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: BANKS, VICTORIA ANNE

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

This statement (consisting of 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: V BANKS Date: 04/02/2005

I am employed by the Hampshire Partnership Trust as a Consultant in old age psychiatry at the Moorgreen Hospital, Botley Road, West End, Southampton. I have held this position since November 2002.

In 1981 I graduated from St Georges Hospital, University of London. I obtained an MBBS which is a Batchelor of Medicine and Surgery.

From August 1981 to February 1982 I was employed as a house officer at St James Hospital, Balham, London.

Between February 1982 and August 1982 I was a house officer in Urology and Orthopaedics at the Mayday Hospital in Croydon.

From September 1982 to January 1983 I worked primarily as a locum in geriatrics. I have GP training experience including posts in Orthopaedics, Psychiatry, Radiotherapy, Obstetrics and Gynaecology.

I also completed a year in General Practice at the Park Lane Practice, Stubbington and Manor Way, Lee-on-Solent.

Between March 1986 and December 1986 I was employed as a Senior House Officer in Psychiatry at the District General Hospital in New Zealand.

From March 1987 I was employed as a Senior House Officer and Registrar Rotation in Psychiatry.

Between August 1989 and May 1992 I was employed at Bristol as a Senior Registrar Rotation which included a period as a lecturer in old age psychiatry.
From May 1992 until October 2002 I worked as the consultant in old age psychiatry for the Gosport catchment area.

Between May 1992 and March 1995 I was based at Knowle Hospital. During this time there was a reprovisioning of the old age psychiatry services to the newly built Mulberry Ward at the Gosport War Memorial Hospital .

The majority of the in-patient services were transferred to the Mulberry Ward.

From January 2000 I was associate head consultant for the Fareham and Gosport locality.

My General Medical Council Registration Number is Code A. I am registered with the Medical Defence Union register number Code A.

In 1986 I became a member of the Royal College General Practitioners.

In 1989 I became a member of the Royal College of Psychiatrists.

In 2004 I was accepted into the Fellowship of the Royal of Psychiatrists.

Whilst I was the consultant at the Mulberry A Ward at the Gosport War Memorial Hospital I also ran the Phoenix Day Unit at the hospital. This was for assessment and treatment of mental illness for patients living in the community of Gosport and Lee-on-Solent.

Mulberry A Ward was a short term functional assessment treatment ward for elderly patients over 65 suffering primarily with depression.

Mulberry A Ward consisted on average of 12 beds.

I was one of 3 consultant psychiatrists who had responsibility for patients on this ward.

I was responsible for patients from the catchment area of Gosport and Lee-on-Solent.

At that time working on the ward would be one or possibly two psychiatrists Senior House Officers (SHO) working on rotation as part of the Solent SHO training scheme in psychiatry. Mulberry Ward was also covered by a part time clinical assistant, Dr W MUNRO .

There would normally be two trained Royal Mental Nurses (RMN) who were not necessarily RGN qualified. The nursing staff would be supported by auxiliary nurses. There would be a Senior RMN on duty on most occasions.

I would only physically attend Mulberry A Ward approximately twice a week.

Also attached to the ward would be an occupational therapist. Their role was primarily assisting in the assessment and management plan of the patients.

I normally worked between 9am (0900) and 5pm (1700) during this period I was on call to manage psychiatric patients.

In 1996 I would conduct a ward round at Mulberry A Ward accompanied by the clinical team which comprised of a junior doctor, trained nursing staff, community psychiatric nurse, social worker, occupational therapist and physiotherapist. The clinical team would discuss each patients case in the staff room on the ward.

At this time there was a local GP practice who covered out of house calls for patients with physical problems on Mulberry A Ward.

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Psychiatric problems for the patients were managed by the on call psychiatry service between 5pm (1700) and 9am (0900) and weekends. I have been shown the photocopy of a microfiche exhibit JBC71 which are the medical/nursing notes relating to Code A .

I do remember Mr Code A he was a very chronically depressed man. Mentally frail, ie, in terms of his ability to cope with life.

I do recollect visiting Mr Code A at his home address. However I do not have the records relating to these home visits to refer to.

I have been shown page 10 of exhibit BJC/71 which is a copy of the letter written by Dr LORD which is a referral initiated by myself relating to Mr Code A .

I have been shown a photocopy of the microfiche dated 13/12/95 (13/12/1995) which are the medical notes for Mulberry Ward A detailing the admission of the patient Code A they are as follows.

Admission 13/12/95 (13/12/1995) - admitted by Dr BAYLY , my registrar at this time. I was not present at the time of admission.

