*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** National Institute for Clinical Excellence (NICE)
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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.
3	**INVESTIGATION and INQUEST** On 21/11/23, I concluded an inquest into the death of David John Lewsey who died on 15/12/22 at the age of 68. . The medical cause of death was recorded as: 1a) Pulmonary thromboembolism 1b) Deep vein thrombosis of left calf 1c) Knee replacement operation I recorded a Narrative Conclusion that Mr Lewsey died from a known complication of an elective surgical procedure.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lewsey was a 68-year-old man who underwent an elective left knee replacement on 29/11/22. [redacted], the consultant orthopaedic surgeon who performed the procedure, confirmed that his default position was to prescribe low molecular weight heparin for the initial period in hospital and then to prescribe a fortnight's worth of aspirin. It was established in evidence that the NICE guidance (NICE 89 – VTE in over 16s – reducing the risk of hospital acquired DVT or PE) suggested at paragraph 1.11.8 that LMWH should be used with TED stockings until discharge. It was [redacted] view that the foot pumps provided in hospital, Flowtrons, were superior to TED stockings and, in this regard, the

	consultant felt the NICE guidance needed to be updated. It is understood that there may be other compression systems or VTE prevention pumps that it may also be appropriate to consider. Mr Lewsey collapsed on the evening of 15/12/22 at his home address and could not be resuscitated.
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. – The relevant NICE guidance may need to be updated to reflect the use of LMWH with products that assist with VTE prevention other than TED stockings.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 19/1/24. 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: - The family of Mr Lewsey; - The legal representatives of [redacted] I am also under a duty to send the Chief Coroner and above IPs 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	**[DATE]** **[SIGNED BY CORONER]** **22.11.23**