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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: REID, RICHARD IAN

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

This statement (consisting of 41 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 in it anything which I know to be false or do not believe to be true.

Signed: Code A Date: 04/10/2004

I am Doctor Richard Ian REID MB, ChB. I reside at the address detailed overleaf. I qualified at Glasgow in 1974.

I became a Member of the Royal College of Physicians (United Kingdom) in 1978.
A Fellow of the Royal College of Physicians (Glasgow) in about 1988 and a Fellow of the Royal College of Physicians (London) in about 1990.

My General Medical Council registered number is 1341171.

Experience

1. House Officer (Medicine) at Royal Alexandra Infirmary, Paisley, Scotland from August 1974 to January 1975.
2. House Officer (Surgery) at Stirling Royal Infirmary, Stirling, Scotland from February 1975 to July 1975.
3. Senior House Officer)Obstetrics and Gynaecology) at Paisley Maternity Hospital, Paisley, Scotland from August 1975 to January 1976.
4. Senior House Officer (Geriatric Medicine) at the Victoria Geriatric Unit, Glasgow from February 1976 to July 1976.
5. Senior House Officer (Cardiology) at the Glasgow royal Infirmary, Scotland from august 1976 to April 1977.

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6. Registrar in General Medicine at the Kilmarnock Infirmary, Kilmarnock, Scotland from May 1977 to July 1979.
7. Senior Registrar in Geriatric Medicine at Portsmouth and Southampton Hospitals from August 1979 to July 1982.
8. Consultant in Geriatric medicine at Southampton General Hospital from August 1982 to March 1998.

My current role which I began in April 1998 is as Consultant in Geriatric Medicine and Medical Director of East Hampshire Primary Care Trust (formerly Portsmouth Health Care Trust). I am based at the Queen Alexandra Hospital, Cosham.

I have a full time National Health Service contract which consists of 11 (eleven) sessions per week. One session is 3½ hours. I have an 'On Call' responsibility and work weekends (Saturday and Sunday on roughly one weekend in ten basis).

I began the responsibility of looking after 'In Patients' at Gosport War Memorial Hospital in either February or April of 1999.

This continued for a period of about 12 months until about March 2000.
As Consultant to Gosport War Memorial Hospital I had a responsibility for the in patients on Dryad Ward of the hospital.

In this role I supervised the work of Doctor Jane BARTON , a local General Practitioner who, in addition to her work in general practice, worked as 'Clinical Assistant' at Gosport War Memorial Hospital.

In the absence of Dr BARTON I supervised the work of any 'locum' or partners at her general practice who covered her responsibilities for her.

It was also my role to supervise the work of any Specialist Registrar who was attached to me on Dryad Ward at Gosport War Memorial Hospital.

I undertook a weekly ward round of Dryad Ward which I usually conducted on Monday afternoons.

During the ward round I would visit each of the in patients on Dryad Ward.
I was accompanied on my ward round by the clinical assistant, Dr Jane BARTON, every two weeks, if she was available to do so.

I also provided consultant cover to Daedalus Ward the other consultant led ward at the Gosport War Memorial Hospital, when my colleague Dr A LORD was on leave or unavailable. This was a reciprocal arrangement with Dr LORD who would normally cover my leave periods or unavailability. In the event of myself and Dr LORD being unavailable for long periods of time then locum consultant cover would be sought, however for short periods of absence then no locum cover was arranged.
If the Clinical Assistant, Dr BARTON was experiencing a particular problem regarding the management of a patient, then I would expect the Clinical Assistant to contact me to seek advice or to ask me to attend Dryad Ward to carry out an examination of the patient or see relatives who were concerned.

