Portsmouth Hospitals NHS
NHS Trust

Matthew Wood
Divisional Clinical Director
Surgical Division

Surgical Division
Queen Alexandra Hospital
Southwick Hill Road
Cosham
Portsmouth
PO6 3LY

27 June 2007

Code A

Mrs S Skye
Legal Services Manager
Education Centre
St Mary's Hospital

Dear Sue

Re: **Code A**

Thank you for asking me for my views on the alleged breach of duty and causation and arguments set out in the letter from **Code A** solicitors dated 24th May 2007.

My involvement with **Code A** relates to my role as Lead Investigator into the events surrounding Code A complications, relating to Code A bilateral nephrectomy for treatment of Code A olycystic kidneys by [redacted] Code A. I was the author of the report along with **Code A** which was issued on 28 February 2006 to the Medical Director. Following that report I also attended a meeting referred to in **Code A** solicitors' letter on the 13 July 2006 to discuss the causes of Code A **Code A** intra-abdominal haemorrhage which was one of the sufficient complications of Code A bilateral nephrectomy.

During the course of the investigation, I found evidence that **Code A** had developed a significant clotting abnormality which was consistent with receiving a large intervenous dose of Heparin. I postulated that the Heparin had been administered inadvertently when the Vascath (the line inserted into her jugular vein at the time of Code A bilateral nephrectomy and used for post-operative haemodialysis as a result of Code A being rendered anephric) was being used as source of blood specimens and fluid administration. It is routine practice on the renal unit to "lock the vascath" with a 20,000 unit bolus of Heparin to prevent the line from clotting, it is possible that despite every effort to aspirate and therefore remove the Heparin at the time of fluid administration through the vascath that a dose of Heparin may have been administered causing the clotting of the abnormality that had lead to **Code A** significant post-operative blood loss following Code A bilateral nephrectomy.

I conveyed this information to **Code A** and Code A friend who accompanied Code A to the meeting on the 13 July 2006 and explained that while not routine to use a Vascath for administration of fluids or taking of specimens for haematological examination but in the context of **Code A** grave clinical situation the use of a Vascath with its attendant risk of inadvertent Heparin administration was a reasonable and possibly life saving action.

With regards to **Code A** solicitors allegation of breach of duty. I would agree with their supposition that **Code A** may have inadvertently received a dose of Heparin, I would however dispute the quantity that Code A would have received bearing in mind that the Renal SHO looking after **Code A** at the time, in Code A interview with me, indicated that Code A had aspirated the Heparin from the Vascath before drawing blood specimens and administering fluid. The assertion that t

the Heparin was negligently administered I would dispute for the same reason, as I believe the Renal SHO Dr Nevols took every precaution to avoid or mininise the administration of Heparin and Code A use of the Vascath in the circumstances was justified.

With regards to the causation of the post-operative hemorrhage. It is difficult to be certain about this. The procedure of a bilateral nephrectomy in the context of polycystic kidney disease produces a large raw area where the kidneys had previously been and post-operative hemorrhage is a well recgonised complication of the procedure. Code A clinical picture was somewhat confusing but was consistent with significant blood loss. Subsequent intervention to resuscitate Code A may have coincided with the inadvertent administration of Heparin leading to sufficient clotting abnormality and exacerbating the existing hemorrhage from the wound bed. What I would agree with is that the need for a further explorative laparotomy to establish the diagnosis of the post-operative hemorrhage led to the need for packs to be inserted to stop the widespread bleeding. Subsequent removal of these packs led to damage to the spleen requiring it to be removed.

In summary, I think Code A has been unfortunate to experience a well recognised complication of a major surgical procedure namely bilateral nephrectomy for polycystic kidneys. During Code A resuscitation in the post-operative period I think Code A may well have inadvertently received a dose of Heparin that caused a sufficient clotting abnormality that is likely to of exacerbated any existing post-operative hemorrhage. It is may opinion that the medical and surgical teams acted responsibly during Code A resuscitation and took reasonable precautions to avoid the inadvertent administration of Heparin and did not act negligently but fulfilled their duty of care during Code A life threatening situation.

I would like to send my sympathies to Code A for Code A continued suffering following Code A unfortunate complication. I hope this letter provides of the information you require. If you have any queries please do not hesitate to contact me.

Regards

Code A

Matthew Wood
Divisional Clinical Director