed
- Good follow up, a call the day after discharge and a visit 4 days post op
- The initial community follow up post operatively went well.

What were the issues?

- Although good information was given initially, following discharge there were not sufficient documented reminders of DVT / PE risks to C
- Key issue was the leg size discrepancy and recognition of the risk present by it.
- A full VTE assessment and referral should have followed the discrepancy, despite there being no other signs of DVT / PE and swelling being a recognised symptom post op.

Learning points

- Assessments of pain in recovery should be documented
- Ask for assistance when uncertain (a call to a nurse for a second opinion would likely have led to a referral).

VTE Case Studies

Surgical VTE management and contraception

C had 2 abdominal surgeries

It was alleged that C should have been told to stop taking the contraceptive pill before surgery due to the increased risk of DVT

Contraception guidance from the manufacturer:

- Contraceptive pill should be discontinued 4 weeks before major surgery, including any surgery to the legs or pelvis.
- Where it cannot be discontinued, thromboprophylaxis should be considered (which it was).

The contraceptive pill changed the risk of DVT for C. The risk should have been higher than recognized, and dosages adjusted accordingly.

Thromboprophylaxis was needed for both surgeries during the inpatient stay.

After the first surgery, C was prescribed prophylaxis, but at too low a dose, and given stockings. No adverse outcome came from this, as C recovered well post operatively.

After the second surgery, thromboprophylaxis was again given, again at the same dose as after first surgery. C developed PE 5 days post op.

VTE Case Studies

Surgical VTE management and contraception

What went well?

- There was not a requirement to stop the contraceptive pill pre-operatively, and most surgeons would not have done so.
- The need for thromboprophylaxis was recognised

What were the issues?

- Whilst thromboprophylaxis was given, the issue came down to assessment of VTE risk given the full history.
- Contraception should have led to a recognition of the patient as high risk, and increased dosage of thromboprophylaxis.
- That increased dosage would, on balance, have avoided PE.

Learning points

- Full history needed for VTE risk assessment
- Reliance on previous assessments of risk is risky (if second surgery had fresh assessment including contraceptive pill, PE would have been avoided despite the fact too low a dose of VTE prophylaxis was given in the first surgery).

VTE Case Studies

Bayley v George Eliot Hospital NHS Trust [2017] EWHC 3398 (QB)

- 1 April 2008 C gives birth to first child
- Normal birth, discharged after 2 days
- 15 April 2008 – attends ED with pain and swelling in left leg. DVT diagnosis. Prophylaxis (clexane and warfarin) given, but not thrombolysis, and discharged to anticoagulation clinic – no criticism made of this.
- C given TED stockings and prescribed warfarin. Warfarin was stopped after 6 months, in October 2008.
- C continued to have problems with her leg, and was referred, on a non-urgent basis, to a vascular surgeon in December 2008.
- Seen by vascular team in March 2009, and aspirin continued.

- C Alleged that D was negligent in:
  - Failing to provide full length graduated compression stockings in April 2008
  - Not referring C to vascular in August 2008
  - Stopping Warfarin in December 2008
  - Failing to tell her, in March 2009, that she could have undergone ilio-femoral venous stenting as an alternative treatment (per *Montgomery)*

- Quantum agreed pre-trial, subject to liability, at £350,000.

VTE Case Studies

Bayley v George Eliot Hospital NHS Trust [2017] EWHC 3398 (QB)

- Court's Findings:
  - Provision of knee length stockings at the time was accepted practice and not negligent. Full length stockings were not compulsory.
  - The 'missed' referral to vascular in August 2008 was during the 6 month 'acute' phase of warfarin treatment, and it was not negligent to await the end of that treatment to refer.
  - Stopping warfarin in December 2008 was not negligent. When used for more than 6 months, the bleeding risks of warfarin outweighed the benefits.
  - Discussion around consent and stenting, concluded that:
    - Ileo-femoral stenting for DVT was not well known in 2008
    - There was a window to perform ileo-femoral stenting, which closed in December 2008
    - The window closed before the Claimant had been referred to the vascular team, and physicians(who had treated her before this) would not have been familiar with stenting
    - The treatment the Claimant did have was the standard treatment in 2008. Stenting had not been widely used in the UK in 2008 and had limited literature in support of it
  - The Claimant's claim was dismissed

Learning from two VTE claims

25.11.25

Edward Duckworth | Senior Associate

Bevan Brittan

Case Study 1 – General Surgery (1)

Background:

- The patient underwent a laparotomy 10 days after admission to hospital.
- From admission, as surgery was planned, daily clexane was prescribed.
- The notes had no record it was given on the three days prior to surgery.
- After surgery, the patient recovered slowly and was discharged after 10 days.
- Daily clexane was prescribed post surgery but the records had no record of it being given for 3 days after surgery.

