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Royal Cornwall Hospitals NHS Trust

Chief Executive Office
Royal Cornwall Hospital
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[redacted]

12 May 2023

Mr Guy Davies
Assistant Coroner for Cornwall and the Isles of Scilly
H.M Coroner's Office
Pydar House, Pydar Street
Truro, Cornwall
TR1 1XU

Dear Mr Davies

Re: Death of John Alfred Roberts - R28 PFD Report & letter (ref: 6930388)

I write in response to the Regulation 28 Report to Prevent Future Deaths, dated and received on the 26th of April 2023, issued as a result of the inquest into the death of Mr John Alfred Roberts, which took place over 12 – 14th April 2023.

I would like to take this opportunity to express my sincerest condolences to the family of Mr Roberts for their loss.

During the course of the inquest, the evidence revealed matters giving rise to concern. These are as follows:

• The concern is the inadvertent reduction of steroid dosage and the arrangements made in relation to the administration of medication dosages and the policies regarding dosage errors, and the application of those policies.

• The Court heard that the dosage of [redacted] prednisolone was inadvertently reduced to [redacted] from 7 to 13 June. The full dose of [redacted] was given either side of that period, on 5 and 15 June 2021. No explanation was offered for this reduction other than it being an inadvertent mistake.

• RCHT Consultants accepted that the dosage error was a serious mistake. Furthermore, this mistake was not drawn to the patient John's attention or to the attention of the GP via the

discharge summary, which made no reference to the dosage error. It was unclear whether treating physicians or discharging physicians were aware of the dosage error.

Please find below an account of the details of the inadvertent prednisolone dosage reduction and then a response from the Trust in relation to each concern you have raised:

Chronology of events regarding prednisolone:

Mr Roberts was initially prescribed [redacted] prednisolone oral dosage alternate days on admission on the Friday 4th June 2021 and received this dose on 5th June 2021 as prescribed. A request came to the pharmacy dispensary on Saturday 5th June 2021 for more prednisolone tablets. Mr Roberts was prescribed [redacted] prednisolone as [redacted] tablets (note 1) This would have meant Mr Roberts swallowing [redacted] tablets. The dispensary pharmacist on duty switched the preparation to the [redacted] tablets to reduce the pill burden for Mr Roberts but inadvertently did not amend the dose to [redacted] on alternate days. This resulted in Mr Roberts receiving a [redacted] dose on the 7th,9th,11th and 13th June 2021.

