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: BEADLES, WENDY IONA

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

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: W BEADLES Date: 22/04/2006

I am at present employed by Lothian NHS Trust as an Infectious Diseases Specialist Registrar and have been since November 2003.

I qualified as a doctor in 1997 gaining a BM (Bachelor Medicine) at Southampton University. Since then I have worked in numerous healthcare settings within general medicine and infectious diseases and produce my curriculum vitae as WIB/1.

In August 1999 I was employed by Queen Alexandra Hospital, Portsmouth NHS Trust as a Senior House Officer in General Medicine working within the general medicine and endocrine departments. As such I was responsible for admitting acute medical admission on a regular rotating basis. These were patients who would be assessed on the acute receiving ward or in the accident and emergency department, prior to possible admission to the ward. I would do the initial clerking and investigations required by the patient prior to them being admitted to the ward. A more senior member of the team would subsequently review the patient.

At that time my consultants were from the field of endocrinology and general medicine.

My GMC Number is 4422576.

I have been asked to detail my involvement in the care and treatment of Geoffrey PACKMAN. I have no personal recollection of this patient but from referral to his medical records (BJC/34) I can say that on the 6th August 1999 I made the following entry in Mr PACKMAN's notes on pages 44 and 45.

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6/8/99 67 yrs ♂

3pm (1500)

Admission via A&E

PC:- ↓mobility

HPC: - Obesity

- Bilateral lower leg oedema - ↑swelling legs over past 6/12/ Dopplers 1/52 ago - results not known

Ulcers on legs for 1/12 - L calf

- R calf - small ulcer

- ↑area erytherma in groin for 3/52. Now discomfort + in groin

- 1/52 - ↑weakness

- Now unable to mobilise

Lives with wife and daughter. Wife recently in patient for Ca breast (discharged home now).

District nurse visiting 3- x week for dressings to legs

Previous to 1/52 ago mobilised around home and occasionally outside with stick.

PMH:- Bilateral lower leg oedema - 5 years

Hypertension - dx 1985

Arthritis

DH:- Doxazosin 4mg OD

Bendroflurazide 5mg OD

Felzopipne 5mg OD

Allergies n/k

SE:- GU:- °Frequency °Dysuria

Poor stream +

GI:- Bowels open 1/7 ago - normal

RS:- °SOB, °cough

CVS:- °SOB °chest pain

SH: Lives with wife and daughter - see above

Non smoker

Usually limited mobility with stick

OE/Temp:37.6°c

Obese ++

°Palor °SOB

CVS pulse 80/min irregular HS Normal, °Added sounds

JVP - unable to assess BP 138/81

RS Trachea O

RR = 18/min

Unable to sit forward PN = Reasonate

Fine crackles mid zone anterior chest

GI Soft & non tender abdomen

°Mass °L °K °K °S BS - n

Erytherma ++ in groins L > R side / weeping clear fluid only

Nurses report:- Blistering on buttocks in shape toilet seat

°ulceration

Legs - Bilateral swelling +++ of legs L = R

°Pitting except in feet

L lower leg:- swollen ++ / erytherma ++ / unable to visualise ulcer

R lower leg:- Swollen + /°erytherma

Imp

Problems 1. Bilateral leg oedema

2. Cellulites groin + L lower leg

3. ↓ mobility due to obesity/oedema/infection
4. AF

P - Urinalysis/MSU
- FBC/U&E/Glucose/ESP/CRP/Blood culture
- C - xray
- ECG (Atrial fibrillation 85/min)
- Swabs from groin and ulcers
- Tilt bed - so can sit him up
- IV antibiotics
- ↑ Diuretics - change to Frusemide

W BEADLES (Signed)
SHO

This note is an initial clerking note whereby I took a medical history of Mr PACKMAN, examined him, assessed his problems and made a management plan.

I saw Mr PACKMAN at 3pm (1500) on 6/8/99. He was a 67 year old male (♂). He was an admission via the Accident and Emergency Department.

His presenting complaint (PC) was decreased (↓) mobility.

His history of presenting complaint HPC was

1. Obesity
2. Bilateral lower leg oedema - a build up of fluid causing increased swelling built up over a period of the past 6 months.

   He had had a venous Doppler's of his legs one week ago, the results of which I was not aware. This is a test to exclude deep vein thrombosis.

3. He had developed ulcers on his legs over a period of a month. He had one on his left calf and a small one on his right calf.
4. He had developed an area of erytherma (an area of redness and inflammation) in his groin over a period of three weeks. He was now reporting discomfort in his groin.
5. He was reporting a one week history of increased weakness in his legs meaning that he was unable to mobilise.

He lived with his wife and daughter. His wife had recently been an in-patient for the management of breast cancer, but had been discharged home.

The district nurse had been visiting their home three times a week to put dressings on his legs.

Up until one week before the admission he had been mobilising around the house and outside the house with a stick.

Past medical history (PMM): Bilateral lower leg oedema for 5 years, hypertension diagnosis in 1985 and arthritis.

Drug history (ie the drugs Mr PACKMAN was prescribed):
Doxazosin 4mg OD (once daily)
Bendroflurazide 5mg OD
Felodipine 5mg OD

These three drugs are used for hypertension, (high blood pressure) and Bendroflurazide is also a diuretic (water tablet).

Systematic Enquiry (SE): (these are questions that I have enquired from Mr PACKMAN as part of a routine enquiry to ensure that you don't miss anything).

Genitourinary: no frequency, no dysuria, poor urinary stream (common complaint).

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GI (Gastrointestinal): bowels open one week ago, normal.

RS Respiratory system - no shortness of breath or cough.

CVS Cardiovascular System - no shortness of breath, no chest pain.

I have record that Mr PACKMAN had no known drug allergies.

SH Social history - which is self explanatory

OE / on examination I found that his temperature was on the upper limit of normal at 37.6. He was obese and had no palor (he was a normal colour) and was not short of breath at rest.

Cardio Vascular System (CVS): His pulse was 80 per minute and irregular, his heart sounds were normal with no murmurs or added heart sounds. His blood pressure was 138/81. I was unable to assess his Julgular venous pressure (JVP) due to his obesity.

Respiratory system (RS): His trachea was central & his respiratory rate was 18 per minute.

I have only examined the front of his chest and not the rear, as I was unable to sit him forward.

The diagram indicates that on auscultation of his chest he had fine crackles at both his midzones. The percussion note (when you tap on the chest) was resonate, which is normal.

Gastro Intestinal (GI) examination was normal. He had a soft and non tender abdomen. He had no masses and I could not feel his liver, either of his kidneys or his spleen. He had normal bowel sounds.

Mr PACKMAN had erythema (redness and inflammation) in his groins, more on the left than on his right. His legs were weeping clear fluid.

Nurses reported that he had blistering on his buttocks in the shape of a toilet seat but no ulceration.

Legs: He has bilateral very marked swelling on both the right and left legs, left equal to right. No pitting except in his feet. Pitting is when you press the skin if the skin stays down that indicates fluid.

His left lower leg was swollen with marked erythema and I was unable to see an ulcer.

His right lower leg was swollen with no erythema.

Impression, (ie, what I think is going on)

1. Bilateral leg oedema
2. Cellulitis of the groin and left lower leg. Cellulitis is a soft skin/tissue infection.
3. Decrease mobility due to obesity, oedema and infection.
4. Atrial Fibrillation (AF)- this diagnosis is taken from an ECG. He had an irregular heartbeat but the rate was controlled.

Plan

Urinalysis (dip stick of the urine) and mid stream urine (MSU) are urine tests to look for infection of the urine.

FBC - full blood count

U&E - Urea and electrolytes & renal function

Glucose

ESR & CRP - these two tests are markers for inflammation and infection

Blood cultures - this is to look for blood stream infections

Chest x-ray - to look for fluid on the chest and infections in his chest

ECG (see above)

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Swabs from his groin and his ulcer again looking for bacteria pointing towards infection.

Tilt his bed so that we can sit him up so he could be further examined, to make him more comfortable and to help drain fluid.

IV intravenous antibiotic (page 174A) for his cellulitus. I prescribed Flucoxacillin (pg 174a), 1 gram four times daily and Benzylpenicillin 1.2 gram four times daily as per his prescription sheet.

Increase ↑ his diuretic - water tablets. I changed his Bendroflurazide to Frusemide 80mg. This was to assist in getting rid of the build up of fluid in his legs.

It appeared that Mr PACKMAN had a build up of fluid in his legs and a superimposed skin/soft tissue infection leading to his worsening mobility and subsequent hospitalisation. The plan was to treat the fluid build up with a stronger diuretic (Frusemide) & to clear up the infection with the IV antibiotics. This would hopefully enable his mobility to increase.