St George's University Hospitals NHS
NHS Foundation Trust

St George's University Hospitals
NHS Foundation Trust
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Ms Veronica Hamilton-Deeley
Her Majesty's Senior Coroner for the City of Brighton & Hove
The Coroner's Office
Woodvale
Lewes Road
Brighton BN2 3QB

30 April 2018

Dear Ma'am

RE: The late Mr. Roger Saxby

I am writing further to the joint Prevention of Future Deaths report which was issued to Brighton and Sussex University Hospitals (BSUH) and St.George's University Hospitals NHS Foundation Trust (SGH) on 8 December 2017, which first to came to our attention on 16 February 2018. We had previously responded to the Regulation 28 report that was addressed solely to St George's and we were unaware at the time that you had also issued a joint report to both Trusts. Thank you for allocating the additional time to respond to these further concerns as set out at paragraph 5 of the report.

For ease of reference, I will respond to the concerns directed at St.George's in the order raised.

- **That on arrival at St George's the start of thrombolysis was delayed.**

Mr Saxby arrived at St.George's at 16:45 hours on Friday 28 July 2017 and underwent thrombolysis at 19:00 hours. Colleagues from both the vascular and interventional radiology (IR) teams have reviewed Mr. Saxby's pathway and they are absolutely confident that thrombolysis in this case was commenced as soon as it was safe and practical to do so. Mr. Saxby had to be assessed and clerked, and prepared for theatre including being consented for the procedure Having reviewed the theatre list for 28 July 2017, the IR service has confirmed that the IR suite was not available to take a patient at around 17:00 hours in any event as they had an on- going case at the time. As soon as the case was completed and the IR suite was cleaned and prepared for the next case, the IR on call team sent for Mr. Saxby. Mr. Saxby arrived in the IR suite at 18:30 hours. He would have required consenting again, transfer onto the angiography table, monitoring to be established, preparation for the procedure and routine checks performed (Local Safety Standards for Invasive Procedures - the LocSSIP checklist). The Interventional Radiologists gained access to the arterial system and started imaging at around 19.00 hours. Considering the time of arrival and the steps required before thrombolysis can be

commenced, I would like to assure you that treatment appears to have commenced as promptly as could reasonably be expected without compromising patient safety.

- **After he received his thrombolysis at SGH, it became clear that the discussion about what should happen to him next was completely unstructured.**

The clinicians involved in Mr Saxby's care have reiterated that they were clear about the actions and plans. There was good communication within the team and they had conveyed the plans to Mr Saxby at each stage. Most regrettably, as you were made aware at the inquest, the clinical notes made by the vascular team were lost and this lamentable situation has meant that they have been unable to demonstrate that there was clarity and structure in the care plan.

As I have alluded to in the initial PFD response letter, the trust has been moving towards fully electronic records in stages. When this is fully rolled out, such incidences of loss of paper notes will be greatly reduced.

- **None of those involved in his case demonstrated any sense of urgency**

[redacted] has reflected deeply on the care provided to Mr. Saxby and discussed this with his peers, including the clinical lead for Vascular Surgery, [redacted] accepts that in retrospect, it may appear that there was no sense of urgency at the time, however, in dealing with the reality of what was before him, he did not feel it appropriate at the time to undertake the amputation over the weekend. His peers, including [redacted] who has independently reviewed the decision not to amputate at the weekend, agree that this was a reasonable decision taking into consideration Mr. Saxby's clinical presentation and the plans that had to be made for his on-going rehabilitation needs.

In respect of all other aspects of decision making, the clinicians involved would like to reiterate that there was an appropriate sense of urgency as it was always the plan to amputate over the weekend should Mr Saxby become unstable or unwell, or on the Monday morning if the proposed transfer had not taken place at the weekend.

The clinicians involved have conveyed their deep regret about the eventual outcome that Mr. Saxby suffered, but they genuinely felt that they were doing what was right and in the best interests of Mr. Saxby at the time.

[redacted] would like to assure you and the family that the issue of "bed-blocking" had never entered his mind as you had intimated at the inquest. [redacted] and his colleagues are absolutely clear that they would put their patients' best interests before their employers interests without hesitation. As Chief Executive of St. George's, I whole-heartedly commend and support this position.

- **There was insufficient discussion with Mr Saxby**

Prof Loftus has indicated that he saw Mr. Saxby on five occasions over the 48-hour period and Mr. Ben Patterson saw the patient more often than that. [redacted] has

confirmed that on two occasions he had discussions with Mr. Saxby specifically about amputation and where it should take place.

Again, the loss of key records has put the clinicians in the most unfortunate position of not being able to corroborate these discussions. This is a source of great regret for the clinicians and the trust.

- **Having had one "most unusual" transfer from hub to hub there was apparently no thought that another "most unusual" transfer from hub to hub might not be in Mr. Saxby's best interest**.

I believe the Brighton trust has provided an explanation for why Mr Saxby needed to be transferred to St.Georges. I will address here the issue of the transfer back to Royal Surrey County Hospital (RSCH). As per the evidence heard at the inquest, the transfer back was discussed with the referring team at RSCH and it was agreed that it would be in Mr. Saxby's best interests to have the amputation closer to home to prevent a prolonged period in a London hospital. The vascular service has confirmed that the repatriation of patients following amputation is extremely difficult and can take many weeks, and this hinders the commencement of any planning for proper rehabilitation and social care that Mr Saxby would have needed at home.

National guidance, including "The Provision of Vascular Services 2015" document, and the "Next Stage Review" supports the delivery of care close to home to improve access to care, and patient and carer experience of the health service.

- **There should never need to be a hub to hub transfer and certainly not two of them within 36 hours of each other**

A hub to hub transfer is, as you have heard, an uncommon event. In this case, Mr. Saxby's transfer was accepted by St. George's because interventional radiology cover was not available at the Royal Surrey County Hospital at the weekend and so transfer was accepted by St. George's to give Mr.Saxby the best chance of salvaging his leg. However, despite best efforts by the interventional radiology team, it was recognised that he was going to need an amputation and, for the reasons explained above, the decision was made, in conjunction with the RSCH, and with Mr. Saxby's full agreement, for the transfer back to RSCH. The subsequent catastrophic turn of events for Mr. Saxby has been a source of the deepest regret for the clinicians and trust.

Going forward, having discussed and reflected on this case, it is the clinicians' and the trust's view that to refuse to accept patients from another hub in similar circumstances as that of Mr Saxby will not be in any patient's best interests, and in fact is more likely to cause patient harm and death However, once a patient is accepted, a transfer back to a hub hospital will only take place in exceptional circumstances and after due consideration.

Thank you for raising these concerns which has given us the opportunity to deliberate carefully about future hub to hub transfers. The vascular and interventional radiology

services are committed to patient safety and the learning from this case will always inform future decision making in similar situations.

I hope this response addresses the further concerns you raised by way of the joint PFD report. Please do not hesitate to contact me if I can be of further assistance.

Yours sincerely

Jacqueline Totterdell
Chief Executive