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: LOGAN, ROBERT FREDERICK

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

This statement (consisting of 6 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: Robert F LOGAN Date: 10/11/2005

I am presently employed by East Hants Primary Care Trust as a Consultant Geriatrician. I have been a Consultant Geriatrician in the Portsmouth area for the past seventeen years.

I went to Bristol Medical School graduating in 1979 with an MBChB, which is a basic medical degree. In 1982 I became a member of the Royal College of Physicians in London and a Fellow of the same college in 1995. The membership entailed passing a post graduate examination.

Code A

In my role as a Consultant Geriatrician I am responsible for supervising the care of a wide range of sick elderly people. These included emergency cases, patients referred by GPs for out patient and day hospital care and occasional domiciliary visits (home visits). My supervisor is Mrs Lesley HUMPHREY who is a general manager at QA hospital.

In 1991 I was contracted as a full time Consultant Geriatrician based at St Mary's Hospital, Portsmouth. I was employed by the Portsmouth and South East Health Authority.

Part of my responsibilities was to provide Consultant cover for continuing care beds at St Christopher's Hospital, Fareham and Redclyffe Annexe, Gosport.

Dr GRUNSTEIN was also employed as a Consultant Geriatrician covering St Christop

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Hospital and some beds at the Gosport War Memorial Hospital.

These hospitals were Community Hospitals, that is they were separate from the Acute District General Hospitals. They were small continuing care units which comprised of elderly frail patients who were in excess of 65 years old.

At St Christopher's Hospital there were initially two GP clinical assistants, Dr Robert BELLINGER and Dr Jeremy FISHER .

At Redclyffe Annexe the GP clinical assistant was Dr Jane BARTON.

In my role as consultant I was in overall charge of the clinical assistants based at St Christopher's and Redclyffe Annexe.

I would conduct a regular ward round once a fortnight and was available for consultation advice between ward rounds.

A ward round, at that time, was conducted on a Tuesday afternoon. I was accompanied by the clinical assistant and the senior nurse on duty. There was normally other nursing staff present, as well.

This was the normal procedure. I would expect to be updated on the patient's condition/ treatment by other team members.

I would expect to be asked to see those patients who were new on the unit or where there had been a significant change in their medical or social condition or where difficulties had been encountered with their management.

I was available for consultation between 9am (0900) to 5pm (1700). Out of hours cover was provided by the on call Elderly Medicine Consultant between 5pm (1700) and 9am (0900).

From my recollection periods of leave taken by me would be covered by Dr GRUNSTEIN. This was a reciprocal arrangement.

The responsibilities of the Clinical Assistants at that time were to provide day to day medical care for the patients. This was a part time commitment in addition to their normal work in General practice.

It was a professional expectation that the Clinical Assistant was present when I conducted a ward round.

I believe I was the Consultant Geriatrician for St Christopher's and Redclyffe Annexe until 1992/1993.

The aim of these units was to optimise the patient's quality of life by managing as best as possible their medical conditions which tended to be multiple.

In some cases it would become possible to discharge them from the unit often to a nursing home. However in other cases the patient's condition was such that this could not be achieved and indeed, some were expected to die.

For those patients that were dying our aim was to provide the best possible palliative care. In certain cases best palliative care required the use of syringe drivers.

A syringe driver has a number of advantages which include the ability to give medication to patients who cannot take it orally. This might be due to impaired consciousness, swallowing difficulties, vomiting, gastro intestinal dysfunction.

Another advantage, is to achieve constant levels of medication without the peaks and troughs associated with oral administration. This allowed flexibility of dosage according to the patients response. The dosage could be decreased as well as increased.

Another advantage would be to minimise the discomfort to the patient who might otherwise require frequent injections. The syringe driver could be used to deliver drugs to relieve pain, breathlessness, excess secretions, nausea, vomiting, anxiety and fear.

Commonly used drugs administered via a syringe driver are Diamorphine, anti-Emetics such as Cyclizine (anti vomiting) and Hyoscine (anti- secretions).

In prescribing drugs including the ones mentioned above, one would have referred to the British National Formulary (BNF).

By that time in 1991 the World Health Organisation had described the so called "Analgesic ladder". This could be applied to patients who could take oral medication and whose pain was not judged as so severe as to require potent opioid analgesics.
Although this had been developed for cancer patients, it was used in a more general way, for the relief of non cancer pain.

I would expect guidelines to be adhered to where appropriate by my Clinical Assistants.

As far as I can recollect, in 1991 there were no policies or set procedures written with regards to the dosage of Diamorphine by the Portsmouth and South East Hampshire Health Authority.

I have been asked, whether I recollect concerns raised by nursing staff, at Redclyffe Annexe, in relation to the prescribing of Diamorphine and the usage of syringe drivers.

I have only a vague recollection of these concerns and the subsequent meetings which I was asked to attend, to address nursing staff concerns.

I have been shown exhibit ref JEP/GWMH/1 which is a red folder containing correspondence relating to the Redclyffe Annexe.

I have previously seen these documents in a photocopy form. Some of these I received in 1991

as the intended recipient and others were given to me at a later stage, possibly during the Commission of Health Improvement (CHI) investigation in 2002.

My recollection at the time in 1991 was that the care patients were receiving at the Redclyffe Annexe was of high quality.

I can remember being surprised by any suggestion to the contrary. I cannot recall a single patient that I saw whilst I was the consultant at Redclyffe Annexe where I thought care of the patient had been inappropriate.

I have no recollection of the first meeting that I attended on the 20th August 1991 for which, unfortunately, there does not appear to be any minutes detailing the discussions that took place.

However I do recall inviting Mr Steve KING to speak at the meeting in August 1991. Mr KING was a nurse manager in Elderly Medicine at the Queen Alexandra hospital, who had special expertise working on Charles Ward, which was a specialised palliative care ward within our department.

I have a copy of the letter that I wrote to Mr KING requesting him to speak about the specific concerns raised by the nursing staff at the Redclyffe Annexe.

I produce this letter as exhibit RFL/1

I can remember being at the meeting in December 1991 which was held at the Redclyffe Annexe.

Records of what was said do exist, in the notes of that meeting, made by Isobel EVANS and notes that I made personally soon after the meeting.

I produce these notes that I have made as exhibit RFL/2.

This meeting was a further attempt to clarify what was regarded by the medical staff as appropriate use of syringe drivers and Diamorphine in particular.

I do not feel that I can add anything further to the minutes of that meeting of 17/12/91.

I informed the nursing staff that I was available, should they have any further concerns. I encouraged the nursing staff to speak to Dr BARTON and other members of the nursing team in the first instance and then speak with me, if they continued to have concerns.

I cannot recall any subsequent approaches on this subject. I had no reason to believe that the nurses concerns had not been allayed.

During the period between 1991 and 1992 that I was the Consultant covering Redclyffe Annexe I had full confidence in Dr BARTON's clinical abilities.