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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: LUSZNAT, ROSIE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation:

This statement (consisting of 8 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: 17/06/2005

I am currently employed by the East Hampshire Primary Care Trust as a Consultant in Old Age Psychiatry working at St Christopher's Hospital, Wickham Road, Fareham.

I am contracted to work 18 hours of Clinical time per week in this position.

I am also employed by the Wessex Deanery as a Director of Specialty Education. I am contracted to work 30 hours per week for graduate training of doctors in all specialities.

My General Medical Council number is 2743743.

I am a member of the Royal College of Psychiatrists registration number 7095.

In 1977 I obtained a 1st degree in Psychology at the University of Munster, West Germany.

In 1980 I qualified as a Doctor at the University of Munster. The equivalent qualification in this country would be an MBBS which is a Bachelor of Medicine and Bachelor of Surgery.

In 1987 I qualified as a specialist in Psychiatry.

From October 1978 to March 1980 I was employed as a house officer at the University Hospitals, Munster, Germany.

Between September 1980 and August 1981 I held the position of Research Fellow, Medical

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Education, Munster, Germany.

From October 1982 until January 1983 I held the post of Locum House Officer in Medicine at Southampton.

Between February 1983 and September 1983 I was employed as Senior house Officer and Clinical Assistant in Psychiatry, Department of Psychiatry, Southampton.

From October 1983 until December 1984 I held the post of Research Registrar in Psychiatry, Department of Psychiatry, Southampton.

From January 1985 until March 1987 I held the position of Registrar in Psychiatry, Solent Rotation.

Between April 1987 and November 1989 I held the post of Senior Registrar in Psychiatry, Wessex Rotational training Scheme.

I have held the position of Consultant Psychiatrist since December 1989.

I have been asked to detail my involvement in the treatment of the patient Robert WILSON Code A Code A

I do not recollect this patient.

I note that on page 172 of the medical notes a request was made for the patient to be seen by a psychiatrist.

I can confirm that I have written the following entry on page 175 of the medical notes.

8/10/98 *Psychiatric Review*

Thank you for asking me to see Mr Wilson who presents with a history of heavy alcohol intake

over the past few years. His current admission was precipitated by a fall resulting in # L humerus.

On examination today he also presents with low mood, Code A *and disturbed sleep -? 2° to pain.*

His ST memory is slightly impaired (MMSE 24/30)

My impression is that Mr Wilson suffers with

1) Early dementia

2) Depression

I suggest

1) Sedative antidepressant to ↑mood + sleep. I have taken the liberty of prescribing Trazodone 50mg nocte.

(I am aware of impaired liver function but this would be a concern with all a/d's)

2)I shall arrange F/U by our team once we know to where Mr W is going to be discharged.

Rosie Luzsnat

Consultant in Old Age Psych.

St Christopher's

To clarify the above entry, # *L humerus.* this translated means a fracture of the Left upper arm.

Where I have written *with low mood, a wish to die, disturbed sleep? 2° to pain.*

Low mood is self explanatory.

"*disturbed sleep*" I am trying to establish whether Mr WILSON's sleep is being disturbed by pain.

- *? 2°* This means secondary to- ie results from pain

St = short term.

MMSE = Mini Mental State Examination. This is a standard test of memory and general brain

function conducted by trained staff. A person scoring 30/30 has a good memory. Someone scoring 5/30 has a very poor memory.

Therefore where Mr WILSON has scored 24/30 this shows that he has a slightly impaired memory and brain function. The whole test includes orientation and concentration in addition to memory.

Early dementia= This equals mild impairment of memory and general brain function as I have discussed above.

Alcohol related= Excessive alcohol intake over a prolonged period of time can cause damage to the brain. I am suggesting that it is a possibility that his brain impairment is due to his excessive alcohol intake.

Depression= is characterised by low mood but can also show itself in his physical signs for example disturbed sleep and appetite.

It is quite common for a depressed person to express a wish to die.
Depression can also lead to increased alcohol intake.

1) Sedative anti-depressant to ↑mood+ sleep. Sedative this means sleep enhancing. I am ttempting to get the patient to sleep better.

"*anti-depressant*" This refers to a group of drugs aimed at improving the symptoms of depression.

↑= To lift a patient's mood.

I have taken the liberty of prescribing Trazodone- This is one of the group of anti-depressants which has a sedative affect. 50 mgs is the lowest possible dose.

Nocte means to be taken at night. This is to improve the patient's sleep.

Where I have written (*I am aware of impaired liver function..)*

I would have reviewed the patient's notes and test results.

(.. but this would be a concern with all a/d's) I am saying that in an ideal world the safest option is not to prescribe any medication due to his impaired liver function.
However in order to promote/assist the patient's sleep and general well being. I have decided to prescribe an anti-depressant as I believe that the risks of not treating his sleep disturbance and depression are greater than the risks of prescribing Trazodone

Where I have written *2) I shall arrange f/u.*

f/u= follow up by our team once we know to where Mr WILSON is going to be discharged. I have planned to review the patient's progress and his response to medication following discharge from hospital for as long as necessary. This would be done by myself or one of our community psychiatric nurses.

I can confirm that I have written the following entry in the prescription chart as shown on page 114 of exhibit BJC/55. The entry reads as follows;

Trazodone 50mg start date 8/10/98 @ 2200 hrs - Route°

Route°=to be given orally

I have drawn a line across to indicate the starting date which was to commence on the 8th. However I note that the Trazodone was not started until the 9th October 1998. I did not prescribe any other drugs

I can confirm that I have dictated the following letter on page 117 of exhibit BJC/55 dated 15th

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October 1998 (15/10/1998) This letter relates to my ward visit of the 8/10/98 to see Mr WILSON at Dickens ward, Queen Alexandra Hospital.

The letter was addressed to Dr GRUNSTEIN who was the referring Doctor. Further copies were sent to the patient's own GP Dr DURRANT and the appropriate Community Psychiatric nurse Kit TEEROOVENGADUM.
Letter reads:

Dr. John GRUNSTEIN
Consultant in Elderly Medicine
QA Hospital
Cosham
Portsmouth

Dear John

Robert WILSON, Code A
Code A

Thank you for referring this 75 year old man whom I saw in Dickens Ward on 8.10.98 (08/10/1998). I understand that he was admitted on 22.9.98 (22/09/1998) following a fall during which he had fractured his left humerus. I gather that he had been drinking heavily prior to the fall and that this had been the pattern for at least the past 5 years. I am aware that he had also been admitted in February 1997, again following a fall when a diagnosis of alcoholic liver disease was made.

During this current admission he had become rather sleepy and withdrawn and had appeared low in mood. His nights had also been disturbed. I gather that on the physical side he had a raised MCV, impaired renal function, active alcoholic hepatitis and hypothyroidism. He was treated with IV fluids and gradually improved. He is now eating and drinking well and appears much brighter in mood. His most recent Barthel score was 5.

Background history: He was born in Ayrshire but has lived in the south of England for the past 60 years due to his career in the navy. He had one sister who died 3 years ago in a road traffic accident and 2 step-siblings from his mother's first marriage. Unfortunately his own father left the family when he was very young and his mother struggled to bring up her 5 children on her own. There is no history of mental illness or dementia. He himself has been married twice, the first marriage ending in divorce 16 years ago. He had 3 sons and 3 daughters from this marriage and there was also one adopted child. His second wife also has a daughter from a previous marriage and I gather from the notes that she tends to drink quite heavily too.

Mr. WILSON has been a regular drinker since the age of 20 but his alcohol intake according to his own account has increased greatly over the past 5 years or so. He used to drink rum but more recently has switched to whisky. He denies any past psychiatric problems. He lives in a council house with his second wife.

