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: ASBRIDGE, MARTIN SCOTT

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

This statement (consisting of 5 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: Martin ASBRIDGE Date: 03/11/2004

I am a practising General Practitioner at the Bridgemary Medical Centre, Gosport . I have been so employed as a GP at this practice since May 1989.

As a GP I had qualified as BMBCh Bachelor of Medicine, Bachelor of Surgery. I obtained these qualifications in August 1984.

From August 1984 to February 1985 I was pre registration house officer in surgery at John Radcliffe House situated in Oxford. From February 1985 to July 1985 I was pre registration house officer in General Medicine at Poole General Hospital.

I obtained full registration with the General Medical Council in July 1985.

My registration number is 2952044.

From October 1985 until February 1986 I was the Senior House Officer in Casualty Department also at Poole General Hospital.

From March 1986 until February 1989 I was a Senior House Officer on the Bournemouth and Poole Vocational Training Scheme for General Practice.

A General Practitioner deals with the day to day care of ill health.

The catchment area for this surgery is the PO12 and PO13 post code areas.

I am employed by the Gosport and Fareham Primary Care Trust.

I have been asked to detail my involvement with the care of the late Code A.

Although Mr Code A was not registered with me but with my partner I was his general medical practitioner from May 1989.

I remember Mr Code A as I saw him frequently in the surgery.

Mr Code A suffered from a chronic depressive illness which necessitated him being on anti depressant medication on a long term and continual basis.

A review of his General Practical Medical notes show that he had suffered from depression at least since 1962. Despite him being on medication for depression his mental condition deteriorated from time to time necessitating hospital admissions.

The GP medical notes show that Mr Code A was admitted to Knowle Hospital for in patient treatment on (8) eight occasions during the period 1967 to 1992.

Following hospital admission in April 1992 Mr Code A was discharged to Hazledene Rest Home as his wife felt that she could no longer cope with him at home.

She thought that he had always been a selfish and obsessional person and she had had enough of him.

He was admitted to Hazledene Rest Home in January 1993.

During the 9 months that Mr Code A was an in patient at Knowle Hospital he had 30 (ECT) Electro Convulsive Therapy treatments without any change of his mental state. There were numerous changes in his medication and he was finally discharged on six (6) different types of

psycho copic medication.

Despite this medication Mr Code A 's agitation remained to a certain extent.

In March 1993 Mr Code A was reviewed by Doctor BANKS , her medical team together with Mr and Mrs Code A

Because he remained anxious and depressed it was agreed that he should remain at the rest home with regular review by the community psychiatric nurse (CPN).

He was assessed by Dr BANKS Consultant Psychiatrist on the 26th May 1993 (26/05/21993) when she wanted to try a change in the medication he was receiving. To this end he was again admitted to Knowle Hospital between the 21st June 1993 (21/06/1993) and the 9th July that year.

During this admission the notes states that he seemed to settle well with the new drug regime and appeared less agitated and restless.

On the 3/9/93 (03/09/1993) I visited Mr Code A after he had fallen in the rest home. He had received a soft tissue back injury which required no treatment.

On the 25/9/93 (25/09/1993) Mr Code A was seen by Dr BANKS who at that time recommended no change in his medication.

On the 18/11/93 (18/11/1993) I visited Mr Code A at Hazledene Rest Home when he received treatment for a rash on his groin.

He was next seen by Dr BANKS and her medical team on the 25/4/1994 (25/04/1994) again she found him anxious and depressed but recommended no change in his medication.

In August 1994 he was again reviewed by Dr BANKS who found him chronically depressed

and again made no changes.

On the 11/10/94 (11/10/1994) Mr Code A was given a flu jab by a colleague from this practice.

Mr Code A was assessed in January 1995 when it was felt that his mental state was deteriorating and new medication was introduced by a locum consultant in old age psychiatry.

He was seen again in Feb and March 1995 but with little change in his mental state.

On the 18th August 1995 (18/03/1995) I was asked to assess Mr Code A by the Hazledene Rest Home staff because of concern about a slow deterioration in his general condition. A physical examination of him showed no abnormalities.

Blood tests were taken at this time which subsequently proved to be normal.

A review of the correspondence in his medical notes shows that he was admitted informally by Dr BANKS to the Mulberry A Ward on the 14/9/1995 (14/09/1995).

According to the notes Mr Code A was discharged on the 24/10/1995 back to Hazledene Rest Home.

During this admission he appeared to improve.

I had no further dealings with Mr Code A after my visit on the 18/8/1995 (18/08/1995).

To summarise Mr Code A's condition he had a chronic intractable depression for which he received continual treatment.

It was apparent in the 5 months before Mr Code A died that his physical condition had also begun to deteriorate.

RESTRICTED

Taken by:DC Code A

Signed: Martin ASBRIDGE

Signature Witnessed by: