Guy's and St Thomas' NHS
NHS Foundation Trust

Office of the Medical Director
Gassiot House
St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH

HM Coroner
Walthamstow Coroners Court
Queens Road
Walthamstow
London
E17 8QP

By fax and Royal Mail

[redacted]

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22 JAN 2014

20 January 2014

Dear Madam

Re Peter Jeffery dec'd – Regulation 28 report

We write in formal response to your letter of 27 November 2013 in this matter, enclosing a report prepared by the Assistant Coroner, Jacqueline Devonish, pursuant to Regulation 28 of the Coroners (Investigations) Regulations 2013. The letter followed the hearing of the inquest in this case on 25 November 2013.

The Trust is always committed to improving patient care and to learning from incidents (and in particular inquests), where aspects of care could have been delivered in a more effective way. We have therefore reviewed our records for this case carefully.

We note that Mr Jeffery died on 10 February 2013, with a medical cause of death as:

1(a) Septicaemia;
1(b) Fractured left ankle joint with abscess formation;
1(c) Infection with beta haemolytic streptococci

The episodes of care provided to Mr Jeffery by Guys and St Thomas NHS Foundation Trust ended on 17 August 2012. At the time of writing, and despite the inquest having taken place, we remain unaware of the precise factual sequence for Mr Jeffery's health and wellbeing for the 6 months between August 2012 and his death in February 2013. In particular, it remains unclear how and when he fractured his left ankle, when the associated abscess formed and who may have treated him in that 6 months. We are satisfied that neither of those clinical features were present in August 2012, on the basis of the evidence of those in this Trust who examined Mr Jeffery at that time. The clinical features observed at that time are described below.

In noting the above, we do not seek to re-open the facts of the inquest but to give some context to our limited ability to respond to the concerns raised in the letter sent us by the Assistant Coroner.

The Regulation 28 report raises 4 specific areas of concern, which we address in turn below:

1. **The scans did not reveal DVT and no alternative effective diagnosis or treatment was considered;**

Response:

In accordance with the statement of [redacted] dated 16 October 2013, and the medical records, the working diagnosis for Mr Jeffery was of a potential DVT, to explain his swollen and painful lower leg. Scans were performed to exclude DVTs as a potentially serious condition. Following the exclusion of that differential diagnosis, on 17 August 2012, the focus shifted to other potential causes and included consideration of possible infection. The records indicate that Mr Jeffery had no fever and a general examination proved normal. His left leg had pitting oedema and was warm and red. He had poor foot care and grubby toes. Examination identified a scabbed blister on the sole of his foot, which the Consultant Physician considered may have been the source of a cellulitis below the left knee (i.e. an infection in the tissues beneath the skin).

Further investigations were performed that afternoon, via blood tests and an ultrasound scan to exclude infection and pus collections in the deep tissues of Mr Jeffery's leg. This revealed only fluid based swelling in the tissues. Blood results were not consistent with the presence of an abscess.

The treatment put in place for a presumed cellulitis in the lower left leg was a 2 week course of flucloxacillin antibiotics, with a recommendation that Mr Jeffery attended his GP in 2 weeks and should be referred as an outpatient to the plastics team. A letter was sent to Mr Jeffrey's GP to that effect.

On the basis of the above information, and despite being aware of the subsequent cause of death 6 months after that intervention, we have been unable to identify what alternative clinical approach might have been adopted for Mr Jeffery in August 2012. The treatment followed the Trust's DVT protocol, with 2 negative scans followed by referral to medics to review for alternative diagnoses. This took place on 17 August 2012, with a working diagnosis of cellulitis being given, and a 2 week course of antibiotics, which would ordinarily be expected to deliver effective treatment.

In the event the condition did not resolve after the 2 week course of antibiotics, we agree that IV antibiotics could have been considered, however at this stage Mr Jeffery's would have been under the care of his GP, and a referral to a suitable hospital to receive the IV intervention, would have been necessary. Mr Jeffery was not seen at this trust after 17 August 2012.

Whilst not a particular feature of the Regulation 28 report, our own reflection in this case identified that the intended referral to the plastics team - to address the scabbed blister on the sole of Mr Jeffery's foot - did not occur. We are taking steps to remind staff of the importance of following through such plans, to ensure follow up appointments are put in motion via referrals.

We are not intending to take any other particular action arising from the diagnostic aspects of this case at this time, but remain happy to receive further information from HM Assistant Coroner as to why this is a concern, if this course of action is not considered to be acceptable.

2. **No culture was taken for testing from the open blister which was full of pus.**

Response:

Please see above for the primary detail. We agree that in the event of an 'open blister' being noted, which included pus or signs of infection, it would be appropriate to expect the necessary organisms to be collected on a swab and then grown and tested in the laboratory.

The contemporaneous records, and subsequent accounts for the coroner, note the presence of a scab over a blister on the sole of Mr Jeffery's foot. They do not indicate an open blister nor evidence of pus. As such, in clinical respects there would have been nothing to swab on 17 August 2012.

It is clear that open sores were present post mortem, 6 months later; however we remain unaware of the point at which such abscesses developed. In addition, despite the careful post mortem description of the location of the abscess within the fractured joint, and the cracked areas on the deceased's heel, it remains entirely unclear to us whether the scabbed blister on the sole of Mr Jeffery's foot noted on 17 August 2012 was the infected area found post mortem.

We understand HM Assistant Coroner had access to a photograph of the abscess, although it was unclear to Trust witnesses when the photograph was taken. The abscess demonstrated by the photograph bore no resemblance to the condition of Mr Jeffery's foot when under the care of this Trust.

3. **No swab was taken.**

Response:

Please see the response to issues 1 and 2 above. There was, on 17 August 2012 as there was no open wound there was nothing to swab.

4. No intravenous antibiotics were considered.

Response:

Please see the response to issue 1 above. IV antibiotics would have been considered in the event the cellulitis persisted after the 2 weeks course of oral antibiotics and if Mr Jeffery had been referred back to this Trust's care (or re-presented via ED). As at 17 August 2012, based on a working diagnosis of cellulitis, oral antibiotics were appropriate.

We are happy to remind those within our medical teams to remain aware to the options around administration of antibiotics, to decide whether any given patient required oral or IV antibiotics in any given situation. In other respects we are uncertain what further action could be taken on this issue.

If an open abscess full of pus had been present in August 2012 and not investigated and treated for Mr Jeffery, we would have no hesitation in identifying ways in which such shortcomings ought to be fed back to the treating staff, and steps put in place to ensure awareness of the appropriate care pathway.

We would of course welcome further dialogue with HM Assistant Coroner in this case, in the event we have misunderstood the evidence that was before the court regarding the state of Mr Jeffery's ankle in August 2012 (as opposed to the clear evidence of abscess formation and fracture in the ankle joint contained in the Post Mortem report).

Finally, it is open to the recipient of Regulation 28 reports to make submissions as to the publication of the reports and responses. Whilst we would ordinarily not seek to make such submissions, we would question whether publication is justified in this case. This is on the grounds that the factual basis on which the Regulation 28 report has been issued, remains, of itself, a matter of some uncertainty.

Yours faithfully

[redacted]

Medical director

Signed electronically