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I anticipate that Dawn will have fed back to you in relation to the details of how the Inquest went, but I would highlight the following issues in particular:-

(a) **Trust protocol**

In the event, neither the Coroner herself nor the family made direct reference to the Trust protocol on Thromboprophylaxis in Orthopaedic Surgery nor to the NICE guidelines on reducing the risk of DVT and PE. I found this surprising given that the Coroner had requested and been supplied with a copy of the Trust protocol in advance of the hearing. As we discussed before the Inquest, there was a potential concern in this case in relation to non-compliance with the Trust's protocol which states that *"On admission to hospital all surgical inpatients and day cases with one or more risk factors should be offered thigh length graduated compression stockings unless contra-indicated"*. The protocol also requires that all patients should be assessed for individual risk factors for venous thromboembolism using the Orthopaedics Thromboprophylactic Assessment Form and failure to complete the form correctly should be recorded using the Trust incident forms. In Mr Highton's case, he was not offered compression stockings and the Assessment Form does not appear to have been used.

It was clear at the Inquest that the family's main concern was the fact that compression stockings were not used in this case. Although the Coroner found that, on balance, compression stockings would not have made any difference to the outcome, there was clearly the potential for the Trust to be criticised for failing to comply with its own protocol in this case.

As I understand the evidence of Mr Purbach and Mr Board, it is not usual practice within Wrightington Hospital to use compression stockings. It therefore seems to me something of a "hostage to fortune" to have a protocol which requires compression stockings to be offered in every case. Whilst this turned out not to be a major problem in this particular case, the inconsistency between protocol and practice at the Trust on this point could arise as an issue in future cases. From a risk management perspective, I would therefore suggest that the current wording of the Trust's protocol be amended to reflect ability of surgeons to exercise their clinical judgment in this regard.

(b) **Place of Death**

There was a lot of discussion at the hearing about whether Mr Highton died at Wrightington Hospital or at Widan Hospital