Nicola Jane Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: National Institute For Health And Care Excellence** Level 1a City Tower Piccadilly Plaza Manchester M1 4BT
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East District)
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 04/09/2014 I commenced an investigation into the death of David Andrew Bladen, 58 . The investigation concluded at the end of the inquest on 13 January 2015. The conclusion of the inquest was Narrative conclusion. The cause of death was : 1a. Pulmonary embolism 1b. Deep vein thrombosis 1c. Ruptured right quadriceps (Operated in July 2014)
4	**CIRCUMSTANCES OF THE DEATH** Mr Bladen ruptured his quadriceps tendon after falling down some stairs on 14th July 2014. He underwent surgery to reconstruct the right quadriceps tendon. He was provided with mechanical thromboprophylaxis during surgery and post operatively received two doses of medication thromboprophylaxis before being discharged two days post surgery. He was prescribed no extended prophylactic treatment on discharge and further assessments led to no further treatment being provided for thromboembolism. Mr Bladen died on 2nd September 2014 from a massive pulmonary embolism. During the course of evidence I not only heard from doctors who had been involved in Mr Bladen's care and the issue of thromboprophylaxis but also from a specialist in this area [redacted] It became clear during the evidence I heard that although NICE provides guidance in relation to the need for extended prophylaxis in certain cases e.g. where a patient has been given as cast, there is no clear guidance for patients in a brace. (As was the case with Mr Bladen) and there are many arguments to say that such patients are at as much risk as developing thromboembolism as those with casts. Medics who gave evidence at the inquest were in agreement that the NICE guidelines does not provide advice as to what is the best thromboprophylaxis management for these categories of patients.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) Absence of guidance for optimum thromboprophylaxis management in patients who are not in casts but still have restriction of mobility eg. due to a brace.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you National Institute For Health And Care Excellence have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 April 2015. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 04 March 2015 [redacted] Signature_____ Senior Coroner for South Yorkshire (East District)

Coroner's Court and Office, Doncaster Crown Court, College Road, Doncaster, DN1 3HS
Tel 01302 320844 | Fax 01302 364833