NICE National Institute for Health and Care Excellence

2nd Floor
2 Redman Place
London
E20 1JQ
United Kingdom

+44 (0)300 323 0140

10 December 2024

Alison Mutch
HM Senior Coroner, Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

By email to [redacted]

Your reference: [redacted]
Our reference: [redacted]

Dear Ms Mutch

Re: Regulation 28 Prevention of Future Deaths Report in respect of Audrey Margaret Lambert who died on 28 May 2024

I write in response to your regulation 28 report regarding the death of Mrs Audrey Lambert. I would like to express my sincere condolences to Mrs Lambert's family and loved ones.

We have reflected on the circumstances surrounding her death and senior clinical advisers within our patient safety team have reviewed the concerns raised in your report.

I understand that the inquest was advised that Mrs Lambert had become very immobile since her fall. The inquest was also advised that there was no national guidance that would assist clinicians in primary care in assessing whether they should consider prolonging the course of anticoagulation prescribed in secondary care to reduce the ongoing risk of elderly immobile patients such as Mrs Lambert developing a fatal deep vein thrombosis (DVT) in the community.

In the circumstances outlined in your report we believe that an assessment of the venous thromboembolism (VTE) risk, balanced against the prophylaxis risk, should have been made at discharge. Although our VTE guideline [NG89] does not give advice on starting VTE prophylaxis de novo in the community, it does give advice on starting and continuing pharmacological VTE prophylaxis after surgery (recommendation 1.11) and having a clear discharge plan. Decisions on prophylaxis should be driven by the needs of the individual, balancing the person's individual risk of VTE against their risk of bleeding when deciding whether to offer pharmacological thromboprophylaxis to surgical and trauma patients (recommendation 1.1.6).

If Mrs Lambert was not fully mobile on discharge, there is an expectation that this would be considered in an assessment as part of the discharge plan, which might result in continued VTE prophylaxis (either pharmacological or mechanical) as is recommended in our guidance.

Both pharmacological and mechanical prophylaxis have well recognised side effects (including a higher risk of intra and extracranial bleeding, higher drug costs and risks of renal impairment especially in elderly patients with poor renal function). We therefore recommend that a risk assessment should be made in conjunction with the patient before they are prescribed (recommendation 1.2.2) and on discharge (recommendations 1.2.4 and 1.2.5).

It is difficult to provide more specific commentary without detailed information about Mrs Lambert's personal clinical circumstances, however our guidance does recommend in several places the use of anti-embolism stockings or intermittent pneumatic compression, which should be continued until the person no longer has significantly reduced mobility relative to their normal or anticipated mobility.

I can confirm that we will review our guidance on stopping and starting VTE prophylaxis to see if an update is warranted. The potential scope of this work is to be confirmed but it may cover the management of people with immobility, if there is sufficient good quality evidence on which to base recommendations.

Please do let me know if you require any further information and again, I offer my sincerest condolences to Mrs Lambert's family.

Your sincerely,

[redacted]

[redacted]
Chief Executive