Your ref: VHD/ST/INQ 13/17 (307/16)
Our ref: GF004/KK

Brighton and Sussex University Hospitals NHS Trust

23 May 2017

The Royal Sussex County Hospital
Eastern Road
Brighton
BN2 5BE

Tel: 01273 696955

Miss Veronica Hamilton-Deeley
HM Senior Coroner
Coroner's Office
Woodvale
Lewes Road
BRIGHTON
BN2 3QB

RECEIVED
25 MAY 2017

Dear Miss Hamilton-Deeley

The Late Paul Barber, date of birth: 09/02/1962

Thank you for your letter and report of 6 March 2017, and for drawing your concerns to the attention of this Trust. As you know, we are always willing to review our practices, to ensure we learn from experience.

I was very sorry to learn about the circumstances of Mr Barber's death and the issues you have highlighted concerning the use of incorrect containers for microbiology samples, and a delay in reporting important results from the laboratory to ward-based clinical staff. I agree that, even though you had concluded these matters did not cause or contribute to the death of Mr Barber, it is still important to address them.

In order to ensure that as many staff as possible learn from these events, a message has been circulated to all Trust staff reminding them that normally sterile body fluids, such as pericardial or ascetic fluid, should only be submitted to the laboratory in a sterile white capped container and not in a blood culture bottle. The same message made it clear that only blood and peritoneal dialysis fluid should be inoculated into blood culture bottles at the bedside. Secondly, the standard operating procedure within the laboratory has been altered so that, if such a specimen is received in the wrong container, an educational message is now sent advising on the correct container to be used in such circumstances so that the staff learn from this.

I note the initial blood culture result was notified to a doctor in the team caring for Mr Barber, who documented a plan about antibiotic treatment should the clinical situation warrant it. Mr Barber was reviewed each day by a consultant so that his condition could be closely monitored. Very unusually for any patient with bacterial pericarditis, sepsis was not a significant factor in Mr Barber's clinical condition.

Concerning the delay in updating the clinicians caring for the patient about the new laboratory findings, the microbiology and infection department have discussed Mr Barber's case in detail at their clinical governance meeting, as part of training for microbiology registrars to help them discriminate effectively in prioritising urgent follow up for appropriate specimens.

Thank you once again for raising these concerns. Finally, please pass on my condolences to the family and friends of Mr Barber on their sad loss.

Yours sincerely

Dr George Findlay
Executive Medical Director