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: FARQUHARSON-ROBERTS, MICHAEL ATHOLL

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: SURGEON REAR ADMIRAL (RN

FARQUHARSON ROBERTS

This statement (consisting of 25 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 FARQUHARSONROBERTS Date: 28/07/2005

I am Surgeon Rear Admiral Michael Atholl FARQUHARSON-ROBERTS and resid address known to Hampshire Police. I am a Surgeon Rear Admiral in the Royal Navy. I am currently the Medical Director General (Naval). As such, I am head of the Naval Medical Branch. I report to the Second Sea Lord but I am also the adviser to the Admiralty Board on medical matters.

I was appointed as Medical Director General (Naval) on 9 December 2003.

I am a qualified Medical Practitioner, on the General Medical Council's full and Specialist Registers. My General Medical Council Registration Number is 1508853.

I trained as a doctor at the Westminster Hospital School of Medicine, part of the University of London, and graduated MB BS (a combined Bachelor of Medicine and Surgery Degree) in 1971.

In 1976 I became a Fellow of the Royal College of Surgeons of England by examination. This is a postgraduate qualification in Surgery and, at that time, was before appointment as a Consultant, albeit after further training.

I was successively a House Surgeon and House Physician in the (initially at Queen Mary's Hospital, Roehampton as a House subsequently at Putney Hospital as a House Physician) for a yea registration' appointments, it being a statutory requirement for suc

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In 1976 I became a Fellow of the Royal College of Surgeons of England by examination. This is a postgraduate qualification in Surgery and, at that time, was the last qualification required before appointment as a Consultant, albeit after further training.

I was successively a House Surgeon and House Physician in the Westminster Hospital Group (initially at Queen Mary's Hospital, Roehampton as a House Officer in Orthopaedics and subsequently at Putney Hospital as a House Physician) for a year. Such posts are termed 'pre-registration' appointments, it being a statutory requirement for such to be undertaken by a doctor

after qualifying. During this year I held a limited registration with the General Medical Council, restricting me to supervised practice in a recognised hospital.

Following those two appointments I moved on to full Registration with the General Medical Council.

Thereafter, I was in full time employment at the Radcliffe Infirmary in Oxford working on the Accident Service and did a Senior House Officer Rotation in Surgery at the Royal Devon and Exeter Hospital (Wonford) from where I took the FRCS Examination.

Having been in the Royal Naval Reserve since 1968, I transferred to the Royal Navy, entering on 1 June 1976.

After General Duties experience at sea and Specialist appointment in Malta, as the single-handed Surgeon, I undertook Specialist Higher Training in Orthopaedic Surgery.

As a Naval Officer, I was trained in Orthopaedics at the Nuffield Orthopaedic Centre in Oxford where I undertook the duties of a Lecturer in Orthopaedics, at Addenbrookes Hospital in Cambridge, where I held an Honorary Senior Registrar Contract (I continued to be paid and employed by the Royal Navy) and at the Royal National Orthopaedic Hospital in London (again on an Honorary Senior Registrar Contract).

I appeared before an Armed Services Consultant Approval Board, a Committee of the Royal College of Surgeons of England, and was approved for appointment as a Consultant in Orthopaedic Surgery in March 1983.

I then took up the appointment as a Consultant Orthopaedic Surgeon at the then Royal Naval Hospital Haslar where, apart from operational deployments to sea, I remained until December 2000. Within the hospital, I was successively Consultant in Orthopaedics and Head of the Orthopaedic Department.

When the Royal Naval Hospital became the Royal Hospital Haslar on 1 April 1996, I remained as Head of Orthopaedic Surgery, subsequently became Clinical Director of Surgery and subsequent to that, Clinical Director of Surgery and Anaesthetic Services.

In the latter role I was responsible for all of the surgical and anaesthetic services including provision of operating theatre services and sterile supplies to the hospital. As such, my Clinical Governance superior was the Medical Director but my Line Manager was the Medical Officer-in Charge of the Hospital.

I had additional responsibilities outside the hospital. I was successively Training Programme Director for the Naval higher training programme in Orthopaedics, responsible for overseeing the training of Naval Orthopaedic surgeons, and from 1 April 1996 became Defence Consultant Adviser and Training Programme Director for the Armed Forces Training Programme. As such, it was my responsibility to oversee the training of all trainees in Orthopaedic Surgery in the Armed Forces and to oversee Trauma and Orthopaedic Services for the Armed Forces as a whole.

It should be noted that the name of specialty changed in the later in the 1990s from 'Orthopaedic surgery' to 'Trauma and Orthopaedic surgery'. The latter reflects the Orthopaedic Surgeon's responsibility for management of fractures etc. This change of title was purely recognition of reality.

Additionally, I held a single-Service Naval appointment as Co-ordinator of Surgical Teams, responsible for operational outputs, reporting to the Assistant Chief of Staff (Medical and Dental) at Commander-in-Chief Fleet's Headquarters.

From 1995 to 2000, I sat on the Specialist Advisory Committee in Orthopaedics (subsequently Trauma and Orthopaedics). This body is responsible for overseeing training in Orthopaedic Surgery in the United Kingdom and the Republic of Ireland. This Committee was responsible for inspecting all hospitals in the National Health Service undertaking Orthopaedic training to ensure they met the appropriate standards.

I remained a Clinical Consultant at the Royal Hospital Haslar and while my duties and responsibilities changed with the merger of Haslar and the Portsmouth Hospitals Trust, in 1998 I undertook an equitable responsibility for on-call for management of trauma cases with my consultant colleagues. Regrettably, I do not have records to indicate how often I was on call for such trauma management in 1998, but would probably have been on duty one night a week and a shared weekend responsibility.

During periods on duty, I would, if not actively employed be able to go home, (my home was approximately two miles from Haslar) and be available to be recalled by junior staff.

The junior staff responsible to me when on call would normally have been a Specialist Registrar, a trainee in Orthopaedics (who had already passed FRCS), a Senior House Officer undertaking pre-Fellowship Specialist Training in Surgery (preparing him/her for the FRCS Exam) and a pre-Registration House Officer, a doctor with limited registration with the General Medical Council, undertaking a year of supervised practice in a hospital prior to full-Registration with the General Medical Council. The staff working for me routinely during the working day, 'my staff' would not necessarily be those on duty when I was on duty. Thus if the duty staff admitted a patient under my care at night or at the weekend, the care of that patient would be handed over to 'my staff' at the commencement of the working day. Similarly, responsibility for patients already in hospital would become the responsibility of the duty staff outside normal working hours.

At the end of 2000 I left clinical practice and went to the Royal College of Defence Studies where I obtained an MA Degree (with merit) in International Studies. I was subsequently appointed as the Change Manager to the Defence Medical and Education Training Organisation. Being then appointed to the Commander in Chief Fleet's Headquarters as Director of Medical Operations in the autumn of 2002 before being appointed to my present post in December 2003.

While a Consultant at the Royal Hospital Haslar during the period when Mrs Ruby LAKE was treated there, my clinical responsibilities included on-call for management of trauma (i.e.

fractures) and elective treatment of some general orthopaedics. However increasingly my elective, that is non-emergency, practice was restricted by my choice to surgery of the lumbar spine, the low back.

During the period in question, it was the normal practice for all patients admitted to the hospital as emergencies to have their x-rays reviewed by the entire Orthopaedic Department, all consultants and doctors, some nurses, physiotherapists etc, each morning at a case conference. This was colloquially described as 'screens'.

Management of each and every patient admitted as an emergency was discussed and the advice of the Consultant body was available to the managing staff.

In preparing what follows in this statement I have had access to photocopies of the medical records of Ruby LAKE, Hospital No: H00206772 (Identification Reference JR/19A) during her treatment at various times in Royal Hospital Haslar. This contains notes made by me, others at my direction, other medical practitioners, nurses and allied health professionals.

