Portsmouth Hospitals **NHS**
NHS Trust

Dr Peter Howlett
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Complaints Dept
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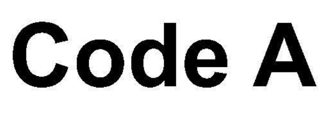
Code A

20th December 2000

PRIVATE AND CONFIDENTIAL



Our Ref: PH/TJR/CP/ Code A 1122/98
(Please quote Our Ref: on all correspondence)

Dear Code A

Please accept my sincere apologies for the delay in responding to your recent letter. I asked one of my Senior Nurses' Mrs. Alyson Stainer, to undertake a full clinical review of your Code A case and this has taken longer than expected. The review included a thorough investigation of the medicines your Code A was prescribed and discussions with a Senior Pharmacist and a Consultant Gastroenterologist.

There a number of outstanding issues which you have raised in your letters dated 11th June 2000 to Code A at Portsmouth and South East Hants Community Health Council, 2nd July 2000 to Code A and your most recent letter to me dated 21st October 2000.

I am unable to comment on the actions of your family doctor or your District Nurse as these professionals do not come under the jurisdiction of Portsmouth Hospitals. You will need to pursue this with Portsmouth and South East Hants Health Authority.

I am very sorry that you feel my letter forwarded to Code A on 16th May 2000 avoided key issues and I will further attempt to respond to them in turn.

Your letter to Code A says that had Code A received earlier diagnosis and treatment for Code A osteoporosis that the fractures would have been delayed or allowed for "complete avoidance". I must reiterate that even had your Code A received earlier treatment for Code A osteoporosis this may not have prevented the fractures occurring.

The prescribing of most medications can be unpredictable and it is not always possible to predict which patients may suffer side effects. All of the medicines your Code A was prescribed fell within the normal dose range. The prescribing of both Diclofenac and Co-Codamol are fairly standard medicines for the control of back pain. Unfortunately, more powerful analgesics, such as morphine, could not be prescribed, as patients with liver impairment may become comatosed due to the liver's difficulty in excreting this drug.

2.
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In your letter of the 11th June you say that the whole regimen your Code A was prescribed, "was wrong and unnecessary". Code A has checked this with both senior medical and pharmaceutical staff. They all agree that this regimen is standard practice for patients with osteoporosis. Your letter also states that the Registrar who attended your Code A blamed the drug regimen solely for the condition that led to Code A death. There is no record of this doctor's statement in your Code A medical notes.

Your letter questioned how medicines are reviewed on the admission of a patient. I would re-refer you to the letter to Code A on 16/5/2000. Paragraph 5 page 2, which states that drug regimens are only reviewed if interacting drugs are started whilst in hospital, or because of other clinical need.

There is no evidence in your Code A medical notes that the drug therapy was prescribed for any reason other than to treat the symptoms of Code A condition. The only exceptions are the Metoclopramide and Dromperidone, both of which are used to reduce nausea and vomiting, which may have been drug induced. Nevertheless, Professor Colin-Jones did state on 27th February 1996, that your Code A did have non-specific reactive hepatitis, probably related to the combination of analgesics which had been prescribed for her back problem. Professor Colin-Jones goes on to say that the liver tests were improving at that time and he gave your Code A a clean bill of health and discharged Code A from his clinic.

It is possible that the prolonged use of Diclofenac (Voltarol) did contribute to the intestinal bleeding that your Code A suffered and Code A stomach pains should have been investigated before the Etirondate was commenced. Nevertheless, the intestinal bleeding could also have been attributed to the pancreatic cancer. It is not known as to whether your Code A had ulcers in her small or large bowel which could also have caused the intestinal bleeding.

In the final admission of your Code A in March 1996, vomiting of blood could have been due to drugs but, most likely, may also have been due to the fact that Code A had cancer. Code A cause of death was recorded as "due to renal failure, sepsis and pancreatic carcinoma". There is no mention of any drug induced/related cause of death.

In summary, whilst I appreciate the distress you must be feeling since the death of your Code A I can only reiterate that your Code A died of cancer which was not drug induced.

Nevertheless, you have raised a number of important factors that the Trust needs to consider, particularly in relation to patients with multiple drug therapies.

1. Reviewing and formalising the whole process of recording patients medication.
2. Reviewing the role of pharmacists, medical staff and nurses in relation to drug administration
3. Introducing regular case discussions for patients with multiple drug therapies.
4. Involving patients, relatives and carers in the decision-making process.
5. The provision of new guidelines for the recording of past and present medications and the compatibility/interactions of newly introduced medicines.

I do hope that these actions will go some way to reassuring you that I have taken the views and your concerns very seriously.

I would like to again offer my sincere apologies for any distress caused and thank you for taking the time to write and bring this matter to my attention. This is very helpful in that the views of patients can be incorporated into how services are planned and delivered.

Yours sincerely

Dr P Howlett
Acting Chief Executive