Case Study 1 – General Surgery (2)

Background:

- 15 days after discharge, the patient suffered a fatal cardiac arrest.
- The post-mortem gave the leading cause of death as being a PE.

Case Study 1 – General Surgery (3)

Allegations (VTE related):

- A failure to give daily clexane.
- Whilst a VTE assessment was carried out just after surgery, and this recommended the use of compression stockings, there was a failure to provide these.
- A failure to prescribe clexane on discharge.

Case Study 1 – General Surgery (4)

What allegations could be defended?

- It was argued that the patient had been provided with compression stockings, as per relevant guidance at the time (but this could not be proven).
- It was reasonable to not prescribe clexane on discharge as according to the then NICE guidelines this was not required where the patient had not undergone major cancer surgery to the abdomen.
- On causation, it was argued that regardless of the alleged breaches of duty, the patient would have suffered a PE in any event and the same sad outcome would have occurred.

Case Study 1 – General Surgery (5)

What allegations could not be defended?

- The medical records were missing several entries to show that clexane was given each day whilst in hospital. We therefore could not positively state it had been given each day.
- The pharmacy records did not assist with this and neither did the witness input obtained.
- There was no note in the medical records that compression stockings had been provided. The Claimant provided cogent evidence that if offered, he would have worn them, and that the family did not see him wearing them after surgery.
- There was risk on the prescribing clexane on discharge point – given wider complications the Claimant had.

Case Study 1 – General Surgery (6)

What was the outcome?

- The case was settled on a litigation risk basis at a significant discount compared to the pleaded value.
- The missed clexane doses and absent compression stockings could well have made the difference in the patient developing the fatal PE or not.

Case Study 1 – General Surgery (7)

What are the learning points?

- Prescription records and the giving of medication must be completed fully each day – even for repeat medication.
- If prescribed mediation is not given for a specific reason on any particular day, that reason should be noted.
- The provision of compression stockings should be recorded in the medical records (we were told this was not always the case) and also whether the patient engaged with wearing them.
- If a patient has complicating factors at discharge that could take them outside the relevant NICE guidance, a brief note about this explaining a decision to not prescribe clexane would be helpful.
- Incomplete medical records, even seemingly administrative details, can undermine the defence of a later claim.

Case Study 2 – Emergency Dept (1)

Background

- The Deceased suffered left leg pain, her GP measured this leg being 4cm swollen compared to the right, and advised her to attend ED.
- Her condition was investigated and this included a D-dimer test.
- The D-dimer result was positive and an ultrasound scan was performed.
- The ultrasound was reported as reassuring.
- The patient was diagnosed with muscular pain, advised to take pain relief and to return to her GP if the pain persisted.
- The patient collapsed and died 9 months later. A PM gave the cause of death as PE and DVT.

Case Study 2 – Emergency Dept (2)

Allegations

- A failure to perform and record a calf measurement.
- A failure to calculate a Wells score. If done, this would have mandated further follow-up leading to earlier diagnosis of a DVT.
- The DVT which led to the PE was present at the time of the ED review, and a repeat ultrasound within a week and a prescription of anti-coagulants for 6m would have revealed this, leading to alternative treatment that would have avoided the PE and death.

Case Study 2 – Emergency Dept (3)

The Defendant's position

- There was no Wells score (which was 1 based on the GP's calf measurement) noted in the medical records – and there should have been.
- The calf-swelling was recognised, and this was the trigger for the investigations that were carried out.
- Even if a Well's score had been recorded in the medical records, it would not have altered the management.
- If the Well's score was 2, this would have warranted a repeat ultrasound within a week.
- Even if there was a DVT present at the time of the ED review, it was not related to the fatal PE given the time period in between the two events.

Case Study 2 – Emergency Dept (4)

Evolution of evidence:

- If a Well's calculation had been recorded in the notes as 1, the same line of treatment would have taken place.
- Even if the Well's score had been 2 (required tenderness distribution), and a repeat ultrasound performed within a week, this would also have been negative and no anti-coagulants prescribed.
- Even if there was a DVT present at the time of the ED review, it was not related to the fatal PE given the time period in between the two events. Any calf DVT present at the time of the ED visit dissipated.
- The cause of the fatal PE was a new acute calf DVT that formed shortly beforehand. So even if anticoagulants had been prescribed for 3m after the ED visit, they would not have altered the outcome.
- The claim discontinued.

Case Study 2 – Emergency Dept (5)

Learning points:

- The importance of accurate note-keeping.
- If there is concern about calf swelling (either visually or in a referral from another clinician), do measure the difference compared to the other calf and note the findings.
- The importance of a Well's score being recorded in the medical records if there is clinical suspicion for DVT.
- Would the claim have been pursued at all if both had been present in the medical records?

NHS Resolution

Thank you for your time

GET IN TOUCH

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Advise / Resolve / Learn