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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: BRIGG, MICHAEL

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

This statement (consisting of 9 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: M I BRIGG Date: 16/02/2005

I am the above named person. I live at an address known to the Hampshire Police.

I am currently a self employed General Practitioner working at the Forton Medical Centre, Whites Place, Gosport PO123GP .

I joined the practice in October 1993.

My Medical Defence Union Number is 171395.

I am fully registered with the General Medical Council since the 22nd August 1982 (22/08/1982) No.2574354.

My medical studies were undertaken from October 1976 through to July 1982.

Pre-clinical studies at Lincoln College, Oxford where I also gained a Bachelor of Arts in Physiological Sciences (BA).

I moved to Downing College, Cambridge in October 1982 where I undertook a clinical medical course at Addenbrookes Medical School at the Cambridge School of Clinical Medicine, New Addenbrookes Hospital.

I took my final medical degree exams in November 1981 gaining a Bachelor of Surgery (B.Chir), I re-sat my final medicine exam in July 1982.

During my professional career I have also obtained the following post graduate diplomas.

1989 A Diploma in Child Health (DCH) Royal College of Physicians, London.
1992 Family Planning Certificate (F P Cert)
1993 A diploma of the Royal College of Obstetricians and Gynaecologist.

From August 1982 until January 1983 I was employed as a pre registration house officer in geriatric medicine at the Chesteron Hospital, Cambridge.

From February 1983 until July 1983 I commenced working as a pre registration house officer in general surgery orthopaedic and hand surgery, gynaecology at the Huntingdon County Hospital.

From September 1983 until July 1985 I was employed as a Senior House Officer in General Surgery, Casualty Department of Anatomy, General Surgery Rotation and Junior Lecturer at The London Hospital and Medical School.

From August 1985 until January 1986 I was Senior House Officer domiciliary care of the terminally ill at St Joseph's Hospice, Hackney, London.

From February 1986 until October 1987 I was Senior House Officer, Community Medical Officer General, Neonatal, Community Paediatric Rotation at Old Church & Rush Green Hospital, Romford, Essex.

From November 1987 until January 1988 I was Senior House Officer Paediatric Neurology and renal medicine, infectious disease, burns unit, intensive care at Guy's Hospital, London.

From February 1988 until July 1988 I was Senior House Officer in General and Neonatal Medicine Rotation Neuromuscular disorders, cardiology, haematology neonatal, general and cardiac surgery.

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From December 1988 until November 1989 I was employed as Registrar at Redhill and Crawley Hospitals.

Between December 1989 and January 1991 I was employed as registrar/community health officer at Newham General Hospital, London E13.

From February 1991 until July 1991 I was Senior House Officer in obstetrics and gynaecology at Charing Cross Hospital, The Westminster and West London Hospitals.

From September 1991 until August 1992 I was employed as Trainee General Practitioner at the Handforth Health Centre, Wilmslow Road, Cheshire.

Between August 1992 and October 1993 I held various locum posts with; Medic International London. Barking Haveing & Brentwood Health Authority as a paediatrician registrar.

St Joseph's Hospital, Hackney as Senior House Officer/Registrar in Palliative care.
From October 1993 to date I hold the position as Principle in General Practice, Dr BEASLEY and partners, Whites Place, Forton Road, Gosport.

I have been asked to detail my involvement with the patient [Code A].

I have been shown the photocopy of the microfiche exhibit BJC/71 which are the medical notes for [Code A] whilst a patient at Gosport War Memorial Hospital .

I can confirm on page 6 of exhibit BJC/71 I was the authorising doctor for the entry relating to Nozinan 100mgs s/c = sub cutaneous in 24 hrs, dated 20/1/96 (20/01/1996), dose 100mgs, verbal order Dr BRIGG, 1720 hrs which has been signed by a Tina DOUGLAS (Staff Nurse) and countersigned by P S RIGG . This entry has, then, later on that day on 20/1/96 (20/01/1996) been signed by myself. I cannot recollect the time that I wrote this entry on the 20/1/1996 (20/01/1996).

The standard practice at that time when a sister/nurse in charge of the ward was concerned with a patient's clinical condition, was to ring the duty doctor to discuss the patient's problem.

The duty doctor could then make a decision based on the information given by the nurse regarding the patient's management, to change treatment and or visit the patient.

If an immediate change in medication was necessary this might require a verbal order to be given in order to avoid delay in carrying out a change of treatment to the patient.

At a later stage this verbal order should be countersigned and confirmed by the ordering doctor.

In this particular case the clinical problem arose when the syringe driver was due for recharging. The nurses review of the patient raised a concern about his clinical response to some of the medication previously prescribed. In particular Haloperidol .

It was thought that the patient was developing side effects from Haloperidol. These affects included agitation and movement disorder. Both of which are recognised with higher doses of this drug.

I was also concerned that several different drugs were being used in the syringe driver which might affect the pharmaceutical properties.

Since Haloperidol and Nozinan have broadly similar indications I felt it was appropriate to stop the dose of Haloperidol and replace it by increasing the dose of Nozinan.

The higher dose of Nozinan then has the added advantage of sedative properties which would be appropriate in this situation as the patient was agitated.

I did not physically see the patient **Code A** prior to the time the verbal order was carried out.

