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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: BRIGGS, SANDRA

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

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 Date: 02/08/2004

I am retired and live at the address stated overleaf. I have been asked, by DC QUADE, about my knowledge of Elsie DEVINE.

Elsie was my mother in law as I married her son Harry, Harry's given name was Henry but he was always known as Harry. As well as Harry, Elsie had two other children, a daughter named Ann and another son named Gerald. Harry and I had two children, Tracy and Stephen.

I always got on well with Elsie, we shared some happy times together, however in 1975 Harry and I separated, leading to divorce in 1976. As a consequence I lost touch with Elsie to a degree, we did not start seeing each other again on a regular basis until 1995 when Tracy got married. Following Tracy's marriage my relationship with Elsie and also with Harry grew stronger again. By this time Elsie who was now widowed, was living in Ann's house in Titchfield. I was a regular visitor, mostly in company with Tracy.

In September of 1999 Ann and her family went on holiday abroad, at this time things were difficult for Ann as her husband David had been diagnosed with Leukaemia. The holiday was taken because of David's illness. Ann asked me if I would look after Elsie while she was away, of course I was quite happy to do so. I visited Elsie every day for the week Ann was on holiday, I cooked her dinners, made sure that she was getting on whilst on her own. She was fairly mobile, she was able to keep the house clean, do small amounts of washing, looked after her Yorkshire Terrier, that sort of thing. She was on various pills and Ann had sorted them out, having placed them in a pill organiser. I checked everyday to ensure that Elsie was taking them I didn't need to worry as she was getting on fine with them. She was perfectly alert, she was as

Signed: Code A Signature Witnessed by:

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was likely to relate to compression from the false aneurism. Nerve conduction studies were arranged.

She was referred to Professor Rolf Birch (Consultant Orthopaedic Surgeon) at the Royal National Orthopaedic Hospital who advised that further surgery was not appropriate.

I was asked to review the records and give an opinion regarding the orthopaedic treatment provided to her and in particular to consider:

1) The vascular injury.

2) Delay in diagnosis of the deep vein thrombosis.

3) Delay in diagnosis of the false aneurism and sciatic nerve injury.

I was able to refer to the following documentation:

1) General Practitioner records.

2) Hospital records.

3) X-rays in digital format on compact disc.

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mobile as she normally was, she walked in short slow steps, we would sit and chat, we would reminisce about the told times.

Following Ann's return home I did not see Elsie again until she was in the Gosport War Memorial Hospital. My daughter Tracy phoned me to tell me that Elsie had been admitted into the Queen Alexandra Hospital, this was either October or November 1999. My understanding was that Elsie had a urinary infection, I further understood that after the infection had cleared she would be allowed home, unfortunately Ann was in London as David was in hospital himself. It was a very difficult time for Ann as she had her husband and her mother both in hospital at the same time. I always believed that because there was nobody at home to look after Elsie she was transferred to Gosport War Memorial Hospital just until Ann returned home. I visited Elsie several times at Gosport, I never saw her in her room, she was always in a communal room sat in a chair. I visited with Tracy once, my husband once and 3-4 times on my own. I visited during the day time. Whenever I saw Elsie she always seemed fine, she appeared to be no different than when she was at home, she always recognised me, always talked, never seemed to be in any pain or distress, to me she seemed quite normal. On each visit she always told me that she wanted to go home, I took this as a good sign, that she was feeling fit and well, I would normally reply that "Ann was not home yet" or something like that. I was not aware of any medication she was taking, in fact I didn't think she was taking any at all. I was not aware of any medical reason which would prevent her from going home, as far as I was aware it was purely the fact that Anne was not home at the time to look after her.

