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2.1.01

Dear Ms Cameron,

After our meeting with the relatives of the late Code A I thought I would take the opportunity to write to you regarding issues raised at the meeting which had not been previously mentioned and rather caught me on the hop.

I am referring of course to the two telephone conversations mentioned, firstly to Mr Windsor at the time of Code A admission to GWMH and secondly to Code A on the day of her admission to St. Mary's.

The circumstances of the first conversation with Code A at the time of her illness at home took the following course. I offered admission into the GWMH to the couple explaining that in the situation then existing; recovering from a bout of enteritis ; admission into an emergency Hospital bed was not possible but we were fortunate in Gosport to have G.P. beds in GWMH and I could try to obtain admission there for say 2 weeks. The couple declined this at that time and Code A followed me into the road and once again said they would prefer admission to a Portsmouth Hospital. I repeated my comments that I did not feel admission to an acute bed was necessary. It is perhaps unfortunate that I made a guess at what I thought it cost to support an Acute bed as it was not really relevant to the discussion , which centred around my opinion that at that time Code A did not require emergency care and that the GWMH was ideal for that purpose. As you mentioned yourself in the meeting admission to an acute emergency unit is determined by medical need alone and I would have arranged that if I had considered it necessary.

To turn to the second phone-call with Code A daughter. This has to be viewed in the light of how I understood Code A condition to be at that time .I had last seen Code A on the morning of May 2nd when it was noticed that her blood-pressure was somewhat low at 95/60.As she was on a medication Atenolol which she had been put on previously for angina in July 1998 which also lowers blood-pressure I advised that it be discontinued in the hope that her blood-pressure would return to normal and improve her general condition.. At the time she was feeling generally weak and was in bed , still I believe having occasional diarrhoea and as a result not feeling like food. My assessment of her condition at that time was that her recovery from her illness was hampered by her two major conditions or CLL and heart disease and complicated by hypotension produced by her medication. This assessment I feel was backed up by Dr Green's comments when he saw her on the following day. It was with this set of circumstances that I received the phone-call from Mrs Lowman on May 5th. With the benefit of hindsight I ought to have delayed my comments regarding future plans until I had visited Code A but I was in the middle of a surgery and presumed Code A was in the same condition I had last seen her. Obviously her condition had changed markedly since I last saw her. I do feel, looking at the nursing notes covering that period that she developed toxic shock from some unknown cause in the time interval 05:03 on 4th May when she was conversing with her carers to 10:30 on 5th May when she was found to be cold and clammy and her B.P. was unrecordable. It was very unfortunate that I was not aware of the change in her condition when I spoke to Mrs Lowman as obviously I would not have raised the question of transfer to a Nursing home (which might have eventually become necessary if her condition had remained static and the Toxic Shock State had not intervened.

I hope these comments will be helpful to you as you prepare your report of the meeting. Should you feel it appropriate to pass on part or all of this letter to Code A please do so. May I take this opportunity to wish you a happy new year.

Yours sincerely

A.C.KNAPMAN