If my advice was sought by the Clinical Assistant then I would expect a note to be made on that patient's clinical notes by the Clinical Assistant. Dr Jane BARTON is a very experienced doctor and as such it would be a serious clinical problem relating to the treatment of a patient that would require her to seek such advice.
If a problem arose requiring a Consultant input during any short term unavailability of both myself and Dr LORD then I would expect the Clinical Assistant to contact the Elderly Medicine Office at the Queen Alexandra Hospital, Portsmouth to obtain the required consultant input.
The clinical notes of a patient are where a record is kept of the clinical treatment of a patient.

I would expect a note to be made on the clinical notes on a patients admission to the

hospital, giving a brief history and the results of any examination and treatment.

I would also expect a prescription sheet to be commenced detailing any drugs prescribed on admission (see separate statement).

The clinical notes of a patient would then be maintained by the Clinical Assistant or doctor covering that responsibility, myself as Consultant, with entries from other clinical staff when consulted regarding the management of a patient.
A nursing record is also commenced on admission of a patient which is maintained by the nursing staff.
During my ward round of Dryad Ward I would visit each patient, read their clinical notes, examine the prescription sheets and obtain additional information from the nursing staff, provided from the nursing records. This information is usually verbally provided and it would be unusual for me to read the nursing record of a patient.

This information together with information I have obtained myself as a result of any examination I have made of the patient, would form the basis of any note that I made on a patients clinical notes.

If there is no marked change in a patients condition, treatment or management then I would not expect any entry to be made on a patients clinical notes by the Clinical Assistant.

However I would make a note on the clinical notes of each patient I saw during my ward round.

Included in my notes on the clinical notes would be any instructions regarding the clinical care of a patient to the Clinical Assistant.

I have been asked to detail my involvement and the care and treatment of Mrs Elsie DEVINE , Code A , who was admitted to Dryad Ward of the Gosport War Memorial Hospital on Thursday 21st October 1999 (21/10/1999), having been

transferred from the Queen Alexandra Hospital, Portsmouth.

Mrs DEVINE was a patient on Dryad Ward until her death on Sunday 21st November 1999 (21/11/1999) at the age of 88.

During this period I was the Consultant for Dryad Ward, Gosport War Memorial Hospital.

I first wish to state that I have no personal recollection of Mrs Elsie DEVINE herself and therefore this statement has been provided by referring to certain entries made by myself and others on Mrs DEVINE's medical notes. In particular entries made on her clinical notes and prescription sheets.

By referring to Mrs DEVINE's medical notes I can state that I saw her on three occasions, between 21st October 1999 (21/10/1999) and 21st November 1999 (21/11/1999).

On each of the three occasions that I saw Mrs DEVINE it was as a result of my weekly ward round of Dryad Ward, Gosport War Memorial Hospital.

The three occasions were as follows:

1. Monday 25th October 1999 (25/10/1999)
2. Monday 1st November 1999 (01/11/1999)
3. Monday 15th November 1999 (15/11/1999)

I have been shown a document bearing an exhibit label BJC/16/PG/154&155. This document I recognised as a speciality history sheet on which doctors record clinical notes in relation to a particular patient. The patient in the case of this document was Elsie DEVINE.

This document is double sided, notes therefore are recorded on both sides. My attention has been directed to an entry on the lower part of page 154 which commences with the date 25th October 1999 (25/10/1999).

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I recognise this writing as mine and that the note ends with a signature that I recognise as my own.

My note is proceeded by a note dated 21st October 1999 (21/10/1999). The handwriting and the signature at the end I recognise as that of Dr Jane BARTON, Clinical Assistant at the Gosport War Memorial Hospital.

These are the only two notes that appear on page 154.

My note of 25th October 1999 (25/10/1999) would have been made during the course of my weekly visit to Gosport War Memorial Hospital (GWMH) and during my ward round at Dryad Ward.

