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: RAVINDRANE, ARUMUGAM

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

This statement (consisting of 11 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: A RAVINDRANE Date: 19/01/2006

I am Arumugan RAVINDRANE and employed as a Consultant Physician in Elderly Medicine by East Hampshire Primary Health Care Trust.

I have been employed in this position since 2nd January 2001.

Prior to this I was employed as a Specialist Registrar, working mainly in Southampton General and Queen Alexandra Hospitals , Hants.

I qualified as MBBS (Bachelor) in Medicine and Bachelor of Surgery, MD and have a Doctorate in Medicine and MRCP (UK) as a member of the Royal College of Physicians (UK) and qualified as a Registrar in December 1997. I had trained in India, coming to Britain in 1989 where I continued my medical training.

In order to become a Consultant Physician I trained as a Specialist Registrar from December 1997 to December 2000. I was accredited as a Specialist in General and Geriatric Medicine and by the Specialist Training Authority, part of the Joint Committee for Higher Medical Training.

In August 1999 I was employed at the Queen Alexandra Hospital, Portsmouth, Hants as a Registrar to Dr GRUNSTEIN .

My responsibilities were to act on the ward as his deputy.

On occasions I also acted as Registrar at the Gosport War Memorial Hospital , under the

Consultant, Dr REID . In this case I would work also with Dr Jane BARTON . My position was senior to hers.

I have been shown police exhibit BJC/34 , this being medical notes relating to Geoffrey PACKMAN b.15/4/31 and who died at GWMH on 3/9/99.

I have no recollection of this patient who, it appears, was admitted to the QAH on 6/8/99 with medical problems and transferred to GWMH on 27/8/99.

Mr PACKMAN suffered from obesity, decreased mobility, inflammation of the skin and underlying tissues (cellulitis) and slight kidney malfunction.

With reference to page 54 of the notes I confirm that this is my entry.

On 23/8/99 I saw Mr PACKMAN at GWMH, I conducted ward rounds, assessing patients condition and discussing this with medical and nursing staff. Dr BARTON may well have been with me on this occasion.

I believe that Mr PACKMAN was stabilised and transferred from Ann Ward, QAH, (elderly care) to GWMH for continuing care.

On page 54 I noted; 23/8/99
Problems
'1. Obesity'
'2. Arthritis bilat knees' (ie both arthritic)
'3. Immobility'
'4. Pressure sores'
'On high protein diet -
?Melaema 13/8/99 HB stable
Q15 - (ie albumen) 29 5. Constipated
On Doxasozin

MTS = very good (ie his mental test score)

No pain

Better in himself

No JVP (ie jugular vein pressure which would indicate heart failure)

CVS, ie, cardiovascular system was normal)

I noted he was obese.

His respiratory system was normal

PA means Per abdomen (ie he had a fat stomach)

I noted his legs were slightly oedematous ie, slightly swollen, due to fluid retention.

I note chronic skin changes, again due to fluid retention.

I asked for his blood to be rechecked on Friday.

I noted that his ulcers were dressed the day before and that his condition should be reviewed later in the week.

Meleama is black stool caused, usually, secondary to bleeding in the stomach, perhaps due to ulcers or strong pain killers like non steroids.

HB is haemoglobin. If the patient has bleeding this would be low however I noted it as stable.

As regards his albumen this was 29 which was slightly low.

As regards his MTS he had no mental problems.

Doxasozin is a drug which controls blood pressure.

With reference to page 74, this is a lifting/handling risk calculator in respect of the patient, for the benefit of nursing staff. This shows Mr PACKMAN to be over 8 stone, could stand but was unable to walk and would perhaps require a hoist to get Mr PACKMAN up.

Page 75 notes a Waterlow scale of 18 on 24/8/99 and 21 on 30/8/99. This indicates that the patient was obese, had broken skin, was 65 to 74 years old, had peripheral vascular disease, was continent, chair or bed bound and therefore classed as very high risk on 30/8/99 and high risk on 24/8/99. He had severe leg ulcers.

Mr PACKMAN was a high or very high risk patient as developing pressure sores due to his immobility.

Page 77 refers to the Barthel ADL index which indicates aspects of the patients well being.

I see that on 23 and 30/8/99 he was continent but on 1/9/99 incontinent of faeces. His bladder was incontinent on all three dates.

He required help with his personal grooming ie, cleaning of face and hair, teeth and shaving, on 30/8 and 1/9/99.

He was dependent upon his toilet needs on all three dates.

On 23 and 30/8/99 he was able to feed himself but on 1/9/99 was unable to do so.

He was unable or required the help of two people to transfer ie, move himself on all three dates.

He was immobile on all three dates.

He was able to dress with help on 23/8/99 but unable to do so on the latter two dates.

He was unable to climb stairs on all three dates and dependent on all three to bathe.

His scores were 6, 4 and 1 respectively showing a decline in his ability to look after himself over the period of eight days. On 23/8/99 he was also very dependent. This shows that Mr PACKMAN was unwell and immobile. There was very little prospects of active rehabilitation.

He was obese and unable to move or take care of himself physically. Six is a low score.

The fact that the patient was transferred from QAH to GWMH for continuing care does not mean in any way that his condition was improving, only that it had stabilised. It meant that he required more care, not that he was in any way more than no longer acute.

I refer now to page 82 of the notes. I see that Mr PACKMAN was prone to constipation due to his state of immobility and that in order to achieve the desired outcome, ie, that he have a regular bowel movement pattern, that he have adequate fibre and fluid intake and be administered the appropriate drugs for this.

