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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: TANDY, JANE C

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

This statement (consisting of 12 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: Jane TANDY Date: 20/12/2004

I am employed by East Hants Primary Care Trust as a Consultant Geriatrician in Elderly Medicine and have been so employed since 1994.

From 1997 I continued in this position on a part time basis.

My General Medical Council registration number is Code A

In 1983 I graduated with an MBChB which is a combined Bachelor of Medicine and Surgery at the University of Edinburgh.

In 1986 I obtained a MRCP which is a post graduate medical qualification and became a member of the Royal College of Physicians.

From August 1983 to January 1984 I trained as a house officer in medicine at the City Hospital in Edinburgh.

In February 1984 I transferred to the Chalmers Hospital in Edinburgh where I trained as a house officer in surgery.

Between August 1984 and September 1986 I was Senior House Officer in Medicine at the New Cross Hospital in Wolverhampton. Then Senior House Officer in Medicine at the Lewisham Hospital in London.

From April 1986 until September 1986 I was employed as Senior House Officer in Neurology at the Brook Hospital in London.

Between October 1986 and September 1988 I held the post of Registrar in Medicine at the Salisbury General Infirmary, Wiltshire and then at the Southampton General Hospital.

From October 1988 until November 1991 I worked as a research registrar under the supervision of Professor J PICKARD at the Southampton General Hospital.

Between November 1991 and May 1994 I held the post of Senior Registrar in Geriatric medicine at hospitals in Portsmouth and at the Southampton General Hospital.

My current responsibilities as a Consultant Geriatrician include working on Mary Ward an acute ward at the Queen Alexandra (QA) Hospital. Patients admitted to this ward are in the main patients over the age of 65 who have suffered from a stroke.

I also hold an 'out patients' session once a week at St Mary's Hospital. I see general medical patients as well as stroke patients. I cover ward rounds on a rotational basis with other colleagues for the Medical Admission Unit at the Queen Alexandra Hospital.

If there are patients on the Medical Admission Unit or the Accident and Emergency Department whose likely diagnosis is a stroke, then subject to availability of a bed, the patient will be transferred to the Mary Ward at the QA.

Mary Ward is currently the responsibility of Dr JARRETT and myself. Patients admitted to this ward are seen on consultant ward rounds. Dr JARRETT and myself conduct two ward rounds per week.

Day to day medical care is provided by junior hospital doctors.

With regards to the one 'out patient' session held at St Mary's Hospital, Portsmouth.

GP's and occasionally hospital DR's refer their patients to this Out Patients session.

I also conduct ward visits where patients are referred by other departments within the hospital to give advice, re elderly care.

On occasions I conduct domiciliary visits at the request of the elderly patient's GP.

I have been shown a photocopy of the microfiche exhibit BJC71, page 9 which is a provider spell summary (which every patient admitted to hospital should be provided with).

I can confirm that I was the consultant for the patient Code A

I have checked the spell summary (page 9, BJC71), I am unable to establish what the diagnosis was in relation to this patient as it is illegible.

I can state that I have no recollection of Code A or subsequent examinations.

On examination of this form I note there are codes relating to the specific diagnosis of the patient.

These codes are inputted by the coding department within the hospital. I am unable to decipher the codes.

On the 10th January 1996 (10/01/1996) I was the consultant for Dryad Ward, Gosport War Memorial Hospital. I had overall medical responsibility for the ward.

Dryad Ward largely contained frail and elderly patients who would be difficult to manage in a nursing home because of their medical and or nursing needs.

These patients would have been assessed prior to transfer to Dryad Ward by a Consultant

Geriatrician.

Dryad Ward was a long term care ward and generally patients were transferred from other wards within Portsmouth Hospital.

At this time in 1996 there was not a resident doctor for these patients on Dryad Ward.

Day to day cover was provided by the local GP. In the case of Dryad Ward this was Dr BARTON and possibly others from her practice.

My responsibilities included a ward round on Dryad Ward once a fortnight. I would normally be accompanied by a senior member of the nursing staff and Dr Jane BARTON.

My usual routine when conducting a ward round would be see all patients. I would discuss the care of the patients with the ward team. I would talk to the patients and examine them if appropriate.

I would review drug regimes where relevant with the ward team. I would also review any blood test results, x-rays or other test results relating to the patient. I would check the medical notes thoroughly especially if the patient was new to me.

One of my responsibilities was to review the prescription of drugs on the Dryad Ward at Gosport War Memorial Hospital.

The majority of drugs can only be prescribed by a doctor. The day to day administration of drugs would be by qualified nursing staff.

As a consultant Geriatrician I covered Dryad Ward from 1994 until the end of 1996.

Drugs can only be prescribed by a doctor. Drug doses could be modified, current drugs stopped or new drugs added depending on the patient's condition.

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The drug regime would be reviewed by the consultant on the ward round as appropriate during the week by the General Practitioner (GP) where necessary.

There was no requirement to notify me of every change to drugs prescribed to a patient by the GP during his or her ward round unless the GP sought my advice.

From my experience it was very infrequent that a doctor would phone me for advice.

I have examined the drug chart page 16, a photocopy of the exhibit BJC71 in relation to Code A Code A

On the drug chart there is recorded the following entries as I understand them commencing on the 5th January 1996 (05/01/1996).

Sertraline 50mg which would have been administered with either 2 x tablets twice a day or 1 tablet once a day.

This drug is an anti-depressant which the patient was taking whilst on the Mulberry Ward at Gosport War Memorial.

Lithium Carbonate which I believe to be 400mg to be administered 1 x day. This drug is used for mood stabilising. It is a drug which was also prescribed prior to his transfer to Dryad Ward.

Diazepham 2mg given 3 x day. This drug is anxiollytic which is used to reduce anxiety. It has a side effect that can make a patient sleepy. Again this drug had been previously prescribed on Mulberry Ward.

Thyroxine 50mg 1 x tablet per day. This is a hormone replacement drug for an under active thyroid gland. This also would have commenced whilst the patient was on the Mulberry Ward.

Also recorded on the drug chart is Daktacot. This is a cream for treatment of skin problems. It contains steroids and an anti fungal agent. Only one application has been recorded as being given to the patient.

Arthrotec commencing on the 8/1/96 (08/01/1996). This is a pain killer. A non steroidal anti flammatory drug with susoprostol which helps protect the stomach against ulceration. This drug is in the form of a tablet given twice a day.

This was initiated by Dr BARTON.

On the 10th January 1996 (10/01/1996) I conducted a ward round together with Dr BARTON and Sister HAMBLIN on the Dryad Ward.

Oramorph 5mg commenced @ 2200 hrs on the 10/1/96 (10/01/1996). 5mg @ 5 x a day. This is an opiate drug which is given orally. It is primarily used as a pain killer.
Oramorph was given as a result of the patient stating that he was in pain. It was given to alleviate the pain and also help alleviate any distress.

On the 11/1/96 (11/01/1996) the drug chart was re-written by Dr BARTON. The Diazepham has been increased to 5mg to be given 3 x a day.

Oramorph has been maintained at 5mg 4 x a day. The dose at night has been increased to 10mgs. This would be to try and render the patient pain free at night.
This dosage being given orally is maintained until the morning drug round conducted by Dr BARTON on the 15/1/96 (15/01/1996).

On the 12/1/96 (12/01/1996) the Sertraline and Lithium Carbonate have been stopped by Dr BARTON.

On the 15/1/96 (15/01/1996) it appears that a syringe driver was commenced containing Diamorphine , an opiate drug. The dosage was recorded at 80mg over 24 hours.

Diamorphine is used as a pain killer and to alleviate distress by making the patient more comfortable.

Also contained within the syringe driver was Hyoscine in the quantity of 400 micrograms. This is used to dry up secretions on the patients chest.

Midazalam 60mg over 24 hours was prescribed and put into the syringe driver. This drug is another anxiollytic drug used to reduce anxiety and agitation.