My note reads as follows:-

'25th October 1999 (25/10/1999), mobile unaided
Washes with supervision - dresses herself
Continent - mildly confused
Blood pressure 110/70
Normochromic anaemia
Chronic renal failure'
'Was living with daughter and son-in-law, believed son-in-law awaiting bone marrow transplant.
Need to find out more regarding son-in-law etc'.
The entry has then been signed by me using my normal signature.
This note should be interpreted as follows:
On Monday 25th October 1999 (25/10/1999) I saw and had contact with patient Elsie DEVINE. It is possible that Dr Jane BARTON was present, it is also possible that I carried out a physical examination of Elsie DEVINE. The main content would have been noted by me from reports made to me by the nursing staff, and/or Dr BARTON, if present.

'Mobile unaided'. This probably meant that Elsie DEVINE was at that time walking without

support and that she, at that time, was probably safe walking on her own.

'Washes with supervision', this probably meant that Elsie DEVINE was physically able to wash herself but due to her confusion required some guidance and prompting to wash.

'Dresses herself', this probably meant that Elsie DEVINE was, at this time, physically capable of dressing herself. I have made no record of if she required any guidance with her dressing.

'Continent', this probably meant that Elsie DEVINE was at this time, continent, regarding 'urine' and was aware of the need and recognised the need to pass urine, also able to control her bladder until she passed urine.

'Mildly confused', this probably meant that, at this time, Elsie DEVINE's short term memory was mildly impaired. She was confused as to time and recent events but was probably aware of her surroundings, ie that she was in hospital.

'Blood pressure 110/70', this blood pressure I would regard as being on the low side, however provided that patient had appeared to be well in themselves it would not be a cause for concern.

'Normochromic anaemia', means that at that time Elsie DEVINE's red blood cells were low in number and that these cells were normal in colour when examined under the microscope.

'Chronic Renal Failure', this is a reference to Chronic Renal Failure being one of a number of causes of Normochromic Anaemia.

These notes would have been completed by me during my afternoon ward round of Dryad Ward, Gosport War Memorial Hospital. This would have been the first occasion that I would have seen Elsie DEVINE as she was admitted to this hospital on Thursday 21st October 1999 (21/10/1999).

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The note is then completed with a brief social background which is self explanatory and related to me by the nursing staff, that prior to her admittance to hospital. Mrs DEVINE was living with her daughter and son-in-law, in a home environment.

That it was believed that her son-in-law was himself in hospital awaiting a bone marrow transplant.

The note of:-
'Need to find out more re son-in-law etc'.

This is an indication that more had to be found out about Mrs DEVINE's current home circumstances and if daughter would be able to care for her mother, following her husband's illness, or if a residential or nursing home needed to be considered.

All the above, would have been obtained from verbal reports of the nursing staff and from Mrs DEVINE's notes.

I would not have relied on a patient in a 'confused state' to provide such information.

The next note on this same document (exhibit BJC/16/PG154&155) is dated 1/11/99 (01/11/1999) and has been written on the reverse side of this document (page 155).

This note has been written on by me and would have been written by me during my weekly ward round of Dryad Ward at the Gosport War Memorial Hospital.
I do not regard it as unusual that no note has been made on the clinical notes since 25/10/99 (25/10/1999) as there had been no major change in Mrs DEVINE's condition and treatment since that date. I would have had access to all medical notes relating to Elsie DEVINE's condition and treatment and in addition could possibly have had Dr Jane BARTON in attendance as well as the nursing staff from all of whom I would have taken verbal reports on which my note would have been based. This should read as follows:

'1st November 1999 (01/11/1999) physically independent but needs supervision with washing and dressing and help with bathing.
Continent.
Quite confused and disorientated.
For example, undresses during the day.
Is unlikely to get much social support at home.
Therefore try home visit to see if functions better in own home'.
This entry is then signed by me with my normal signature.

This note could be interpreted as follows:
'Physically independent', probably means that Mrs DEVINE, at that time, was physically able to walk, at least short distances, unaided by either staff or walking aides.

'But needs supervision with washing and dressing and help with bathing', this probably means that at this time due to Elsie DEVINE's confusion she needed guidance and direction but that she was physically capable of both dressing and washing. However if Mrs DEVINE was taking a bath, then she needed physical help to do so.