Current medication:
Thiamine 100 mgs. Daily
Multivitamins 2 tablets daily
Senna 2 tablets b.d.
Magnesium Hydroxide 10 mls b.d.
Paracetamol 2 tablets q.d.s.

On examination, mental state: He was sitting by his bed, appeared calm and was friendly and co-operative throughout my visit. He was slightly deaf and it was difficult to understand him due to a degree of dysarthria and his strong Scottish accent. His speech did however seem coherent with appropriate answers. He was subjectively low in mood and objectively easily tearful but also able to smile. His thought content was appropriate and there was no evidence of delusions or hallucinations. He did not express any active suicidal ideas or plans but did admit that there was no point in living. His insight seemed well preserved. Assessment of his cognitive functioning revealed full orientation in place, partial orientation in time and a mildly impaired short term memory. His score on the MMSE was 24/30.

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Physically he was obese with his left arm in a sling and his left hand still grossly swollen and bruised. There was also marked oedema of both legs. I gather his mobility remains poor.

In summary it seems as though Mr. WILSON may have developed an early dementia which could well be alcohol related. Alternatively this might be an early Alzheimer's disease or vascular type dementia. In addition he seems to have developed a depression and it is difficult to say whether this was preceding his increased alcohol intake or whether it has developed since withdrawal.

Suggestions for management: I think Mr. WILSON would benefit from antidepressant treatment and I have taken the liberty of starting Trazodone 50 mgs. Nocte both as an antidepressant and a night sedative. I do of course hope he tolerates it in view of his liver and renal failure. Trazodone could be increased as appropriate in 50 mg. increments.

On the practical side he may well require nursing home care though at the moment he is strongly opposed to that idea. I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged.

Best wishes

Yours sincerely

(signed) Code A

DR. R.M. LUSZNAT

Consultant in Old Age Psychiatry

c.c. Dr. DURRANT, Brook Lane Surgery, Park Gate

Kit TEEROOVENGADUM, CPN

This letter summarises my assessment of my examination of Mr WILSON on the 8/10/98. It also provides a summary of Mr WILSON's personal and medical history.

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Where I have written in the letter:

MCV- (Mean Corpuscular Volume) This is a blood test which indicates the size of red blood cells. In the patient's case the MCV was raised ie his blood cells were enlarged. This can be caused by a number of illnesses and by alcohol abuse.
degree of dysarthria - this means unclear speech.

He was subjectively low in mood- This means that the patient himself described himself as feeling low.

Objectively easily tearful - This means that I observed him close to tears whilst I was talking to him.

Delusions - This means abnormal thoughts and beliefs. An example of a delusion "I'm being poisoned" where there is no evidence of this occurring.

Hallucinations - This means seeing, hearing or feeling things which are not there.
Active suicidal ideas or plans- This means the patient thinking about or planning to take his life by a particular method.

His insight seemed well preserved- This means the patient is aware of his current problems and the possible causes. Basically he is aware that he is unwell, needs to be in hospital and that his drinking may have contributed to his condition.

Assessment of his cognitive functioning- This relates to his brain function which revealed full orientation in place, which means that he knew where he was.

Partial orientation in time- This means he was not fully aware of date or time.
Oedema- This means swelling.

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Where it is written *Early Alzheimer's disease or vascular type dementia-* This refers to the possibility that Mr WILSON's impaired brain function may be caused by two other types of brain disease.

Alzheimer's disease is a gradual dying of brain cells.

Vascular type dementia is a deterioration of brain tissue related to poor blood supply.
Where I have written *I do of course hope he tolerates it in view of his liver and renal failure.* I refer to the possibility that the impairment of liver and kidney function could lead to Mr WILSON tolerating Trazodone less well than if he was a fit person.

This is also intended to alert the medical team responsible for his care that monitoring for any possible side effects is important.

I had no further dealings with this patient.