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However I subsequently visited the ward, checked the patient, to ascertain whether he had responded/settled to the treatment change that I had made.

I have recorded my clinical decision on page 15 of exhibit BJC/71 as follows.
20/1/96 (20/01/1996) - "Has been unsettled on Haloperidol in syringe driver. Discontinue, + changed to higher dose Nozinan".
"Increase Nozinan 50mg → 100mg in 24 hrs"
(Verbal order).

With regards to this entry I have stopped Haloperidol and ordered an increase in dosage of Nozinan.

This entry confirms the verbal order that I had given at 1730 hrs on the 20/1/96 (20/01/1996) to the nurse.

I have been shown page 7 of the microfiche of exhibit BJC/71 which is the drug record for Code A.

On the 20/01/96 (20/01/1996) at 1530 hrs it shows that the syringe driver was charged with Diamorphine 120mgs, Midazolam 80mgs, Hyoscine 1200 mcgs, Haloperidol 20mgs.

The syringe driver was subsequently charged at 1800 hrs the same day as per my verbal order.

(The 4th edition of the book of terminal care by the Countess Mountbatten House lists a dosage range for Haloperidol between 5-60mgs as an anti emetic. Nozinan has a dosage of 25 to 500 mgs in 24 hours.

It is also noted however that extra pyramidal side effects are likely to occur with dosages above 20mgs of Haloperidol.

The entry for Nozinan suggest a lowest effective dose to be used unless sedation is required).

On this basis I felt that 100mgs of Nozinan in 24 hrs was appropriate for the patient's needs.

I was discontinuing Haloperidol and anticipated a compensatory increase would be necessary in the alleviate anti-emetic (Nozinan) tranquilliser.

To show that a change of drug regime has been made, the original syringe dosing has been crossed out in a manner, which does not obscure the previous dose record.

This allows a continuous retrospective analysis of administered drug dosage.

I presume this has been completed by the nurse at the time of changing the drug dosage and is entirely appropriate to the maintenance of an accurate record.

It is my understanding that the previous dose would have been disposed of according to standard hospital protocol.

With regard to the Haloperidol dosage recorded on page 7 of BJC/71 this prescription has also been discontinued marked by a double hatched line (which I recognise as my usual way of indicating this). It also looks like my handwriting style. In this case I have not signed the entry (which is my usual practice).

The entries relating to Diamorphine 120mgs, Midazolam 80mgs, Hyoscine 1200mgs have been written/recorded by a member of the nursing staff.

I note that on page 6 of the microfiche BJC/71 that the original 50mg dose of Nozinan appears to have been omitted when the driver was recharged at 1530 on the 20/1/96 (20/01/1996).

Had I noticed this error at the time when countersigning the verbal order to change the drug regime, it is quite possible that I would have revised my decision to increase the dose of Nozinan from 50mgs to 100mgs and in these circumstances I might have continued with the

Haloperidol.

However in general I tend to favour Nozinan over Haloperidol and it is quite possible therefore that I may have let my decision to stand as the patient appeared to be well settled on the dosage he was receiving.

I would also have brought the error to the attention of the nursing staff in order that appropriate investigation and audit could be undertaken according to standard hospital procedure.

It is worth noting that the Nozinan is written up on the 'As required' section as opposed to the 'Regular' prescription which is on page 7.

I can confirm that I wrote the following entry on page 15 of the clinical notes.
'Much more settled. Quiet breathing'.
'R Rate 6 per min. Not distressed'.
'Continue'.

With regards to this entry 'much more settled' is self explanatory. 'Quiet breathing' means that he did not have any rattle, there was no excess labour in the breathing pattern.

'R Rate = respiratory rate 6 per minute' - I would have noted of the breathing was irregular or shallow. The rate of 6 per minute is slow but I would bear in mind that he was under the influence of Diamorphine and therefore this would have been expected.

I would also have noted whether his skin colour suggested excessive respiratory depression (ie, cyanosis, pallor, or sweating).

Where I have written 'continue', I mean 'to continue with the current drug regime'.

Where I have reviewed the drug regime and stopped the Haloperidol, this has been based on a report on the patient's clinical condition which I received from the nurse by phone.

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This included a discussion with the nurse about possible causes. A senior nurse such as S/N DOUGLAS has extensive personal experience of palliative care, including a knowledge of different drugs and their specific side effects.

S/N DOUGLAS expressed a suspicion that Haloperidol may be causing a side effect.

I agreed with this opinion and gave a verbal order to change the drug regime.

I do not remember the patient Code A however I clearly remember the clinical issues involved and the reasons for my decision.

At this time in 1996 the medical cover for elderly care patients at Dryad, Daedalus and a limited number of Sultan Ward beds at GWMH was undertaken by my partnership.

This was a consequence of an agreement between one of our partners Dr BARTON and the practice,(ie at that time Dr KNAPMAN and Partners) that the practice would undertake Dr BARTON's responsibilities as a clinical assistant in elderly care.

It is my understanding that in effect Dr BARTON sub contracted on call responsibilities for the hospital to the practice when she was not on cover to the practice.

I would undertake all of my on call commitments and did not make use of deputising services. I would also therefore take responsibility for seeing any clinical problems arising in elderly care patients at the GWMH. Whilst I was on call for the practice. When this occurred I was in effect acting as a clinical assistant for the ward.

Taken by: Redacted