On the 16/1/96 (16/01/1996) the mixture of drugs in the syringe driver continues at the same dosage rate. However Haliperidol @ 5mgs over 24 hours was added to the driver. Haliperidol is an anti psychotic drug which can be used for acute confusion and agitation.

The above driver containing Diamorphine, Haliperidol, Midazalam, Hyoscine were only given as the patient was distressed. These drugs administered subcutaneously are intended to alleviate the patient's symptoms.

On the 17/1/96 (17/01/1996) it is noted at 0900 hrs that nurses records show the patient remaining tense and agitated and distressed on turning. The patient is seen by Dr BARTON and note recording the medication has been reviewed an altered.

However I am unable to read the entry for the prescribed dosage of drugs for the 17/1/96 (17/01/1996) as they are illegible. However it would appear the dosage of Diamorphine has been increased to 120mgs. From the 18th January 1996, 18/1/96 (18/01/1996) the following dosage of drugs are administered in the syringe driver for Code A.

Haliperidol 20mg over 24 hrs
Diamorphine 120 mg over 24 hrs
Hyoscine 12000 micro grams over 24 hrs
Midazalam 80mgs over 24 hrs

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At this stage there were two (2) syringe drivers in operation delivering this dosage at a constant even rate.

Also added/included in the syringe driver at the same time was Nozinan 50mg over 24 hrs.

On page 27 of the nursing notes of the exhibit BJC/71 Nurse DOUGLAS notes the fact that the patient's skin was marking easily despite hourly turning. The patient remained distressed on being turned. The patient was on a special mattress to help prevent pressure sores.

Code A at this stage was very poorly.

My observation with regards to the initial dosage of drugs used when the syringe driver was set up is as follows.

I would have used a lower dosage of the Diamorphine and Midazalam.

However I must point out that I did not see the patient when this dosage was commenced.

At that time there was no resident doctor at Gosport War Memorial Hospital to review the medication and these dosages.

Therefore the prescribing doctor cannot always be present to change the dosage if and when required.

I will add that I am not an expert in palliative care.

From the 18/1/96 (18/01/1996) the doses of Midazalam, Diamorphine and Hyoscine were not changed.

The Haliperidol was stopped on the 20/1/96 (20/01/1996).

The Nozinan was increased to 100mg over 24 hrs on the 20/1/96 (20/01/1996) as the patient's symptoms were still not controlled.

From the 20/1/96 (20/01/1996) the dosage of Diamorphine, Midazalam, Hyoscine and Nozinan remained the same and continued to be administered until the death of Code A
On reviewing the nursing and medical notes it would appear from the 21/1/96 (21/01/1996) that the patient was much more settled.

Where I have stated that the patient, Code A, was very poorly, from reading his notes it was likely that this patient was dying.

I have been shown and reviewed the photocopy of the microfiche of exhibit BJC71, page 13.

I can confirm that the entry dated 10/1/96 (10/01/1996) was written by me during a ward round at Dryad Ward, Gosport War Memorial Hospital.

The following has been written
10/1/96 (10/01/1996) - Depression)
- Catheter)
- Superficial illness) transfer from Mulberry
- Bartel O)
- Will eat and drink)
For TLC -
(1) D/W wife - agrees in view of v poor quality TLC
Signed J T (Jane TANDY).

Where I have written 'Depression' I have observed that the patient was seen by Dr LORD on the Mulberry Ward. There is a letter from the Consultant Dr Lord (on page 10 of exhibit BJC/71) outlining the psychiatric and medical history of the patient which resulted in the transfer of Code A Code A to Dryad Ward. The letter states that Code A diagnosis was chronic resistant

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depression. He had also suffered from a recent chest infection. At the time of transfer to Dryad Ward he was also hypoproteinmic.

This means that the proteins in his blood were low which might be due to his poor nutritional state.

The history of the patient has also been summarised by Dr BARTON at the beginning of the medical notes on his admission to Dryad Ward on the 5/1/96 (05/01/1996).

