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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: KNAPMAN, ANTHONY CHARLES

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

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: 20/01/2006

I am Dr Anthony Charles KNAPMAN and am employed, part time, as a General Practitioner at the Forton Rd Medical Centre, Gosport, Hants .

My GMC number is 0327347.

I qualified at Bristol University in June 1966. I undertook pre registration training in Surgery and Medicine in Bristol with full registration in June 1967.

I conducted duties in Obstetrics and Paediatrics in Bristol and Brighton and one years General Practise, attached to a practise in Bristol in 1969.

I commenced employment at my present practise in 1970 and have been there ever since.

During the past ten to fifteen years the partners covered, when necessary, for Dr Jane BARTON who acted also as Clinical Assistant in the Elderly Medicine at the Gosport War Memorial Hospital, Hants.

I probably worked one night in six, that is to say, on call, however at weekends I would go in both days for emergencies and ward rounds.

My role as a GP is to administer appropriate medication to patients, as their illness required according to their symptoms.

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I have been referred to police exhibit BJC/55 , this being medical notes of Robert WILSON , Code A and who died on 18/10/98.

I confirm that the entry on page 179 of 642, dated 16/10/98, is mine.

The entry reads 'Decline overnight with SOB' (ie, shortness of breath).
'O/E bubbling', ie, fluid in the chest.
'Weak pulse' irresponsive to spoken orders' (ie: words)
'Oedema ++ in arms and legs' (ie: fluid retention)
'Silent MI' indicates he may have had a heart attack or deterioration of his liver.
?Deterioration liver function'
↑Frusemide to 2x40mg O.M.' That is to say increase his Frusemide to 2x40mg in the morning. Frusemide is a diuretic. It is a prescription drug.

I note that Dr PETERS wrote on 17/10/98 that the patient was comfortable but rapidly deteriorating and nursing staff to verify death if necessary.

I have been referred to exhibit JP/CDRB/24 a Ward Controlled Drugs Record Book from Dryad Ward, GWMH, (Oramorph Oral Solutions).

On 14/10/98 WILSON was written up for 10mg in 5ml of Oramorph. He had two doses, one at 1445 hrs, the other at 2345 hrs.

I can say that all I wrote him up for was the increase in Frusemide. I believe the reason I was called was due to Mr WILSON's fluid retention.

I cannot comment on his other drugs.

I can say that on his transfer to GWMH Mr WILSON was being given 2-5mg Morphine intramuscularly every four hours by referring to his drug chart.

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Referring to pages 258 to 262 of the notes I see that Mr WILSON was prescribed Paracetamol, Hyoscine (an anti nausea drug). He was not given these.

He was administered Frusemide, Spirouslactone and Bendrofluozide. These are all diuretic drugs.

He was also given Trazadone, an anxiety/anti depressant.

He was given Thiamine, Vitamin B and Multi-vitamins. Thiamine is given to alcoholics. Mr WILSON was given Magnesium Hydroxide, a laxative, senna for loosening of the bowels. He was given Oramorph which is morphine in liquid form. This is an opiate given for control of pain. On 15 and 16/10 he was given 10mg, three doses on each day and one dose on the night of 15/10/98 of 20mg. I see on page 262 he was switched to Diamorphine, the last dose of Oramorph on 16/10 being at 1400 hrs.

He was transferred to a syringe driver and 20mgs over twenty four hours given 16/10/98.

On 17/10 in the afternoon his dose was increased to 40mg and increased to 60mg on 18/10/98.

The parameters set by Dr BARTON were 20mg - 200mgs. This is a relatively small amount for someone in pain. I refer to the 200mgs. Mr WILSON was only ever on 60mg for one day, the day he died.

Mr WILSON was also given Hyoscine to dry up secretions and Midazolam to combat anxiety.

In my opinion none of the doses were excessive.

My role on the ward was to see any patients referred to me by nursing staff and to deal with their medical problems appropriately.

I never spoke with any of Mr WILSON's family.

Signed: Code A Signature Witnessed by: J Code A

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Continuation of Statement of: KNAPMAN, ANTHONY CHARLES

Signed: Code A

Signature Witnessed by: Code A