Hampshire NHS
Primary Care Trust

**TEMPLATE** **APPENDIX 4**

**CORONER'S REPORT / WITNESS STATEMENT IN THE MATTER OF**

**Patient name (if applicable) – Incident Date:**
(e.g. This report relates to the death of ..... Code A .... who died on ..... Date not known to me..... )

**NAME**: Dr Donal Collins

**JOB TITLE AND EMPLOYER**: GP Dr ~~Jordan~~ Rushan and Partners

**ADDRESS**: Code A

29 JUL 2008

SCAN
READ CODE
SHIRLEY
NORMAN
MAIL

**QUALIFICATIONS**: MB BCh DME DCH PG DipENT

**SUMMARY OF EXPERIENCE**: Qualified in 1989 in Cork
Worked for 5 years as Junior Doctor in Limerick West of Ireland.
Finished GP training 1995 in Gosport Hampshire. Worked as a GP principal since then in Fareham, which included 5 years as clinical assistant in a stroke rehabilitation ward at St Christopher Hospital Fareham.

**BODY OF REPORT: (see sections below)**
My contact with this patient was on 04/05/2007 when I admitted her to Sultan ward at Gosport War Memorial Hospital following her being referred in by a GP (Dr Harris). This is a PCT run ward with medical cover from the local GP community.
I would have seen this lady in the afternoon between the hours of 1400 to 18.30 (this when I normally do this work on this ward).
I would usually admit patients without a nurse being with me, though nurses do walk through the ward doing their normal work.

The history was that this lady had some falls over the last 2 weeks and in the previous 48 hours her mobility had significantly deteriorated. The patient herself had no recollection of her last fall.
It was noted that in her past history she had problems with Ischaemic heart disease, transient ischaemic attacks, osteoporosis, and osteoarthritis of the back.
Her medication included Aspirin, atenolol, Indapamide, felodipine, atorvastatin, lansoprazole, calcichew D3 fotre, fosamax, paracetamol, Dihydrocodeine and diazepam.
When I examined this lady I noted that she was drowsy, but otherwise her physical examination was unremarkable. I have not recorded her level of hydration but it would be usual for me to note clinically dehydrated if I thought so. This leads me to believe that it was my impression on this admission that she was not dehydrated.
I felt she was oversedated from her current regime of medication. My instruction to the ward was to stop the diazepam, and if the drowsiness continued then to stop the dihydrocodeine.
Bloood tests were done that morning and we needed to chase the results and also arrange for a mid stream urine specimen to be sent (as urine infection may be a common cause of falls in the elderly).
I also asked the staff to do lying and standing blood pressure reading to see if there was a significant drop in blood pressure when the patient stood.
This ended my involvement with the patient. I have no recollection of seeing this lady and the above notes are made from records of her admission on the 04/05/2007.

**STATEMENT OF TRUTH:**

**This report/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 in it, which I know to be false, or do not believe to be true.**

**Signature:** ..... Code A .....

**Date:** 25/7/08

Dr D COLLINS
Highlands Medical Centre
102 Highlands Road
Fareham Hants. PO15 6JF
Tel: 08444 778939