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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: BIRLA, CRISTIAN

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

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: C BIRLA Date: 25/07/2005

I am Doctor Cristian BIRLA, presently employed in the post of Clinical Fellow/Registrar in Medicine at Brighton and Sussex University Hospitals, NHS Trust, Princess Royal Hospital, Haywards Heath.

I have held this post since the 2nd of August 2002.

My responsibilities are in Acute General Medicine, on call 1 in 9 at Registrar level.

Once weekly Geriatric/General Medicine Clinic. I have day to day care of acute general medicine patients and the supervision and teaching of doctors in training.

I gained my Medic/Doctor Diploma in Bucharest, Romania in 1988, passed the Professional and Linguistic Assessment Board in London 1993 and became a Member of the Royal College of Physicians (UK) in 2004.

My GMC registration number is Code A

Between 1988 and 1991 I held various House Officer (HO) and Senior House Officer (SHO) posts in Romania. I performed six months in each of the following:

Paediatrics, General Surgery, Infectious Diseases, (clinical: all age groups) Obstetrics and Gynaecology and Registrar in General Medicine.

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Between 1991 and 1992 I had a Clinical Attachment at the Royal London Hospital, Whitechapel, London.

From February to August 1993 I was House Officer in Medicine at Leigh Infirmary, Manchester.

Between August 1993 and February 1994 I was SHO in Medicine at Hull Royal Infirmary.

From February to August 1994 I was SHO in Haematology at William Harvey Hospital, Ashford, Kent.

Between November 1994 and November 1996 I held various Medical Officer posts in Romania.

Between February and August 1997 I was SHO at Prince Philip Hospital, Llanelli, Wales.

Between August 1997 and February 1998, SHO in Medicine at Blackpool Victoria Hospital, Lancashire.

From February 1988 to April 1988, SHO in Medicine (Locum), Solihull Hospital, West Midlands.

From 1st April 1998 to 30th September 1998 I was Senior House Officer in Medicine at the Queen Alexandra Hospital , Portsmouth, Hants.

My responsibilities in this post were as follows:- Acute General Medicine for the Elderly on call 1 in 4, full shift. General Medicine for the Elderly Clinics under Consultant supervision. Day to day care of acutely unwell elderly patients, palliative care patients and long term care patients. Supervision and teaching of the House Officer.

From November 1998 to November 1999 and June 2001 until 1st August 2002 I worked as a locum registrar and SHO in medicine for Premier Locums an agency. This entailed working in

various hospitals whilst awaiting granting of full registration by the GMC.

On Tuesday 14th June 2005 I was referred to police exhibit reference BJC/55 , the medical notes of Robert WILSON (8/3/23).

I can say that Mr WILSON was admitted to the Queen Alexandra Hospital on 22/9/98 with a fractured left humorous. He stayed there until the 14th October 1998 when he was transferred to the Gosport War Memorial Hospital , Hants for continuing care.

Firstly with reference to the entries on page eight of the notes regarding resuscitation status, I confirm that my entry of 23/9/98 reads 'Yes' and on 29/9/98 reads 'No'. 'Yes': this means that if the patient stops breathing, attempts should be made to resuscitate. Conversely 'No' means not.

Usually on admission 'Yes' applies however as the patient is reassessed during their time in hospital regarding their health it may become 'No', as in this case.

'No' is when doctors assess that the process of resuscitation is unlikely to be successful. In this case the doctor in question would speak with the relevant consultant to ensure agreement. The family of the patient would also be spoken with regarding the decision made.

Resuscitation: Nurses observe the patient. If the patient has no pulse then the Resuscitation Team are called. The nurses start the resuscitation process at once. This would involve cardiac massage and 'mouth to mouth'. The team then try to establish why the patient has stopped breathing or their heart has stopped and act accordingly. This is the resuscitation protocol.

Having observed Mr WILSON between 23rd and 29th September 1998 I decided that due to his physical condition, I believe he was alcoholic, he would not be resuscitated if he stopped breathing at any point.

On 23/9/98 and 24/9/98 Mr WILSON was given 5mg of Morphine. This is a moderate amount of this opiate to administer for painkilling. I did not give this. I believe it may have been my

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junior HO Dr PEIRISS , who I think has now left the country.

He last had Morphine on 3/10/98 again 5mg.

In the case of a broken bone as in Mr WILSON's case, in my experience the patient will complain of pain. This is normal as the ends of the bone may rub and cause discomfort. I would not increase the dosage from 5mg as the patient would be less mobile and the fact is I would want him mobile in order for the healing process to commence.

Opiates have a strong analgesic effect and the more you give the less mobile the patient.

Cancer patients who are seriously ill can tolerate huge amounts of Morphine and whilst being treated may progress to 30mg twice a day, given orally. This would have been reached on the analgesic ladder, ie, starting with perhaps 5mg and increasing as their level of pain heightened. There is a conversion scale for dosages of orally given Morphine vis a vis those administered subcutaneously or intravenously. The amount given orally is higher because of its effect.

I refer to page 13 of the notes where it indicates that on 29/9/98 I would be reviewing Mr WILSON's resuscitation status. I believe I have already explained this.

On page 171 of Mr WILSON's notes it shows evidence of alcoholism. His renal function, ie, his kidneys, was not working properly and liver function was affected. This whole page was written by me. I noted 'Not for resuscitation in view of poor quality of life and poor prognosis'. I also noted that he was suffering from alcoholic hepatitis.

The entry of 1/10/98 is a ward round with the Registrar. He agreed the 'No' status regarding resuscitation for Mr WILSON. I can say this as if he had not agreed with my decision then 'Yes' would still have applied.

Referring to pages 175 and 176, the entry of 8/10/98, I can say that Mr WILSON had a psycho-geriatric review by Rosie LUSZNAK the Consultant Psychiatrist. She noted early dementia

and depression on Mr WILSON's part. She prescribed 50mg of Trazedone.

If a patients liver is damaged caution has to be exercised in the administration of opiates as this can make the patient feel ill. This is noted in the British National Formulary. This is protocol (book) which is updated every six months. Doctors have to use the book and cannot contradict what the book says. It should be used when prescribing drugs as it shows safe parameters and the effects of drugs.

In my opinion as a patients condition improves the administration of Diamorphine should cease because its effect is to make the patient drowsy and less mobile than may be desirable.

Trazadone Hydrocholride is given for depression and anxiety.

I note from page 166 of the notes that Mr WILSON declared that he drank six double whiskies a day and smoked 40 cigarettes.

On page 168 I have written 'Plethoric face' ie: red face.

'Dupuytrea contracture'. This is when the skin at the base of the fingers contract. It is indicative of alcoholism, equally it could be familial.

'Gynaeconestion'. This is the development of breasts in a man who drinks excessive amounts of alcohol.

'1½ yr ago in hosp ã heart problems', ie one and a half years ago he was in hospital with heart problems.

I also note Mr WILSON was on Spirouolectone. This is for heart disease.

Mr WILSON was administered Thiamine, ie Vitamin B, given to alcoholics.

Mr WILSON had a deficient diet due to alcoholism. Thiamine would help this.

I should like to say that I feel that Mr WILSON's state of physical health was such through alcohol abuse that if his health deteriorated to the extent that he were to die, it would not be unexpected, in that near future.