I last visited Elsie on Thursday 18th November 19999 (18/11/1999). As I arrived at the hospital two nurses were just finishing washing her hair, they brought her into the communal room, I remember that her hair was still wet. I told the nurses that I would dry Elsie's hair, her hair was very fine so it did not take too long to dry. We then had a good chat as we normally did. I asked the nurses if I could take Elsie into an adjacent room where they served tea, however they said she was not allowed, I couldn't understand why they should say no. I ended up getting the tea myself and bringing it back to the room for the two of us. The tea was hot so I put it onto a small table until it had cooled down, Elsie had no trouble drinking it on her own. We talked about the old times and especially past Christmases, Elsie often used to spend Christmas at our

4) Witness statement of Mrs O'Connor.

5) Medical report of Mr Parvin (Consultant Vascular Surgeon).

CHRONOLOGY OF CONDITION AND TREATMENT

This report relates to treatment provided to Mrs O'Connor's fractured right proximal femur. I have identified the following relevant entries:

22/4/06 Date of injury.

22/4/06 Attendance at the Accident and Emergency Department at Frenchay Hospital. The nursing triage notes *"Hip slightly shortened. No rotation. ?fracture neck of femur"*.

An x-ray confirmed a fractured right proximal femur and she was referred to the orthopaedic surgeons for further management.

There is a written note by a Senior House Officer, Dr Mansoor. *"Analgesia. Admit. Nil by mouth after 12am. To be consented DHS ? IM nail"*.

23/4/06 Operation performed by a Mr Ashmore. *"Right femoral gamma nail. Subtroch fracture. Fracture reduced with Leadbetter manoeuvre. Traction table.*

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house when Harry and I were together. I kissed her goodbye and was fully expecting to see her during the course of the next week, I knew that she would have enough visitors over the next few days as Harry usually went in the evening and Tracy was intending to go over the weekend. Also during this visit I had taken in Elsie's pension book as that weeks pension needed to be withdrawn, Elsie signed the part that authorised to do so as her agent, as I say she was perfectly coherent and normal in her manner and behaviour. I would have arrived at the hospital between 2.15pm (1415) and 2.30pm (1430), I remember that I had to get to Fareham Post Office with the pension book before it closed so I only stayed for about 1½ hours.

The next day, Friday 19th November 1999 (19/11/1999), Tracy phoned to tell me that Harry had phoned her to say that Elsie was dying and that she should visit her as soon as possible. I was shocked, I had only seen her the day before and she seemed fine to me, I certainly was not prepared to hear such news. On Sunday Harry phoned to tell me that Elsie had died that day. I just could not believe it.

I have since learnt from Ann that Elsie had been given Diamorphine , this has surprised me as I was not aware that she had been in any great pain or discomfort, especially during my last visit.

I have been aware, via the local press and media coverage, of the police investigation into the Gosport War Memorial Hospital.

Taken by:DC1162 QUADE

- aggression + confusion
- no [illegible] of mental decline
- not told of [illegible]
- not told that she was regarded as terminally ill
- no pain
- appropriate for her to sign pension book

Signed: Code A

2003(1)

Signature Witnessed by:

Lateral approach to GT tip. Awl →guidewire. 17 prox, 13 distal ream. 380 x 11 x 130° gamma nail. Wire/screw into central neck. Derotation bolt ✓. Distal lock x 2. Closed vicryl deep/clips to skin".

It looks like this operation note has been written by the consultant supervising the procedure. The signature is illegible.

The operation note also includes *"Hb check 24 hours. DVT prophylaxis. Clips 2 weeks".*

The medication chart indicates that she was given Cefuroxime 3 doses. She was prescribed Aspirin 150mg daily for 5 weeks presumably for anti-thrombembolic prophylaxis.

The anaesthetic chart indicates the procedure lasting approximately 90 minutes under, I think, a general anaesthetic.

The consent form includes the following: *"Right intramedullary nail femur proximal... intended benefits: fixation of fracture for improvement in pain and function. Serious or frequently occurring risks include but are not limited to: bleeding, infection, pain, damage to blood vessels, nerves, skin, muscle. Failure to unite, malunion/non-union, fracture, myocardial infarction, chest infection".* This is signed by Mr Davies a Specialist Registrar and the patient.