'Continent', this is a further reference to Elsie DEVINE's passing of urine and a reference to the fact that with regard to this, there had been no change in Mrs DEVINE's status, since the last occasion on which I saw her. Namely she was still aware of any need to pass urine and was able to control that need and was not 'wetting herself'.

Had Mrs DEVINE suffered from any incontinence of the bowel then this would have been separately noted.

'Quite confused and disorientated', this would probably mean that at that time Mrs DEVINE may not have been aware that she was in hospital or of the time of day, day in the week etc.

This information would have been obtained from verbal reports given by the nursing staff of

Dryad Ward. The note is supported by the following example:'
'Undressing during the day'

This part of the note is self explanatory and has been entered on the notes as an example of Mrs DEVINE's confusion at that time.

As previously stated this information would have been provided in the form of verbal reports provided by the nursing staff from their nursing notes.

'Is unlikely to get much social support at home'.
This sentence is a reference to earlier and current reports of Elsie DEVINE's home circumstances provided by the nursing staff namely that prior to her admittance to hospital Mrs DEVINE was living with her daughter and son-in-law. However her son-in-law was in hospital himself undergoing a bone marrow transplant at a hospital in London. Mrs DEVINE's daughter was staying with her husband in London. There was not anyone at home to provide care, support or supervision to Elsie DEVINE at that time.

'Therefore try home visit to see if functions better in own home'.
This note is a suggestion made by me in order to assess Mrs DEVINE's level of 'confusion'. Elsie DEVINE appeared to be suffering from 'Dementia'. Persons suffering from Dementia (confusion) often function worse in unfamiliar surroundings for example:- within hospital, changing hospital, changing ward within a hospital.

It appeared to me that Mrs DEVINE's condition with regard to her confusion had worsened since my visit of 25th October 1999 (25/10/1999). It is often the case that a person suffering this condition can improve if returned to more familiar circumstances.

The suggestion was therefore to try a supervised part of a day at home with an occupational therapist to see how Mrs DEVINE functioned in her 'activities of daily living' within familiar surroundings and circumstances.

At the same time an assessment could be made of what support would be required for her to return home, or whether Mrs DEVINE would require a position in a residential home or a nursing home. In addition what support she would require in these circumstances. This home visit would be dependent on Mrs DEVINE's physical condition, which appears from my note of the 1st November 1999 (01/11/1999) to be stable.

The main focus of my note of 1st November 1999 (01/11/1999) appears to be Mrs DEVINE's confusion. Had there been any concerns regarding her physical condition at that time then I would have made a note of it. I note from the prescription sheets that on 1st November 1999 (01/11/1999) Dr BARTON prescribed to Elsie DEVINE the drug 'Amiloride' in the form of 5mg tablets, one tablet daily. It is possible that the prescription of the drug 'Amiloride' to Mrs Elsie DEVINE was discussed by myself and Dr BARTON during my ward round.

However I have not made any mention of this in my note of 1st November 1999 (01/11/1999) and do not have any personal recollection of such a discussion.

The drug 'Amiloride' is used to treat fluid retention and heart failure. The drug is entirely compatible with the other drugs prescribed to Elsie DEVINE at that time.

I have provided a further statement regarding drugs prescribed to Elsie DEVINE.

In my further statement I have detailed the dosage and two possible reasons for its prescription.

I note from the prescription sheets that Mrs DEVINE was first administered 'Amiloride' on 2nd November 1999 (02/11/1999) and continued to be given the drug until 18th November 1999 (18/11/1999). The dosage remained the same throughout this period.

The next note on this same document (exhibit BJC/16/PG154&155) is dated 15/11/99 (15/11/1999). This note has been written by me and should be read as follows:

'15th November 1999 (15/11/1999)

Very aggressive at times.

Very restless.

Has needed 'Thioridazine'

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*On treatment for urinary tract infection - mid stream specimen sent because blood and protein in urine.
On examination pulse rate 100 per minute.
Regular temperature 36.4°C
Jugular venous pulse not seen
Hepato-jugular reflux negative
Oedema gross extending to thighs
Heart sounds - nil added
Chest clear
Bowels regular - rectal examination on 13/11/99 (13/11/1999) revealed rectum empty
But good bowel action since
(* mid stream specimen urine - no growth)
Ask Doctor LUSZNAT to see'

.

My interpretation of this note is as follows:-

On Monday 15th November 1999 (15/11/1999) I saw Mrs Elsie DEVINE as part of my weekly visit to Dryad Ward at Gosport War Memorial Hospital.

This is two weeks since my last visit to Dryad Ward as I had been on leave. No note has been made on Mrs DEVINE's clinical notes since my note dated 1/11/99 (01/11/1999). It was reported to me as a result of face to face contact and verbal reports from the nursing staff and possibly Dr Jane BARTON that Mrs DEVINE had been:-

'Very aggressive at times'.

This could mean her having been either verbally or physically aggressive, or both, towards either staff or other patients or both.

'Very restless'

This probably meant that Mrs DEVINE was continually moving about whilst sitting or lying in bed. In addition she may have been pacing around the ward.

Both the above symptoms can be brought on by a deterioration in a persons physical state which causes anxiety and further confusion, which in turn can cause the person to become aggressive and restless.

The above comments on the notes have been bracketed by the words 'Has needed Thioridazine'.

Thioridazine is a major tranquillizer. The fact that this drug had been administered to Mrs DEVINE would have been obtained from my face to face contact with the nursing staff, Dr BARTON if present and from my examination of the drug/prescription chart.

I would not necessarily expect the administration of this drug to have been entered onto the clinical notes although it would be good practise to do so. In my opinion this was the correct drug to be given for the reported behaviour displayed by Mrs DEVINE. The dosage given at that time in my opinion was low.

'* On treatment for urinary tract infection - mid stream specimen sent because blood and protein in urine'.

This information would have also been gleaned from reports (verbal) made to me by staff and also from Mrs DEVINE's medical notes that since I had last seen Mrs DEVINE on 1/11/99 (01/11/1999) a mid stream urine specimen had been taken from Mrs DEVINE which had been subjected to a 'Dipstix' check which had shown the presence of blood and protein in Mrs DEVINE's urine. This is a simple test carried out by the nursing staff which involves the use of a reactive strip which indicates the presence of blood and protein within urine.
Having identified this presence the staff have then sent Mrs DEVINE's mid stream urine sample for further examination to the Microbiology Laboratory at St Mary's Hospital.

The nursing staff could have carried out this test and submission of the sample on their own initiative or on the instruction of the Clinical Assistant, Dr BARTON.

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It appears that there was concern regarding Mrs DEVINE having developed a urinary tract infection and that steps had been taken to treat this.
It would have been best practise that a note of this had been made on Mrs DEVINE's clinical notes recording the start of any new treatment.

Beside this entry on the notes, I have entered an asterisk.

This indicates to me that at the time of making this entry I had questioned the staff, as to the result of the urine sample being sent to St Mary's Hospital for examination.

Later in the note made by me on 15/11/99 (15/11/1999) the following appears:
(*MSU - no growth).

This indicates that whilst still engaged in my examination and/or making my note of the examination of Mrs DEVINE the result of the mid stream urine samples examination by the laboratory at St Mary's had been obtained and that it showed:
'- no growth'.

Which indicated to me that there was no infection in Mrs DEVINE's urine.

'On examination pulse rate 100 per minute and regular, temperature 36.4°C'
On examination is a note by me that indicates that I carried out a physical examination of Mrs DEVINE.

A pulse rate of 100 per minute and regular would be regarded on the 'upper limit' of normal. The normal pulse rate being 60 to 100 per minute.

