DOH800971-0001

Code A

FC/LD

02 January 2001

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Dear Code A

Thank you for meeting with Dr Knapman, Ann Haste and myself on 20 December 2000.

The purpose of the meeting was to discuss your ongoing concerns regarding your mother's care on Sultan Ward at Gosport War Memorial Hospital. Also present were your sisters, Mrs Lowman and Ms Rothwell.

You first wrote to the Trust on 11th August 2000 expressing your concerns regarding the care and treatment of your mother Code A whilst a patient on Sultan ward at Gosport War Memorial Hospital. Following this an investigation was conducted and a letter detailing the results of that sent to you on the 14th September 2000. You then wrote to me on the 9th October requesting access to your mothers medical records and expressing further concerns. We also received your father's authority to release Code A records to you. As a result of the above and my telephone conversations with Mrs Lowman we agreed that a meeting would be useful.

Your letter of the 9th October 2000 specifically asked three questions:-

- Explain why our mother's condition was as it was on admission to St Mary's?
- Does kidney failure, liver failure, dehydration, poison in the blood stream all happen in the time it takes to transfer a patient from one hospital to another?
- How did all this go unnoticed while our mother was under the care of Sultan Ward?

In order to address the issues, we wrote, as you know, to Dr Wilkes (Consultant Cardiologist) and sent you a copy of his reply prior to our meeting, along with copies of Code A medical and nursing notes.

When we met you continued to express concerns regarding:-

1. Why your mother Code A was admitted to Sultan Ward and not an acute ward.
2. Why Dr Green was not adequately informed of all your mother's symptoms by nursing staff when he visited.
3. Why your mother's condition was allowed to rapidly deteriorate during her stay on Sultan.
4. Why she was not transferred by emergency ambulance on the day of transfer back to St Mary's General Hospital.
5. Why no-one listened to you as family members regarding your mother's deterioration.

You were also of the view that if Mrs Windsor had been transferred sooner she would have survived.

We discussed many issues during our meeting and I have attempted here to capture the key issues which were, I believe as follows:-

1. Dr Knapman explained that the decision to admit Code A to Sultan was based on his view that she was suffering from weakness and exhaustion, following a bout of diarrhoea and vomiting, and that he would admit her to enable her to regain her strength. Dr Knapman was also of the view that Code A s deterioration could not have been foreseen.
   I explained that Sultan Ward was a GP Unit. There are no resident medical staff and patients are seen by their own GP. The GPs visit regularly and will also call in at the request of a nurse, as was the case on the morning of 5th May.

2. You noted that Dr Green had recorded that Code A had reported vomiting but that the nurses had seen no evidence of this. There are several references in the nursing record to loose stools and one episode of vomiting is recorded. I can therefore offer no reasonable explanation for this.

3. Dr Knapman explained that in his view your mother's condition had deteriorated little between the 27th April and the 3rd May in that there was little change in her generally. Dr Green's visit on the 3rd May appeared to support this view as Dr Green recorded that Code A was miserable, not eating but had not lost weight and could be referred for Physiotherapy for her back pain.

   On review of the record however, deterioration was evident between the 4th and 5th of May. The nursing record indicates that Code A became unwell at 10.30 a.m. on 5th May. Prior to this, entries were made in the record indicating that Mrs Windsor was returned to bed at 9.45 because of shortness of breath, that she had taken sips of fluid early that a.m. and that she had been having loose stools overnight.

   Dr Knapman was called on the 5th and arranged for Code A to be transferred to a medical ward at St Mary's General Hospital.

Portsmouth Hospitals were on amber alert that day and no bed was immediately available. Transfer therefore took place at 1740 hours as soon as a bed was available.

4. In relation to emergency ambulance transfer - I explained that this was an option for us, but the nurses do not appear to have considered emergency ambulance transfer and with hindsight this would have merited consideration. However, given the lack of beds at St Mary's General Hospital, which was on amber alert, this course of action could have meant that Code A would have remained on a trolley in casualty for a long period of time. In his view Dr Knapman thought that this would have been an inappropriate course of action.

5. You indicated both in your letter and at our meeting that you felt the nursing staff had not listened to you regarding deterioration in your mother's condition.
It is clear from the record that Code A condition deteriorated between 4th and 5th May.

On 4th May there is a record of two conversations with the family who were expressing concern. In the first of these it was suggested that you ring Dr Knapman. This you did but were unable to speak with him. With hindsight, this is something which I believe we should have undertaken to do for you and I apologise unreservedly for this oversight.

In the second conversation with nursing staff, concern was expressed regarding Mrs Windsor's eating and her ability to mobilise and you subsequently organised your visiting to ensure that someone was always with your mother at mealtimes.

I would reiterate what I said at our meeting and apologise unreservedly for the distress you felt when apparently no action was taken with regard to your concerns.
It seems clear from discussion with staff that communication between members of the nursing team left something to be desired.

Ann Haste apologised for these shortcomings and, as we explained, has worked with the team to develop an altered method of work which improves communication between team members regarding patients. The new system allows for each patient to have a named nurse who works with a team of other nurses to ensure that information regarding patients is shared within this team and that there is always someone from each team on duty.

Lastly, you indicated that you remain convinced that if Mrs Windsor had been transferred sooner she would not have died.

Dr Knapman explained that he was not familiar with septic shock. However, from Dr Wilkes' letter and his own recent research into the subject, he was sure that he could not have predicted the deterioration in Code A condition. However once deterioration was

noted, Dr Knapman believes his interventions to have been appropriate. The delay in transfer to a medical bed was outside of our control.

I would again like to fully acknowledge our shortcomings in our communications with you and between nursing staff and apologise unreservedly for these. Steps have been taken to improve this and ensure there is no recurrence of these problems.

As I explained there are a number of options available to you if you remain dissatisfied and I briefly outlined these.
I was aware of a potential difference of opinion between you, with regard to how you might wish to proceed. As your sisters have now become involved with your original complaint, I think it would be important that all three of you were in agreement as to what any future action might be.

I am enclosing copies of this letter for both Mrs Lowman and Mrs Rothwell which I would be grateful if you could pass on to them as I do not have either of their addresses. Please let me know within one month if there is any further action you would like us to take.

I would also like to take this opportunity to thank you for your honesty and for providing us with an opportunity to review some of the aspects of the care we provided to your mother, Mrs Windsor.

Lastly I am enclosing a copy of a letter from Dr Knapman to me which I believe addresses the issues you raised with him at our meeting but which were not part of the original concerns you raised in your letter of complaint.

Yours sincerely

Fiona Cameron
Divisional General Manager

Copies to:

Mrs Lowman
Ms Rothwell
Dr A C Knapman
Lesley Humphrey, Quality Manager, St James' Hospital