On page 83 I see that on 25/8/99 he had several loose bowel actions throughout the afternoon and evening with fresh blood and his medication was questioned.

On 31/8/99 a large amount of black faeces were passed overnight by him and again on 1/9/99. There are nursing notes. I assume Dr BARTON would have been made aware of this by nursing staff, on the relevant dates and given due attention to the patient.

Mr PACKMAN's haemoglobin was stable, on 20/8/99 and his medical condition was stable, no extra care would be required at that moment in time, regarding the state of his stools, however this would be reviewed constantly, due to his medical conditions. That is why I asked for repeat Hb. It is not normal to pass black faeces. Black faeces are an indication of gastro intestinal bleeding (GI bleed). The treatment for this is firstly to confirm the GI bleed, carry out an endoscopy to find the cause of the bleeding and to give the patient anti ulcer treatment, ie: medication.

He had not been on any anti ulcer treatment as far as I can see.

I can say that on his admission Mr PACKMAN was prescribed Clexane which is an anti coagulant drug. He had an episode of black stools on 13/8/99. His haemoglobin level was stable when he transferred to GWMH on 23/8/99 and he was given no treatment for this.

When I saw Mr PACKMAN on 23/8/99 I was told of his passing black stools on 13/8/99 that his haemoglobin was stable and that he should be reviewed later on that week.

On 24/8/99 his level was again stable indicating he was not actively bleeding at that time.

On 26/8/99 his level dropped dramatically, indicating a massive internal bleed.

Referring to page 196 of the notes I note that on 6/8/99 Mr PACKMAN was dehydrated and had low - normal albumen. The level dropped then stabilised as he rehydrated in hospital and on 20/8/99 it was 36 which was normal. He was seen on Ann Ward, QAH by Dr TANDY.

On 20/8/99 his haemoglobin was 12.9. This is good.

On 24/8/99 his haemoglobin was 12, well within the normal range, indicating no obvious bleeding at that time.

On page 83 I note that on 25/8/99 he had several loose bowel actions with fresh blood. His medication was questioned. This note corroborates the drop to 7.7 of his haemoglobin (Hb).

The test for haemoglobin is to determine whether the patient is bleeding or anaemic. Albumen affects the total protein in the blood and reflects the nutritional state of the patient and also the stage of liver function.

Mr PACKMAN was admitted to hospital in generally poor condition. He was immobile and dehydrated with kidney impairment. His kidney function was normal on 13/8/99. On 6/8/99 his kidneys were not functioning well. On 12/8/99 his kidney function returned to normal and he rehydrated or rather that his dehydration was corrected.

Page 52 shows that Dr TANDY saw him and ordered he should have his haemoglobin checked due to black stools. I cannot say if this was 13 or 18/8/99.

On 20/8/99 he was seen by Dr CHATTERJEE who noted no further black stool motion. He requested a repeat haemoglobin test. He was transferred to GWMH because his haemoglobin was stabilised. He was not anaemic.

On page 55 I note he was seen by Dr BARTON who thought he may have had a heart attack or GI bleed as he collapsed and thought him too unwell to be transferred to an acute unit. She suggested he be kept comfortable and she was happy for nursing staff to confirm death.

On page 170 I note that on 25/8/99 the Clexane was stopped. This shows that it was felt that Mr PACKMAN had a GI bleed.

I can stay that Mr PACKMAN died of internal bleeding. I cannot say if this could have been prevented. It may have been that if we had acted when we noted Mr PACKMAN's black stools at QAH and had stopped the Clexane then, it may have been prevented if done in conjunction with the administration of anti ulcer drugs.

In my opinion, on 26/8/99 it was too late for any such action.

Doctors initial their entries in notes to ensure accountability.

I note that on page 53 Dr CHATTERJEE wrote that Mr PACKMAN was not for 555, ie, resuscitation. This could have been for several reasons, I do not know how Dr CHATTERJEE decided this. He would have made his decision based on the clinical condition of the patient in his position as Specialist Registrar.

To summarise this patient was first seen by me on 23/8/99 at GWMH when he was transferred from QAH where he was an inpatient of Dr TANDY since 6/8/99. His main problems on admission were poor mobility, cellulitis in both legs, dehydration, renal impairment and obesity. He was given Clexane, appropriately, to prevent veinous thrombosis and his dehydration was corrected. There was a question of passing black stool on 13/8/99 and his haemoglobin

periodically checked to rule out or confirm internal bleeding but it was stable with no further evidence of black stool and as his mobility and physical conditions were still poor (Barthel 6) he was transferred to GWMH for continuing care. When I saw him on 23/8/99 at GWMH he was still medically stable but in view of the history of black stool I requested a repeat test of haemoglobin that week. I did not think of stopping Clexane at that time which, in retrospect, I could have. On going through his notes I find that on 24/8/99 his haemoglobin was still 12 indicating Mr PACKMAN was not actively bleeding when I saw him. Also on reading the notes I note that nursing staff noticed fresh bleeding on 25/8/99 and his Clexane was stopped. On 26/8/99 he collapsed, found by Dr BARTON pale and clammy and his repeat haemoglobin was 7.7 indicating a massive or large internal bleed. At this stage Dr BARTON felt he was too unwell to transfer to an acute unit.

I visited GWMH once a week. Dr BARTON was the physician on the spot. I do not know what her duties were specifically as regards ward rounds or her working hours.