RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: LASRADO, IRWIN F N

Age if under 18: (if over 18 insert 'over 18') Occupation: CONSULTANT ORTHOPAEDIC

This statement (consisting of 3 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 16/11/2005

I am a Commissioned Officer in the Royal Air Force, Medical Branch, and work as a Consultant in Orthopaedic Surgery at the Royal Hospital Haslar , Gosport and Queen Alexandra Hospital, Portsmouth. I have been in the current post since September 2004. As a Consultant Orthopaedic Surgeon I am primarily involved in the treatment both Outpatient and Operative for people with bone and joint pathology. This includes the treatment of fractures and elective orthopaedic problems. I have included a copy of my Curriculum Vitae showing my medical qualifications and a list of my previous posts as IL/1 .

In August 1998 I was a Registrar in Orthopaedic Surgery at the Royal Hospital Haslar. I practised under the supervision of a variety of Consultant Orthopaedic Surgeons. A Registrar's post is a training Grade post, usually under the supervision of a Consultant in the Speciality. After a period of 6 years training and on successful completion of the FRCS (Orth) exam leads to the provision of a CCST by the SAC/Royal College and progress onto work as a Consultant.

I have been asked to detail my involvement in the care and treatment of Ruby LAKE . I have no personal recollection of this patient or my involvement of her care and I refer to the medical records kept here at the Royal Hospital Haslar for this patient in the preparation of this statement. (Exhibit Ref JR/19A) .

I have been asked to comment on the appropriate entries in the operation records of this patient (Pages 54-59). However, the pages 54, 55 are a record of the anaesthetic progress of this patient per operatively and have such been filled in by the Anaesthetist who was involved in this case

(Dr PHIPPS) and I do not feel that it is appropriate on my part to comment on these.

Addressing pages 56 and 57, which is an entry by myself in the operation records; it states that I performed a left cemented hemi-arthroplasty (Furlong) on Ruby LAKE on 5 August 1998 (05/08/1998). The procedure was performed under the direct supervision of Mr JASANI who was my supervising Consultant at the time. The anaesthetist involved was Dr PHIPPS. The operation began at approx 1430 hours.

In the operation notes I have documented that the patient was in the right lateral position and that I performed a Harding approach to the left hip in layers. Once the hip joint was approached the femoral neck was osteotomised and the head of the femur was extracted. This measured 43mm. Subsequently the femoral canal was prepared with a variety of reamers and broaches to enable the femoral stem to be cemented in place. Once this was performed the hip was reduced and was noted to be stable. Subsequent to this the operative wound was closed in layers.

It should be noted however, that the photocopied operation notes available to me for preparation of this statement are unreadable because of the problems with the photocopying process rather than the fact that the handwriting is illegible. On page 56 are my post operative instructions where I have recommended that the patient be given further doses of intravenous antibiotics as a prophylactic procedure. In addition I have recommended prophylaxis against deep vein thrombosis and I have also suggested that the patient have a check x-ray and blood tests performed the following day. I have also suggested that the patient be mobilised when comfortable.

The above procedure ie hemi-arthroplasty is a common operation performed for patients with hip fractures. This operation involves the replacement of the fractured part of the femoral head and neck with an artificial implant. Unlike a conventional hip replacement operation, the acetabulum (the socket) is not replaced as this is usually uninjured during the hip fracture process. In the operation notes are the relevant implant stickers from the manufacturers of the particular stem and femoral head that was used (JRI), which have been retained in the patient's records. Of note is the fact that the size of the femoral head after it was extracted was measured

and found to be 43mm and in fact the sticker confirms that the size of the implanted femoral head was also 43mm.

The end of the operation note also supplied the fact that I performed a routine closure of the hip wound and from what is visible on the photocopied operation note, I used vicryl to close the fascial layer and clips for the skin.

Of note also is the fact that the patient had been given peri operative antibiotics. These are given routinely just before the start of the actual surgery and for a few doses post operatively to prevent or minimise the risk of infection.

On page 126 of the medical record copies is the prescription sheet (Drug Record) and there are 3 doses of Cefuroxime prescribed by myself, which has been initialled as having been given both on 5 August 1998 (05/08/1998) and 6 August 1998 (06/08/1998).

I have also as mentioned previously, ordered DVT prophylaxis in the post operative instructions. These vary from Consultant to Consultant, and in this particular case I requested it according to Lieutenant Colonel B SINGERS protocols. I suspect she must have been admitted under his care initially for me to have requested this. DVT prophylaxis involves both mechanical means ie the use of foot pumps or treatment with medication (eg Heparin, Clexane etc) which are given as injections to work as chemo prophylaxis. These are given to minimise the risk of a deep venus thrombosis ie a clot in the veins and subsequently an embolism, which these patients are at high risk for, following the injury and surgery.

Page 58 on the operation record is a record of the time frame when the patient is in the theatre recovery department prior to being transferred back to the ward following their surgery. It records the patient being brought into recovery at 1535 hours on 5 August 1998 (05/08/1998) and it is also recorded that she was stable, and discharged to E Ward.

Page 59 of the medical records is a consent form for the operation signed by Ruby LAKE on 5 August 1998 (05/08/1998). This shows that she consented for the operation of the left hip hemi-

arthroplasty to be performed and the consent was taken by Mr Karl TRIMBLE on that day.

In conclusion Ruby LAKE sustained a fracture of her left hip. She underwent a hemi-arthroplasty procedure, which is a type of a replacement operation. This is a fairly routine operation performed on a daily basis in the Orthopaedic Departments of most hospitals. However, surgery is always associated with certain risks and these risks sometimes are increased if the patient has other associated medical problems eg heart disease, hypertension or high blood pressure, diabetes etc. The risks of surgery are also increased in patients who are elderly.