I first met Mrs Middleton on A6 Ward at Haslar Hospital on 24 May 2001. I had been asked to assess her for stroke rehabilitation on Daedalus Ward at Gosport War Memorial Hospital. I concluded that she would benefit from rehabilitation and she was transferred on 29 May 2001 when I took on Consultant responsibility for her care.

Mrs Middleton was a lady of 85 who had a dense left hemiplegia and severe dysphagia following a stroke she had suffered on 10 May 2001. Unfortunately, in spite of considerable input from the multidisciplinary team, she had made very little functional recovery.

1. Nutrition

Mrs Middleton had severe dysphagia and feeding did present a problem. I discussed the possibility of enteral feeding with Mrs Middleton on 7, 11 and 25 June 2001 during my Consultant ward round. The Staff Grade Physician also discussed this with her on 6 July. I discussed the issues of nutrition and feeding with Mrs Middleton's daughter on 7 June and her daughter and son-in-law on 25 June. On all of these occasions there is clear documentation in the medical notes that neither Mrs Middleton nor her daughter wished her to have a nasogastric or a Percutaneous Endoscopic Gastrostomy (PEG) tube inserted for feeding. Assessments were carried out regularly by both the Speech and Language Therapist (SLT) and Dietitian. We were all aware that Mrs Middleton had difficulty with swallowing and that this was very slow but it did improve gradually in June and early July, although her intake remained poor. Mrs Middleton's oral intake was supplemented by a litre of subcutaneous fluids administered overnight and at no time was she "nil by mouth".

On 18 July Mrs Middleton came around to the idea of enteral feeding and the Staff Grade Physician, dietitian and speech and language therapist discussed the issue with her on a daily basis for the next three days. I saw her on 23 July and discussed this further and she agreed that she would try a nasogastric tube as an interim measure until a PEG tube could be inserted. I contacted her grandson, James, at his request and I was given to understand that he was a neurosurgeon. I discussed with him her problems from the stroke and that we were embarking on enteral feeding. On 24 July I referred Mrs Middleton to the Consultant Gastroenterologist at Haslar Hospital for a PEG tube insertion and this was done as a day case on 31 July. Before and after PEG insertion, Mrs Middleton was assessed by one of the nutrition sisters.

2. Fluid Balance

Mrs Bulbeck has questioned why there was a problem with fluid overload when her mother was receiving fluid through an intravenous drip and also had a catheter insitu. There are a number of reasons for this and I am sorry that Mrs Bulbeck feels that she did not receive the necessary explanation whilst her mother was on the ward.

On 4 July Mrs Middleton was in congestive cardiac failure and this was confirmed on clinical examination and chest x-ray carried out the same day. Cardiomegaly was also noted. She was also in rapid atrial fibrillation with a ventricular rate of 125/min. New lateral T wave inversion was noted on the ECG with a slightly raised Troponin I level of 0.28 ug/l indicating Ischaemic Heart Disease. Mrs Middleton was also a known hypertensive.

Diuretics had been discontinued on my instructions on 2 July as Mrs Middleton's potassium was low at 2.9 mmol, in spite of the potassium supplements that were being given (Sando-K 2 bd). I requested that the Sando-K be increased to 2 tds and that 20 mmol potassium chloride be added to the subcutaneous fluids. Therefore between 2 and 4 July, Mrs Middleton had a total of 1 litre of subcutaneous normal saline in addition to her (poor) oral intake. There was no excessive administration of fluids and no intravenous fluids were administered.

Mrs Middleton's congestive cardiac failure responded well to treatment with Digoxin, diuretics and oral nitrates.

3. "Blockage in the Bowel"

On 1 August 2001, the day following the introduction of the PEG tube, Mrs Middleton complained of abdominal discomfort, distention and had not opened her bowels for two days. A rectal examination was carried out by the Staff Grade Physician and subsequently Mrs Middleton evacuated a large liquid stool and her discomfort settled. I had no direct involvement in these events. I regret that this caused Mrs Middleton discomfort. She did receive a Domperidone suppository that evening.

4. Hospital Moves

It is always unfortunate when a patient has to move around a hospital or from one hospital to another but within the existing framework of bed distribution and services in Portsmouth, the

I am not in a position to comment on the aspects of Mrs Bulbeck's complaint that relate to nursing care but hope that the above comments will be helpful. If there are any further medical issues that are of concern to Mrs Bulbeck, then please let me know.

Yours sincerely

Code A

Dr A Lord FRCP

Consultant Physician in Geriatrics