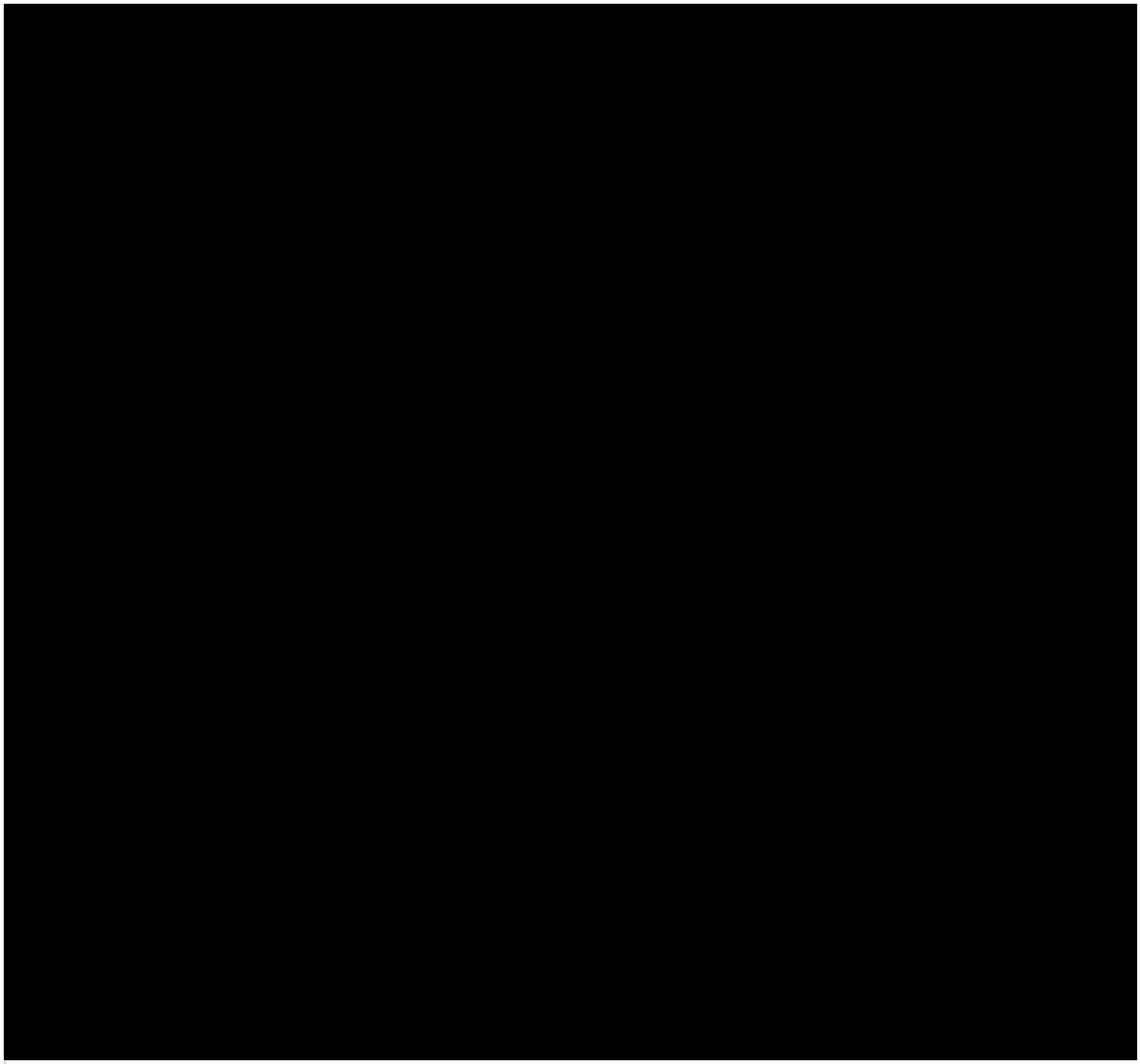
Note 1

[redacted]

On admission to hospital, the hospital aims to undertake a medicines reconciliation for each patient, to ensure the medicines they have been prescribed on admission match those prescribed by their GP. This reconciliation process was undertaken by the ward pharmacist on Monday 7th June 2021 and recorded on the Electronic Prescribing and