A pulse rate of 100 per minute and regular would not cause any undue concern.

A temperature of 36.4°C would be regarded as normal, normal temperature range being 35 to 37°C.

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'Jugular venous pulse not seen. Hepato- jugular reflux negative'
This indicates that when examining Mrs DEVINE's jugular veins in her neck I saw that they were not distended (sticking out) and that the pulse in the vein was not visible.

When I applied pressure to Mrs DEVINE's liver this also failed to produce any neck vein distension.

Applying pressure to the liver is to cause the increased return of blood to the heart. At this stage Mrs DEVINE's veins remained undistended which indicated to me the absence of heart failure in Mrs DEVINE's case.

'Oedema - gross extending to thighs'
This means that on examination of Mrs DEVINE I found that her legs were very badly swollen to the thighs due to fluid retention. This condition can be caused by heart failure or renal failure and is also a symptom of other conditions. The above examinations were carried out in order to eliminate heart failure as a cause of Mrs DEVINE's very bad 'oedema'.

'Heart sounds - nil added'
This indicates that I listened to Mrs DEVINE's heart sounds and found them to be normal, with no murmurs or abnormal beats.

'Chest clear'
This is a note that during the course of my examination of Mrs DEVINE I listened to her chest and found her breathing sounds to be normal.

Both these examinations gave no indication of any significant chest or heart problems.

'Bowels regular - rectal examination on 13/11/99 (13/11/1999) revealed rectum empty but good bowel action since'.

This would have been reported verbally to me by the nursing staff as a result of enquiries made by me regarding Mrs DEVINE's bowel movements and formed part of my investigation into Mrs DEVINE's increased aggression and confused state.
The nursing staff would be expected to carry out a rectal examination of a patient if a period of time had elapsed without a patient having any significant bowel movement (passing of solid waste). It was reported to me by the nursing staff that such an examination had been carried out by them on 13th November 1999 (13/11/1999) and that the result of that examination showed that Mrs DEVINE's bowel was empty.
This was an indication that Mrs DEVINE was very unlikely at this time to be suffering from constipation.

The further note of 'But good bowel action since' is a result of further reports by the nursing staff that since their rectal examination on 13th November 1999 (13/11/1999) it had been noted that Mrs DEVINE had passed solid waste normally. This provided a further indication that she was not suffering from being constipated.

Constipation can be a cause of increased 'confusion, aggression and anxiety in an elderly patient'.

The final note made by me on Mrs DEVINE's clinical notes (after the mid stream urine result) was:

'Ask Doctor LUSZNAT to see'.
This note is an instruction that Mrs DEVINE be referred to Doctor R M LUSZNAT. I believe that this doctor's initials (RM) stand for Rose Marie but I'm not sure of this. She is however known as 'Rosie'. Dr LUSZNAT is a Consultant in 'Old Age Psychiatry'.

Due to Mrs DEVINE's increasingly, 'confused', 'aggressive' and 'restless' condition and having found 'no apparent' physical reason for this from my physical examination of Mrs DEVINE I have written the instruction:

'Ask Doctor LUSZNAT to see'
This instruction would be for Dr Jane BARTON or the doctor covering her responsibilities to carry out.

The next note on this same document (exhibit BJC/16/PG154&155) is dated 16th November 1999 (16/11/1999) the note begins 'Dear Rosie' and ends with the words 'Can you help? Many thanks' this note is then signed. I recognise the writing and the signature of this note to be that of Dr Jane BARTON. This indicates to me that the notes of my examination of Elsie DEVINE on Monday 15th November 1999 (15/11/1999) made during my weekly ward round of 'Dryad Ward', Gosport War Memorial Hospital have been read by Dr Jane BARTON and a referral has been made to Dr LUSZNAT as instructed.

I have been shown a document bearing the exhibit reference of BJC/16/PG156&157. This is the next page of the 'clinical notes' of 'Elsie DEVINE'.

