**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: KNAPMAN, ANTHONY CHARLES

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

This statement (consisting of 4 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 N Date: 08/05/2006

I am Dr Anthony Charles KNAPMAN and am employed as a General Practitioner at the Forton Road Medical Centre, Gosport, Hampshire .

My GMC number is

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

Following full registration I conducted duties in Obstetrics and Paediatrics in Bristol and Brighton and one years Practise, that being in Bristol in 1969.

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

Over the past ten to fifteen years the partners at the practise covered, when required, for Dr Jane BARTON who acted, as well as a General Practitioner at my practise, as a Clinical Assistant in Elderly Medicine at the Gosport War Memorial Hospital, Hants.

My role as a General Practitioner is to administer the appropriate medication, as is individually required according to the needs of the patients.

I make this statement, further to my statement of 20th January 2006 in relation to Robert WILSON and the entries I referred to in his photocopied medical notes, police exhibit BJC/55.

Signed: Code A N Signature Witnessed by: Code A

2004(1)

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I previously referred to page 179 of the notes and to the entry dated 16/10/98. I considered Mr WILSON may have suffered myocardial infarction due to the fluid noises in his chest. Because of his alcoholic condition I determined that an increase in Frusemide might improve his breathing and make him more comfortable. He may have, and it was only a thought, had a silent heart attack whereby he may not have suffered any pain. This was a query. The references on paragraph seven of page of four of my (typed) statement clarify my queries.

Because of the poor prognosis in the patient I felt it was in his interest to make him comfortable at GWMH. If he had had an obvious heart attack I probably would have had him transferred to a hospital with acute care. To have transferred him in the state he was in may have jeopardised his health further. He was more comfortable on 17/10/98. On 14/10/98 he had two doses of 10mg Oramorph (as per 262 of the notes). The charts indicate that on 15/10/98 he had no morphine. On 16/10/98 he went on to 20mg daily of Diamorphine. This was prescribed by Dr BARTON and started at 1610 hrs.

I had seen him in the morning of 16/10/98. Dr BARTON prescribed the Diamorphine after this. I never spoke with Dr BARTON regarding this and there is nothing in the notes.

I believe that 16/10/98 may have been over a weekend because there is nothing in the nursing notes indicating anything other than a routine weekend visit. Both me and my partners covered GWMH at weekends, public holidays and when Dr BARTON was unavailable.

When I saw Mr WILSON there was no issue with Diamorphine since he last took opiods at midnight on 15/10/98, some thirty six hours previously.

20mg is a small dose and presumably given to relieve his distress and to replace the Oramorph.

Signed: Code A

Signature Witnessed by: Code A

2004(1)