ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Guys & St Thomas'NHS Foundation Trust (Inquest Office) Risk Management and Legal Services Departments, 2nd Floor, Tabard House, Guy's Hospital, Great Maze Pond, London, SE1 9RT** **2.**
1	**CORONER** I am Jacqueline Devonish, Assistant Coroner for the Eastern District of London.
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 10 February 2013 I commenced an investigation into the death of Peter Jeffrey, then aged 53. The investigation concluded at the end of the inquest on 25 November 2013. The conclusion of the inquest was that the left foot ulcer was not tested and consequently went untreated. The medical cause of death being: 1(a) Septicaemia 1(b) Fractured left ankle joint with abscess formation 1(c) Infection with beta haemolytic streptococci
4	**CIRCUMSTANCES OF THE DEATH** Mr Jeffrey worked for the Ministry of Defence in Whitehall. His job involved being on his feet for up to 8 hours a day. In July 2012 he developed a swollen left leg and foot. Mr Jeffrey saw his GP who prescribed 2 courses of antibiotics. On 10 August 2012 his employers accompanied him to the A&E Department at Guys and St. Thomas' as he had been in pain and limping at work. He was referred to the DVT team for a scan. As a precaution he was given Clexane injections. Blood tests revealed a raised D-dimer and mild anaemia. He returned to the hospital on 14 August when he was advised to go to his GP for Clexane injections over the weekend and to return on the 17th for a scan. On 17 August 2012 he returned to the hospital for an ultra sound scan which was negative. The Doctor was unable to feel foot pulses in the left foot and noted the open blister on the left side of the foot and speculated that the foot was the cause of infection to the leg. Mr Jeffery was given further antibiotics for suspected Deep Vein Thrombosis. On 10 February 2013 Mr Jeffrey collapsed at home and died from his condition.

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. The scans did not reveal DVT and no alternative effective diagnosis or treatment was considered. 2. No culture was taken for testing from the open blister which was full of pus. 3. No swab was taken. 4. No intravenous antibiotics were considered.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 21st January 2014. 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] 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	**[DATE]** 27 November 2013 **[SIGNED BY CORONER]**