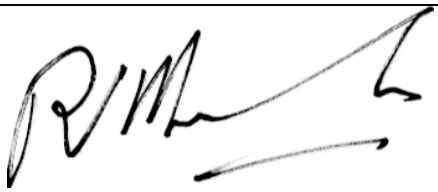
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Medical Officer, Hull & East Yorkshire, NHS Trust**
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 5th February 2023 I commenced an investigation into the death of Tracey Elizabeth Rose, aged 52 years. The investigation concluded at the end of the inquest on 2nd October 2023. The conclusion of the inquest was: **ACCIDENT**
4	**CIRCUMSTANCES OF THE DEATH** These are set out in my summary and findings of facts which are attached. Tracey Elizabeth Rose suffered an injury on 2nd January 2023 resulting in a fracture of the right tibial plateau. This was treated by open reduction and internal fixation on 4th January 2023. She was at higher risk of thromboembolic disease due to obesity and systemic lupus erythematosus and at discharge was recommended to have a course of six weeks dalteparin. Due to a dispensing issue, she missed up to three doses. She was readmitted to Hull Royal Infirmary on 25th January with shortness of breath and dizziness. She was suspected of having a pulmonary embolism which was subsequently confirmed, but despite embolectomy using interventional radiological techniques in which a large amount of thrombus was retrieved, her heart did not restart and she died on 25th January 2023.

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) This woman 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action by ensuring no doses are missed and that patients who have been prescribed such medication leave hospital with the appropriate supply.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday, 12th of December 2023. 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], Next of Kin I am also sending a copy to NHS England and equivalent organisations in the other countries of the United Kingdom. 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	 **17th October 2023**