NHS
Hull University
Teaching Hospitals
NHS Trust

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NHS
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NHS Foundation Trust
Hull Royal Infirmary
Anlaby Road
Hull
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Friday 22 December 2023

Private and Confidential
Professor Paul Marks
HM Senior Coroner for East Riding of Yorkshire and Hull
The Coroner's Court and Offices
The Guildhall
Alfred Gelder Street
Hull
HU1 2AA

Dear Professor Marks,

Re: Death of Tracey Elizabeth Rose – Response to Regulation 28 Report to Prevent Future Deaths

I write in response to the Regulation 28 Report to Prevent Future Deaths, dated and received on the 17th October 2023, issued as a result of the concluded inquest into the death of Ms Tracey Elizabeth Rose.

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

Upon conclusion of the inquest the following concerns were raised:

- Ms Rose was discharged home without her prescription of Dalteparin being dispensed, also her last dose whilst in hospital may not have been given. Evidence was heard that missing up to three doses of this anticoagulant, in someone with increased risk factors for thromboembolic disease, may have significantly contributed to her developing a pulmonary embolism.

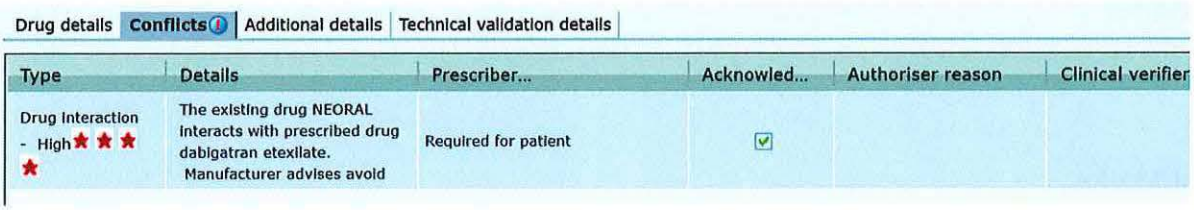
I would like to confirm that following receipt of your Regulation 28 correspondence, the Trust has investigated the concerns you raised and we are able to provide a response and detail the actions we have taken.

Prescribing and Dispensing of Dalteparin
As established at inquest, Ms Rose was prescribed Dalteparin via injection once daily immediately following surgery for open reduction and internal fixation of a right tibial fracture on 4th January 2023. This is a standard VTE prophylaxis used widely for patients following this type of surgery.

Following discussion with the Trust Pharmacy Team and review of the Trust's electronic prescribing system, we can confirm that on 19th January 2023 at 09:42am, a Foundation Year 2 (FY2) doctor on the ward where Ms Rose was an inpatient raised a prescription for her. This prescription was requested for Ms Rose in anticipation of her planned discharge on 20th January and included Dabigatran, a VTE prophylaxis. It is standard practice for patient's receiving Dalteparin injection whilst an inpatient to be switched to Dabigatran when discharged from the hospital. This is because Dabigatran takes the form of a capsule that can be taken orally and

therefore does not require the patient to self-inject or have a third-party to inject them when they are at home.

The Trust pharmacy records indicate that when the FY2 doctor processed the prescription for Dabigatran, the electronic prescribing system identified that Ms Rose was already taking ciclosporin – brand name Neoral - a medication which was known to have a strong adverse interaction with Dabigatran. The Trust electronic prescribing system rates any identified adverse reactions between medications on a scale of 1 to 4 stars – 4 stars being the most severe adverse interaction. The adverse reaction between ciclosporin and Dabigatrin is rated at 4 stars. When the FY2 doctor processed the prescription the below alert message would have appeared informing them of the adverse interaction:



At this time the electronic prescribing system required the prescribing clinician to tick a box which confirmed that they had noted the alert but wished to override and proceed with the prescription. Although the prescribing system can raise alerts about medications, ultimate decisions around their prescription and consideration of risk rest with the treating clinicians. The prescription was processed by the Trust pharmacy and dispensed to the ward at 15:43 on 19 January 2023 in advance of Ms Rose's planned discharge the following day.

Although not recorded in the patient notes, it appears from the pharmacy records that the above issue was identified by one of the treating clinicians, as part of the safety check, prior to Ms Rose's discharge on 20 January 2023 and a new prescription was requested replacing the Dabigatran with Dalteparin.

Unfortunately, although this prescription was processed and dispensed in a timely manner by the Pharmacy team, it was not ready before Ms Rose had left the ward, and Ms Rose did not wish to wait for it. According to the Trust prescribing system, the prescription was issued at 17:43 on 20 January 2023. The pharmacy at Castle Hill Hospital closes at 18:00, therefore the Dalteparin was not dispensed and collected from the pharmacy until the following day at 13:12.

Circumstances around Ms Rose's discharge on 20 January 2023

Following discussion with the Ward Sister and Matron for Ward 9 at Castle Hill Hospital and the nursing staff involved we have established that a dose of Dalteparin was administered to Ms Rose shortly before discharge on 20 January 2023. Unfortunately, the administering nurse did not record the dose in the medication record and has advised that the ward extremely busy as it was around the time that the patients were being given their evening meal. The patient transport had also arrived to take Ms Rose home and she was keen to leave. The transport for Ms Rose on 20 January had been organised on 17 January, this was because a risk assessment had to be undertaken of Ms Rose's home to ensure it was a safe place to discharge her, and Ms Rose was very keen to leave the hospital. The nurse has explained that as a result she felt pressured to get Ms Rose ready for discharge and subsequently failed to record the administered dose of Dalteparin.

Due to Ms Rose receiving a dose of Dalteparin on the ward prior to discharge on 20 January 2023, it appears that the nursing staff were assured that Ms Rose could wait until the following day to receive the Dalteparin when her next dose was due; unfortunately, this did not happen. The Trust's prescribing system shows the ward incorrectly returned Ms Rose's Dalteparin to the pharmacy on 21 January 2023, the note on the system states that the prescription was 'no longer being needed'. We were unable to establish who returned the prescription to pharmacy on 21 January 2023, as we were able to confirm that the need to the prescription to be sent to Ms Rose via taxi was included in the nursing handover.

It is usual practice in these circumstances for medication to be sent to the patient at home via taxi and we sincerely apologise to Ms Rose's family that this did not happen on this occasion.

Changes Implemented by the Trust since the death of Ms Rose
In May 2023, changes were made to the adverse interaction alerts issued by the Trust's electronic prescribing system. In circumstances where a serious potential adverse reaction is identified, the system now requires prescribing clinicians to type an explanation as to why they are overriding an alert, rather than simply ticking a box. This change is intended to make our clinicians pause and further consider the alert before deciding whether to override it.

The circumstance regarding Ms Rose's prescription and the findings of the investigations have also been brought to the Trust's VTE Steering Group for learning to be shared.

I like to sincerely apologise that this information was not made available to you at the time of the inquest. I hope that this letter provides both you and Ms Rose's family with assurance that the Trust has taken seriously the matter of concerns you raised in your report.

Yours sincerely,

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