Where I have written 'Catheter', I have reviewed the patient's notes and noted that due to his inability to pass urine a catheter was fitted on the 23/12/95 (23/12/1995) whilst he was on the Mulberry Ward.

Where I have written 'Superficial Ulcers', these were noted to be on the patient's left buttock and left hip. This is a sign of immobility and general poor health.

The nursing notes on page 12 state that the patient has broken skin on his scrotum.
Where it is written 'Bartel Score 0'. This means that the patient was completely dependent on nursing care. He had a catheter inserted and was incontinent.

was also noted within Dr LORD's letter that the patient is eating very little and will drink moderate amounts with encouragement.

Where I have written 'will eat & drink'. At this stage it was one of the few activities of daily living that Code A was able to manage.

Where I have written 'Transfer from Mulberry Ward' this is self explanatory.

Where I have written 'For TLC', I mean that the patient is kept comfortable, that he is not in pain or distressed.

Where I have written 'D/W - wife agrees in view of v.poor quality = (scribble not legible) TLC'

This means I have discussed Code A very poor condition with his wife at the time of the review of Code A I have made her aware and she agrees with the care plan to be provided for her husband.

'TLC', I translate this to mean that the patient's prognosis was extremely poor'.

I believe that the relief of suffering for the patient is paramount. This does not preclude active treatment if the intervention would improve the patient's symptoms.
The overall prognosis that I have made has been reached as a result of reviewing available medical notes, discussions with members of the clinical team discussion with Code A wife and examination of the patient.

My role as a consultant geriatrician is to check that both current and planned care is appropriate to their needs and where possible to verify in accordance with the patient's and family's wishes.

I note from the nursing notes on the 9/1/96 (09/01/1996) (page 25 of exhibit BJC/71) that the patient had told the nursing staff that he had generalised pain.

also note that on the 9/1/96 (09/01/1996) in the clinical notes (page 13 of exhibit BJC/71 refers) Dr BARTON recorded the fact that the patient had pain to his right hand.

Dr BARTON also recorded the fact that the patient was becoming increasingly anxious and agitated.

With reference to page 15 of exhibit BJC/71 which relates to the final entries on the clinical notes, which are as follows.

18/1/96 (18/01/1996) 'Further deterioration' (The next two lines of this entry I am unable to read) the final entry is 'try Nozinan'.

It is my understanding that Code A symptoms were not controlled by his current drug regime. He was commenced on Nozinan, a drug used in palliative care to help control agitation and anxiety.

20.1.96 (20/01/1996) 'Has been unsettled on Haliperidol in syringe driver' the next part of this entry is unreadable. The last line of this entry reads 'Increase Nozinan 50mg → 100mg in 24 hrs (verbal order).

I note the Haliperidol has been stopped on this date 20/1/96 (20/01/1996).

The following entry dated the 21/1/96 (21/01/1996) appears to be written by the author of the entry dated 20.1.96 (20/01/1996) which is as follows.

'Much more settled - quiet breathing R Rate 6p min. Not distressed - continue - (entry signed by unknown doctor).

R Rate is the respiratory rate which is noted as 6 per minute which is slow. (The normal respiratory rate is between 10-15). It would appear that as the patient's symptoms were finally alleviated that it was felt appropriate to continue the current drug regime.

I have nothing to add with reference to the final entry on page 15 of exhibit BJC/71 where the death of Code A is verified by two members of nursing staff.

With regards to my observations concerning the initial dosage of Diamorphine and Midazalom given to Code A administered via a sub-cutaneous syringe driver I wish to clarify why I would have administered a lower dosage initially.

My normal practice is to use the lowest dosage likely to achieve the desired outcome for the patient thereby diminishing the possibility of adverse effects.

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This dosage would be reviewed and increased as necessary. I note it proved necessary to increase the dose of diamorphine administered to Code A

Taken by: DC2134 GREENALL

Signed: Jane TANDY
2004(1)

Signature Witnessed by: