Portsmouth Hospitals NHS
NHS Trust

Trust Headquarters
F Level, Queen Alexandra Hospital
Southwick Hill Road
Cosham
PORTSMOUTH, PO6 3LY
[redacted]

Ursula Ward MSc MA
Chief Executive

[redacted]

PRIVATE & CONFIDENTIAL

23 June 2014

Mr D C Horsley
Senior Coroner for Portsmouth & South East Hampshire
Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth
PO1 2AB

Our ref: UW/SS/Q67/13
(Please quote our ref in all correspondence)

Dear Mr Horsley

Courtney Jordan Mills – 1063/13 (DOB 12/06/2002 – DOD 19/04/2013

I refer to your letter with which you enclosed a Regulation 28 Report dated 12 May 2014. I note that this report was also sent to the Practice Manager of the Waterside Medical Centre in Gosport.

As you will of course recall, [redacted] Consultant Paediatrician, gave evidence at the Inquest and I have therefore sought his input into this response as well as from our Pharmacy Department.

The report states that there had been a history of delay in Courtney obtaining her medication (Clonidine) due to communication difficulties between the hospital and the GP surgery and you have asked that action be taken to prevent future deaths.

I understand from [redacted] that the Clonidine was not in fact prescribed by Portsmouth Hospitals NHS Trust and our Pharmacy Department have also confirmed that we have no evidence to suggest that Queen Alexandra Hospital were approached for a supply of the drug, although had we been approached, we would have supplied it. In past situations like these, where community pharmacists have had trouble getting hold of non-routine medicines, the patient's family have contacted our Children's Assessment Unit (CAU) who have arranged for it to be prescribed by a doctor here and then we have dispensed it from the QAH pharmacy. This is a situation that we are used to and we would have done this in this case. However, had CAU been asked, they may have had a problem verifying the usual dosage, in which case we would have had to contact Southampton prior to writing the prescription.

I am aware that maintaining correct medication when patients leave hospital is a significant problem across the NHS as it involves co-ordination between hospitals, GP practices, pharmacy and patients themselves, often with an important medication change made as a result of acute illness. While doctors clearly share responsibility for this, Pharmacists may be best placed to ensure safe processes around this. In the first instance, and if you feel that this issue needs to be considered on a national level, I would suggest that the Royal Pharmaceutical Society may be the best body to contact.

In the circumstances, I should be grateful if you could confirm that this response is sufficient and that you do not require Portsmouth Hospitals NHS Trust to take any further steps in respect of your report.

With best wishes

Yours sincerely

[redacted]

Ursula Ward MSc MA
Chief Executive