Administration system (ePMA) noting system as per the Trust's policy (see note 2).

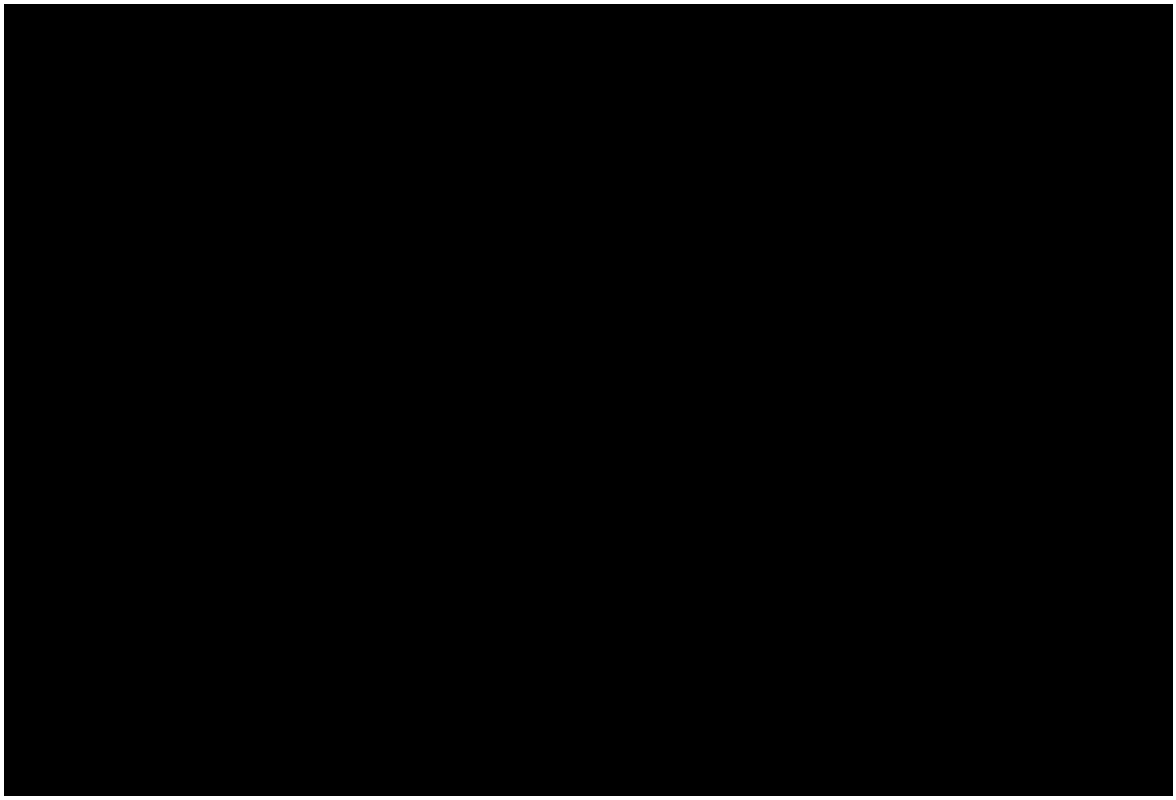
The pharmacists use several sources when undertaking the medicines reconciliation process, including the summary care record (SCR) and list of medicines from the GP. In this instance it would appear the GP list and SCR showed the prednisolone dose to be 10mg on alternate days.

