Code A
Chief Executive

Management Centre
St Mary's Hospital
Milton Road
PORTSMOUTH
PO3 6AD
Code A

PRIVATE & CONFIDENTIAL

8 December 1998

Code A

Our ref: RB/KLM/NLW/Code A 285/98
(Please quote our ref on all correspondence)

Dear Code A

Further to my letter of the 12 November 1998, I have received a report from Dr Duncan, Consultant Physician in charge of Code A care, which enables me to respond to your letter of complaint. He has given me a good deal of information about your late Code A medical history, has also investigated your concerns for me, and given his clinical opinion.

I understand that Code A was first admitted to this Hospital Trust on the 25 September 1997, with an acute anterior myocardial infarction, which is a type of heart attack. Following this heart attack, there was some damage to Code A heart which meant that the apex and septum of the left ventricle were not functioning normally.

Code A was subsequently admitted under Dr Duncan's care on the 4 September 1998, as Code A had collapsed. Code A remembered falling but did not remember anything else. Code A was seen by a member of Dr Duncan's medical team, and was found to be in sinus rhythm, with a blood pressure of 160/92, Code A was alert and orientated and did not look unwell. Blood tests showed no evidence of a further myocardial infarction, but to expedite matters Dr Duncan kept Code A in hospital to obtain a 24 hour ECG and echocardiogram.

The echocardiogram showed that Code A had poor left ventricular systolic function, with a dilated left ventricle, with elements of regurgitation (leaking of valve) in the mitral valve and aortic valve. The 24 hour tape showed sinus rhythm with occasional runs of ventricular ectopics. In other words there was nothing on the 24 hour tape to suggest that your Code A had malignant arrhythmias which may have explained Code A episode of collapse. However, a single 24 hour tape does not exclude significant arrhythmias, and in view of the echocardiogram report and Code A medical history, it was felt possible that Code A had an arrhythmia that had caused Code A to collapse.

Dr Duncan did not start anti-arrhythmic treatment as there was no hard evidence that this was necessary, and indeed many of the anti-arrhythmic drugs can actually cause arrhythmias and, therefore, should only be used with extreme caution. Code A remained well during Code A stay in hospital, and was discharged home on the 11 September 1998.

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There are two levels of discharge summary, one goes to the GP on the day of discharge, and the other is dictated by one of the medical team in the form of a detailed letter to be typed to the GP. On the copy of the initial summary (KMR1 form) it is of note, that unfortunately, the results of the 24 hour tape and echocardiogram were not written for the GP's information. Dr Duncan has pointed out to his junior staff that this type of information does need to go to the GP, and has asked them to do this in future.

Even with the benefit of hindsight, Dr Duncan does not feel that Code A was discharged too early, and in fact Code A stay in hospital was longer than it other wise perhaps should have been, to try and expedite Code A investigations. The delay in the GP receiving a full typed discharged summary, did not in any way contribute to Code A Code A sudden death as Code A was on appropriate treatment and the list of medication was on the KMR1 form. Unfortunately, the discharge summary was not dictated until the 1 October, and was typed on the 15 October following which it would have taken at least a week to get to Code A GP. I would like to offer my sincere apologies for this time delay, the summaries are dictated by the Senior House Officer Doctors, who work under enormous pressure, and although they strive to dictate discharge summaries as soon as possible after the patient has gone home, in the real world it is not always feasible. However, we have a good relationship with most of the General Practitioners in the area, and I am confident that the GP would have telephoned if he needed information prior to receiving the summary about Code A and the care she had received,

I sincerely hope that this letter has not been too distressing to read, and reassure you that the care and treatment provided to Code A was of a very high standard. I also hope I have been able to assure you that the delay in the discharge summary reaching Code A GP did not contribute to Code A death in any way, and I am aware that Dr Duncan has spoken with Code A explaining that Code A had poor cardiac function and was at risk of sudden death at any time, regardless of whether Code A was in hospital or in the community.

I enclose a copy of a Trust leaflet which gives a summary of the entire NHS Complaints Procedure. If you have any outstanding comments or questions about this letter, please let me know so that we can consider the best way forward.

Yours sincerely

Code A
CHIEF EXECUTIVE

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s.c. Dr H Duncan, Consultant Physician, Queen Alexandra Hospital
Code A Information & Data Quality officer, F Level, Queen Alexandra Hospital
Code A Operational Director, MS Directorate, Queen Alexandra Hospital