'Informal admission' - Mr Code A was willing to come into hospital.
'PC' - Presenting complaint.
"Everything is horrible" this is the patient's actual statement to Dr BAYLY.
'From R/H - Rest Home
'Verbally aggressive to wife and staff' - My interpretation of this entry is that the patient was shouting, swearing, raising his voice.
'Staying in bed' - this is a symptom of his low mood.
'Not mobilising' - he is not initiating activities of daily living.
'Constipated' - self explanatory.
'Not eating well' again self explanatory.
Sleep - Mr Code A states "Alright".

No DVM - translated this means Diurnal Variation in Mood - this is a symptom of depression.

"Feels bad all the time" as stated by Mr Code A.

"Hopeless and suicidal".

The above entry by Dr BAYLY are a précis of Mr Code A s presentation re his feelings.

PPH = past psychiatric history

Chronic Depression

Previous ECT course (Electro Convulsive Therapy)

Chronic Depression means patient has a substantial history of persistent depression with acute exacerbation. This patient has suffered with depression since his 50's, ie, for 30 years.

PMH = Past Medical History

Hypothyroid = Under active Thyroid Gland

Constipation

DH = Drug History

Mag Hydrox Codenthrusate - both are laxatives which have been administered to treat his constipation.

Sertraline 100mg ON - an anti depressant drug given orally (in this instance at night).

Lithium CO3 400mg ON ON = at night Lithium Carbonate. This is a mood stabiliser which is also a treatment for depression.

Diazepam 10mg bd = twice daily - this drug is used for treating symptoms of anxiety.

Thioridazine 50mgs QDS = 4 times a day - this drug is an anti-psychotic used in the treatment of depression, agitation and anxiety.

Temazepam 10mg ON. This drug is given to assist in sleeping at night.

Thyroxine 50 micro grams marne = in the morning.

Background - see previous notes. This indicates that the patient has been admitted on previous occasions which will include family background, upbringing and work history.

The drug history as detailed would have been the same as on his previous admission to

Mulberry A Ward from the 14/9/95 (14/09/1995) to 24/10/95 (24/10/1995), ie, he would have been maintained on this regime between admissions.

MSE = Mental State Examination

A+b = Appearance & Behaviour - withdrawn, monosyllabic (ie speaks only odd words), unwilling to move or mobilise. Seems a little agitated and irritable.

Speech - indistinct, quiet, nil spontaneous except one statement.

Mood "I might as well tell you I just want to be dead". This reinforces that Mr Code A was depressed and has thought about overdosing.

Thoughts (Mr Code A 's form and structure).

"No hallu" = hallucinations, delu = delusions - these are severe psychotic symptoms of depression.

Insight, ie, someone's understanding of their illness.

"I'm a wreck, I might as well be dead".

Physical - full rectum, ie an examination of the patient's rectum has revealed his passage was full of stools which could be a reflection of his constipation.

P80 reg - Pulse 80 reflection of heart rate - in this case showing it is regular.

HS1-11 - heart sound 1st and 2nd nothing abnormal noted.

Shuffling gait - this normally indicates that a person walks with very small steps, does not lift feet off the ground.

2 mobilise - ie, that it takes 2 nurses/members of staff to get Mr Code A out of a chair or bed.

Slight tremor on moving - I believe this refers to Mr Code A 's hands slightly shaking.

Ä = Diagnosis. Depressed.

The following is the care plan and investigation initiated by Dr BAYLY.

ECT discussed - no decision, ie, Mr Code A was not sure that he wanted this course of therapy.

Bisocodyl suppositories - a laxative inserted into the back passage.

Check [LI] - check Lithium - this means to check that he is on an effective dose of Lithium.

U&E = Urea & Electrolytes - this means check with blood tests to establish levels are normal or otherwise.

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Recent = means tests completed TFT, LFT & FBC normal.

TFT - thyroid function test ie, that he is receiving adequate thyroid replacement.

LFT = Liver function test

FBC = Full blood count - checks were made to ascertain if he was anaemic.

D/W = discussed with Dr BANKS , this indicates that Dr BAYLY would have either phoned me or spoken to me in my office at Gosport War Memorial Hospital regarding Mr Code A 's admission, treatment and care plan.

+further info from R/H = further information available from the rest home.

15/12/95 (15/12/1995) - asked to see - fell yesterday evening no injury noted, not any pain except back pain this am - physio will assess long standing mobility problems - ?2° to OA this means secondary to Osteoarthritis which is a degenerative joint disorder.

Try PRN = Paracetamol, ie, as required.

With reference to the above entry I am unable to identify which doctor made this entry.

20/12/95 (20/12/1995)

Bowels → loose stools 5 days

? diahorrea

? overflow

This would indicate that the bowels of Mr Code A were very full of hard stools with liquid stools bypassing the hard stools.

Abdo = abdominal examination of the middle torso

Soft = non tender. BS - Bowel sounds normal

PR = Rectal examination empty

→ = plan for Mr Code A . AXR = abdominal x-ray which in this case have been seen showing the bowel is empty.

→ = for reporting.

Stop aperients - stop laxatives.

This entry has been signed by Dr BAYLY.

20/12/95 (20/12/1995) WR = Ward Round by Dr DAOUD (a specialist registrar). This indicates that I was not present at the hospital at this time.

Mobility ↓↓- this indicates that it has reduced, is poor.

V. Parkinson features - this indicates that the patient is stiff has a shuffling gait and tremors.

Low +++ = very depressed

↓ = decrease Thioridazine to 25mg QDS - 4 x a day

+PRN = as required.

Procycladine 5mg BD = 2 x a day - review Friday.

?↑ = increase Sertraline next week.

This entry has been signed by Dr BAYLY.

22/12/95 (22/12/1995)

Diahorrea x 1 this morning

Generally weak today.

Left basal crepidations = abnormal noises in the bottom left had side of the chest.

Chest Infection

Plan - Encourage oral fluids - no solid food yet.

Enythromycin suspense = antibiotic in fluid which is the treatment for his chest infection.

250mgs TDS = 3 x a day.

This entry signed by W P MUNRO (a part time clinical assistant at the time of this entry).

27/12/95 (27/12/1995) W R by Dr BANKS

Chesty - sounds noisy coughing sputum

Poorly = unwell, abusive (to staff and family).

Not himself at all.

→ plant, chest physio, sputum sample. Enythromycin finished → for cefactor = a different variety of antibiotic to treat the chest infection.

STOP procycladene until well.

Reassess mood once medically better.

Also ? further INX - investigation of bowel. This means there may be an underlying problem

with Mr Code A 's bowels which may need further investigation and treatment.

Catheterised end of last week by on call GP as in urinary retention = on call GP attended and inserted a tube into Mr Code A 's penis in order that he can relieve himself.

Geriatrician review may be helpful.

CXRV = chest x-ray form has been organised.

This entry has been signed by Dr BAYLY.

27/12/95 (27/12/1995)

Physio = Physiotherapist has attended.

Thank you for this referral - obs = observations, BS = throughout = has listened to Mr Code A 's chest.

↓ (L) = left, LZ = indicates reduced breath sound to the left lower zone of chest - few scattered coarse inspiratory crackles = added noises indicating a possible infection.

RXACBTS = Active cycle breathing treatment.

- ↓° expectorated = no sputum produced.

Post drainage shown to N/S, ie, nursing staff shown how to move/shift the patient in order to move the sputum.

RV Marne =review morning.

This entry was written by an unknown physiotherapist.

2/1/96 (02/01/1996) - remaining poorly and lethargic.

Reports of him saying "Why don't you let me die".

Skin breaking down - Pegasus bed = a specially designed very expensive bed designed to alleviate pressure on the skin.

V. Poorly - I interpret that Mr Code A was very frail, very unwell. The chances of recovery are becoming increasingly unlikely.

FBC √ = rechecking blood tests.

U&E √ = (LI) + TFT = all tests to be arranged again.

Geriatrician review to make sure not medical problem - which translated means an examination

by a geriatrician has been requested.

This entry has been signed by Dr BAYLY.

The following entry is written also by Dr BAYLY.

2/1/96 (02/01/1996) - Dear Dr LORD

Thank you for seeing Les who has been treated for many years for resistant depression. On this admission his mobility initially deteriorated drastically and then he developed a chest infection. His chest infection is now clearing but he remains bed bound, expressing the wish to just die. This may well be secondary to his depression but we would be grateful for any suggestion as to how to improve his physical health.

Thanks Rosie.

(PS He also complains of some abdo pain intermittently which I thought may have been constipation but an AXR showed his bowels to be very empty so his aperients were stopped. Unfortunately he still has pain intermittently).

3/1/96 (03/01/1996) W R Dr BANKS

Poor food intake, fluid ok

Deteriorating, some breaks in skin now.

? fit for ETC - may not agree to it? Would it work.

→ (means go to) fortisips (a high calorie drink) plus high protein diet.

Await EC - elderly care review.

Needs more time to convalesce. ↓ = decrease Diazepam. Stop Thioridizine + Temazepam.

Watch for benzodiazepine withdrawal - this means that Mr Code A has been on both these drugs for some considerable time and stopping them can cause an unpleasant, distressing withdrawal symptom.

Probably will need NH - nursing home.

This entry has been written and signed by Dr BAYLY.

The following entry relates to blood test results.

GLU 4.3 = a normal reading.

U = Urea -7.2 PO4 1.05 AST 127

Na = (Sodium) 137 Ca (Calcium) 2.21 (2.45) adjusted calcium Alk 110 K = (Potassium) 4.8

Bili (bili Rubin) 9 Cr (Creatine) 91 Alb = (Albumin) 27 T.Pro 57.

I am unable to state who wrote this entry.

These readings obtained from the blood test results are indicators of bodily function.

Noticeably the albumin scored at 27 is low which is a reflection of his poor dietary intake.

The next entry dated the 4/1/96 (04/01/1996) is the examination and assessment of Code A Code A by the consultant geriatrician Dr LORD, which reflects the entries as previously shown in the patients medical notes.

4/1/96 (04/01/1996) Elderly Medicine

Thank you. Frail 82 year old with

1.Chronic Resistant Depression - very withdrawn

2.Completely dependent - bartel 0

3.Catheter by passing

4.Ulcertaion (superficial) of (L) buttock and hip

5.Hyproproteinaemic

Suggest

1.High protein drinks

2.Bladder wash outs x 2/wk, ie twice a week

3.Catheter by passing, ie, the urine is going down the inside and outside of the tube from the bladder.

4.I'd be happy to take him over to a L/sty bed at GWMH.

I feel his RH place can be given up as he's unlikely to return there.

(This entry signed by Dr Alhela LORD - geriatrician).

In this letter by Dr LORD I believe she has summarised Mr Code A 's severe mental illness and has recognised that he has been physically unwell with a chest infection.

Dr LORD has identified that Mr Code A is entirely dependent on nursing staff for his activities of daily living (ADL).

She has summarised his poor physical condition which outweighs his mental condition. Therefore she has suggested that Mr Code A should be transferred to Dryad Ward which could manage his physical state more appropriately.

She has given guidelines as to his management.

The letter also notes that Mrs Code A has been made aware of her husband's frailty and poor outlook, ie, that he may not survive to leave the hospital.

Mr Code A was transferred to Dryad Ward on the 5/1/96 (05/01/1996).
I had no further dealings with Mr Code A.

At this time in 1996 the policy and procedure in respect of entries in the clinical notes written by doctors were completed/recorded when the patient was reviewed on or shortly after a ward round. There would be timely entries detailing the review of the relevant problems which had been noted and discussed by the clinical team in relation to each patient.

These entries would summarise current medical, physical and psychiatric problems.

Other entries would be initiated as part of a planned review by medical staff including physiotherapists or at the request of other members of the clinical team, ie, nursing staff or at the request of the patient or relatives.

Entries into the clinical notes are only made where necessary and relevant.

There is no set format for entries written into the clinical notes.

There are no entries in the clinical notes over the weekends as there were no resident doctors at that time.

I have previously been consultant for the treatment of Mr Code A 's mental health illness since I started as a consultant in 1992. I was aware that Mr Code A had suffered from a chronic resistive depression since the early 1960's.

In my role as a consultant psychiatrist I monitored Mr Code A 's illness with other members of my community mental health team primarily his CPN (Community Psychiatric Nurse) a Mr John ALLEN and his social worker Jacqui YOUNG
This was undertaken whilst Mr Code A was resident at Hazledene Rest Home, Bury Road, Gosport . He was monitored on a regular basis by the mental health team whilst he was at the rest home this was between 1993 and 1995. From researching the medial notes I am able to state that Mr Code A was admitted to Alverstoke Ward on the 27/4/92 (27/04/1992) and discharged on 3/2/93 (03/02/1993) at Knowle Hospital and again on the 21/6/93 (21/06/1993) until the 9/7/93 (09/07/1993) when he was discharged back to Hazledene Rest Home.

He was again admitted on the 14/9/95 (14/09/1995) to the Mulberry Ward at Gosport War Memorial Hospital for assessment and treatment for his chronic depression. He was discharged on the 24/10/95 (24/10/1995).

Mr Code A was again admitted on the 13/12/95 (13/12/1995) on an informal basis to the Mulberry Ward at the Gosport War Memorial for further treatment and assessment for his chronic resistant depression.

On the 5/1/96 (05/01/1996) Mr Code A was transferred to the Dryad Ward as previously mentioned.

Where it is written on Mr Code A 's notes that geriatricians advice would be helpful, it had been agreed by the team review that his physical state was very poor. It was therefore decided to request examination of Mr Code A by a geriatrician in order that his physical state could

be reviewed. This was done promptly by Dr LORD.

In the event that a patient on Mulberry Ward was expected to die then the process that was undertaken at that time as far as I can recall is as follows.

If there were concerns about someone's physical health and there was a possibility of the patient dying then a member of the medical team would meet with the family or discuss over the phone with the family the patient's poor prognosis.

Once it had been established with the family that the patient was expected to die.
The next step would be a formal 'sick noting' of the patient. This was a form written by a nurse or a ward doctor giving a brief outline of a patient's very poor physical state or poor prognosis. A copy was given to the relatives and a copy was pinned to the front of the patient's notes.

If the patient subsequently died then it was the procedure for qualified nursing staff to verify the death.