The first note on this document (page 156) APPEARS to be dated 18th November 1999 (18/11/1999) and is headed 'Elderly Mental Health'. This note appears to have been signed off by a 'a locum staff psychiatrist'. This indicates to me that Elsie DEVINE was seen by someone from Dr LUSZNAT's team on 18th November 1999 (18/11/1999) following my instruction of 15th November 1999 (15/11/1999).

My next ward round of 'Dryad Ward', Gosport War Memorial Hospital would have been on Monday 22nd November 1999 (22/11/1999). From my examination of exhibit BJC/16/PG156&157 I note that Mrs Elsie DEVINE died at some time during the evening of Sunday 21st November 1999 (21/11/1999).

It appears from the 'clinical notes' that I had no further dealings in the care of Elsie DEVINE after Monday 15th November 1999 (15/11/1999).

I have been asked to comment on the lack of notes made on the 'clinical notes' between the following dates:

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21/10/99 (21/10/1999) note - Dr BARTON on admission (exhibit BJC/16/PG/154&155) and 25/10/99 (25/10/1999) my note -ward round, Dryad Ward (exhibit BJC/16/PG/154&155) and 1/11/99 (01/1//1999) my note - ward round, Dryad Ward (exhibit BJC/16/PG/154&155) and 15/11/99 (15/11/1999) my note - ward round, Dryad Ward (exhibit BJC/16/PG/154&155).

As previously stated if there is 'no marked' change in a patient's 'condition', 'treatment' or management then I would not expect an entry to be made on a patients medical notes.

Between 21st October 1999 (21/10/1999) and 25th October 1999 (25/10/1999) there appears to be no marked change in the condition, treatment or management of Elsie DEVINE. Therefore I would not necessarily expect any note to be made.

Between 25th October 1999 (25/10/1999) and 1st November 1999 (01/11/1999) other than Mrs DEVINE appearing to be slightly more 'confused' there again appears to be NO marked change in Mrs DEVINE's condition and management., The drug 'Amiloride' was prescribed that day and was first administered on 2nd November 1999 (02/11/1999). I am unable to recall if I discussed the prescription of this drug with Dr BARTON.
It would have been 'best practice' for an entry to have been made on Mrs DEVINE's clinical notes.

Between 1st November 1999 (01/11/1999) and 15th November 1999 (15/11/1999) a period of 14 days no entry has been made on the 'clinical notes'. During this period I took a period of leave which included my weekly ward round which would have been due on Monday 8th November 1999 (08/11/1999). I am unable to say if this responsibility was covered by another consultant in my absence.

However, as previously stated, had the 'Clinical Assistant' required any 'consultant input' regarding a patients treatment or management then I would expect the 'Clinical Assistant' to contact the Elderly Medicine Office at the Queen Alexandra Hospital and a note to be made on the patients 'clinical notes'.

Signed: Code A

Signature Witnessed by: Code A

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From my review of the 'clinical notes' and 'prescription sheets' of Elsie DEVINE for the period of 1st November 1999 (01/11/1999) and 15th November 1999 (15/11/999) it appears that Mrs DEVINE's condition and treatment had undergone a 'marked change'.

On 11th November 1999 (11/11/1999) Mrs DEVINE began a course of the antibiotic Trimethoprim for 5 days to treat a urinary tract infection.

In the early hours of the morning of 11th November 1999 (11/11/1999) at 0115 hours Mrs DEVINE was administered one 10mg 'Temazepam' tablet.

On 11th November 1999 (11/11/1999) Dr BARTON prescribed on an 'as required basis' the drug 'Thioridazine', a drug used in the treatment of 'agitation', 'restlessness' and 'confusion' which has a sedating and tranquilizing effect.

'Thioridazine' was first administered at 0830 hours on 11th November 1999 (11/11/1999) (see further statement).

Whilst in my opinion, the prescription of both 'Trimethoprim' and 'Thioridazine' in the case of Elsie DEVINE and the above drugs administration to her was wholly appropriate, at that time, I would have expected a note to have been made on Elsie DEVINE's 'clinical notes' regarding this. It would have been 'Best Practice' to do this as clearly on 11th November 1999 (11/11/1999) there had been a 'marked change' in Mrs Elsie DEVINE's 'condition', 'treatment' and 'management'.

The treatment of the 'urinary tract infection' and the administering of the drug 'Thioridazine' are both mentioned in my 'ward round' note of 15th November 1999 (15/11/1999).

My next ward round of Dryad Ward, Gosport War Memorial Hospital would have been during the afternoon of Monday 22nd November 1999 (22/11/1999).

Mrs DEVINE died during the evening of Sunday 21st November 1999 (21/11/1999). Having seen Mrs DEVINE on three occasions I am almost certain that I would have enquired as to her whereabouts on my subsequent visit to Dryad Ward.

This is mainly because the 'turnover' of patients on 'Dryad Ward' was relatively low and therefore I could usually remember from the previous week which patients had been there. In addition when last seen by me Mrs DEVINE had been 'very agitated' and I had made a full note on her 'clinical notes' which included an instruction for her to be seen by Dr LUSZNAT.

I would normally make an enquiry of Dr BARTON and/or the nursing staff as to what had happened to any patient I noticed was no longer on the ward.

There would not normally be any requirement for me to take any further action after the death of a patient, unless there were suspicious or unexplained circumstances or that the death required discussion with the 'Coroner'.

I do not recall there being any such discussion of any concern regarding the death of Elsie DEVINE at the time.

I have been asked what contact I have had with Mrs Elsie DEVINE's family since Mrs DEVINE's death on 21st November 1999 (21/11/1999).

I am unable to remember the specific dates but I do recall that Mrs DEVINE's daughter, Mrs Anne REAVES made a formal complaint regarding her mother's treatment. This complaint resulted in two or three meetings taking place with Fiona CAMERON from either the Portsmouth Health Care Trust or Fareham and Gosport Primary Care Trust. I believe on one or more occasions Mrs DEVINE's grand daughter (Mrs REAVES daughter) was also present.

I recall that at times Mrs REAVES was angry and had a number of legitimate complaints/concerns regarding poor communication between Gosport War Memorial Hospital and herself, despite her having made it very clear at the time that she wished to be kept fully

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informed of her mother's condition. This it appeared had not been done until a late stage.

Mrs REAVES was concerned regarding her mother's treatment and I recall spending a long time going through the whole medical picture, concerning her mother, with Mrs REAVES trying to explain fully the circumstances leading up to her mother's death.

I recall that one of Mrs REAVES questions was:-
"Was it Dr BARTON's decision alone to terminate my mother's life?"

I recall that Mrs REAVES was very upset by her perception of Dr BARTON's attitude and by Dr BARTON's explanation of what was happening in the last few days of her mother's life.

It was apparent to me as a result of the first meeting I had with Mrs REAVES, after her mother's death that Mrs REAVES intensely disliked Dr BARTON.

I felt that as a result of my meetings with Mrs REAVES on the two or three occasions in May or June 2000 that I developed a 'rapport' with Mrs REAVES which at one stage led to her making a comment that indicated that she felt her concerns would have been addressed had she had myself to deal with at that time, as opposed to Dr BARTON and that this would possibly have negated the need for her to make any complaint. It was unusual for me to have any involvement on any level with relatives, after the death of a patient, unless requested by the relatives. Had Mrs REAVES or any relative asked to see me at any stage then I would have seen them.

I am aware that there were other issues raised by Mrs REAVES concerning her mother's treatment, medication and care. However I am not able to recall these in any detail without access to the minutes of these meetings.

Taken by Code A

Signed: Code A

Signature Witnessed by: Code A