Note 2:



A later 'pharmaceutical care plan' note (see note 3) suggests the ward pharmacist confirmed the [redacted] dose with the ward doctor (this was likely with the renal team who Mr Roberts was under the care of, rather than the neurologist). It is common practice for prednisolone doses to increase and decrease depending on disease flare; so a dose change would not be unusual. The pharmacist noted on the reconciliation record 'INC AS IP' (increased as inpatient), as the SCR and GP record showed his usual dose to be [redacted] on alternate days.

Note 3:

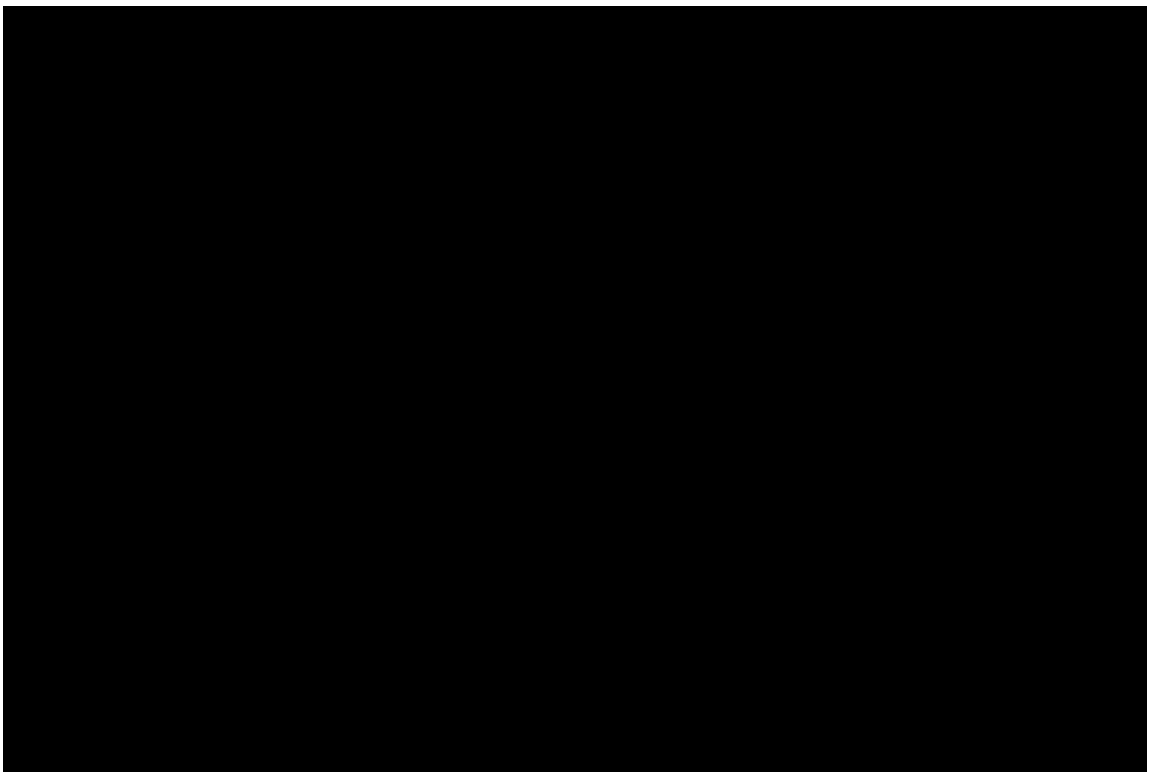


As per note 3, the pharmacist covering the ward on 15th June identified the discrepancy in the dosing and recorded it on the ePMA system as an intervention. The medicines reconciliation note (note 4) was amended to reflect the [redacted] alternate days dose.

Note 4:

Shortly after the medicines reconciliation note was amended on the 15th June 2021, the same pharmacist has recorded an 'intervention counselling' note (note 5) onto ePMA- stating '*counselled patient on all medicine changes and amended personal list'*. We are unable to confirm if this discussion included a discussion regarding the prednisolone discrepancy.

Note 5:



The pharmacist also entered two ‘DMR’ (discharge medicines reconciliation) notes (note 6 & 7). These notes appear in the discharge letter that goes to the GPs and gives information about changes to medication during admission. Note 7 includes information relating to reducing the prednisolone dosing after discharge, though does not mention the dosing discrepancy during the admission.

Mr Roberts was subsequently discharged home on the 15th June 2021.

Note 6:

Note 7:

In relation to each concern you have raised;

The concern is the inadvertent reduction of steroid dosage and the arrangements made in relation to the administration of medication dosages and the policies regarding dosage errors, and the application of those policies.

The Trust's policies concerning medicines reconciliation on admission and discharge were applied and did pick up the dosage error before any harm came to the patient. The picture was confused as Mr Robert's summary care record and GP list recorded his dose as [redacted] on alternate days. This was a causative factor in the discrepancy not being picked up on the admission reconciliation. The error was picked up at the discharge reconciliation and recorded on the ePMA system in an 'intervention note' but with hindsight should also have been recorded on the Trust's incident management system-Datix.

The Court heard that the dosage of [redacted] prednisolone was inadvertently reduced to [redacted] from 7 to 13 June. The full dose of [redacted] was given either side of that period, on 5 and 15 June 2021. No explanation was offered for this reduction other than it being an inadvertent mistake.

I trust the chronology of events described above gives an explanation to dosage discrepancy, how it occurred and how it was rectified.

RCHT Consultants accepted that the dosage error was a serious mistake. Furthermore, this mistake was not drawn to the patient John's attention or to the attention of the GP via the discharge summary, which made no reference to the dosage error. It was unclear whether treating physicians or discharging physicians were aware of the dosage error.

The notes within the ePMA system (specifically note 2) evidence that the treating and discharging physicians were aware of the dosage error.

Note 4 shows that Mr Roberts was counselled about his medicines and the changes in dosing but we cannot confirm this included a discussion around the prednisolone dose.

As stated in evidence during the inquest hearing over 12 - 14 April 2023, the dosage discrepancy caused no harm to Mr Roberts and there was no action required by the GP in relation to the dose discrepancy of [redacted] doses administered from the 7th-13th June. It is not within our procedures to communicate to the GP incidents that cause no harm to the patient and require no action by the GP following discharge.

Information was passed on to the GP relating to any changes in dosing at discharge and any subsequent actions that were required, including the need to reduce the prednisolone dose (notes 5&6).

I hope that this letter provides both you and Mr Roberts' family with assurance that the Trust has taken seriously the matter of concerns you raised in your report.

Yours sincerely

[redacted]

Chief Executive Officer

Cc

Care Quality Commission
VIA email

[redacted]
Director of Governance
Bedruthan House, RCHT