I have no memory of Mrs LAKE herself or my management of her.

Prior to the admission to Royal Hospital Haslar on 5 August 1998, that is the subject of this Statement, Mrs LAKE was seen at the hospital for an eye condition which, I believe, to be unrelated to the condition that led to her admission on 5 August 1998 and has no bearing on it.

Included in the medical records is an Hampshire Ambulance NHS Trust Patient Report Form referring to the management of Ruby LAKE on the 5 August 1998. The Ambulance had been called at 1013, arrived at her address at Code A at 1018 and departed at 1034, arriving at Royal Hospital at 1041.

In what follows I have abstracted text from the medical records. Material within quotation marks is a verbatim quote, material in square brackets thus [ ] is a transliteration to explain either medical terminology or a medical abbreviation. For example in the next paragraph the

portion [diagnosis] in the original is actually a triangle, commonly used as medical shorthand. If not in quotation marks, reference to material from the notes is a paraphrase.

The notes record: On page number 4

'C/O TRIPPED + FELL, C/O PAIN LT HIP.
O/E PAIN ++ LT HIP SHORTENING + ROTATION LT LEG UNABLE TO WEIGHT BEAR.
PMH LVF [diagnosis] .... # NOF [LT]'

Translated from medical 'shorthand' this reads that she had fallen, following a trip, and had marked pain in her left hip. The left leg was shortened and rotated and she could not walk on it and a presumptive diagnosis of a fractured neck of left femur was made. She was recorded as having a past medical history of left ventricular failure, a heart complaint.

Note: The femur is the thighbone. The bone is potentially a long tube formed of hard or cortical bone filled with fat and or bone marrow, broadening at its lower end to form the upper part of the knee joint. At its upper end, just before its upper tip (termed the greater trochanter), there is an angular projection at about 120°, angling upwards and inwards. This terminates in a spherical head of femur that forms the ball of the ball and socket joint of the hip. The short portion below the head is termed the neck of femur and is about 5 to 8 centimetres long. It is important to understand that the blood supply that keeps the head of the femur alive can only run up the neck either inside it or on the outside.

The elderly, particularly females suffer from osteoporosis that leads to weakening of bone. A very common result of this is fracture of the neck of the femur. If this is markedly displaced, the blood supply to the head is damaged and the head will eventually die. This affects the treatment choices (see below).

Left ventricular failure is again common in the elderly and gives rise to shortness of breath, swelling of the ankles due to fluid retention.

Mrs LAKE was recorded as arriving at the Accident and Emergency Department at Royal Hospital Haslar at 1052 on 5 August 1998.

Note: I cannot explain the discrepancy between the recorded time of arrival by the Ambulance crew and the recorded time of arrival by the Accident and Emergency Department.

The triage notes on page 2 recalled 'fell over at 1000, 'o' LOC. C/O PAIN LHIP, SHORTENED [and] EXTERNALLY ROTATED.'.

Note: In this context, triage is carried out by a specially trained nurse or paramedical to assess priorities for treatment.

The note records that she had not undergone any loss of consciousness but had the signs compatible with a fractured neck of femur.

She was then seen at 1100 by a Dr REECE who recorded that an X-ray showed a fractured neck of femur with a displaced sub-capital fracture.

Note: I assume that the note was written in two portions, the initial portion recording clinical findings of a shortened rotated left leg and the X-ray note was written in after the X-ray had been taken sometime later.

Note: A displaced sub-capital fracture, implies that the fracture was immediately below the head of the femur, the displacement would indicate that the blood supply described above had been significantly damaged.

The doctor, on seeing her, recorded that matters had been 'D/W ORTHO ADMIT E3'.

This indicates that Mrs LAKE's management had been discussed with the Orthopaedic Department and she was to be admitted to E3 Ward which, at that time, was an Orthopaedic Ward.

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Continuation of Statement of: FARQUHARSON-ROBERTS, MICHAE
ATHOLL

Before going to the ward she underwent a series of blood tests, a
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She underwent an electro-cardiograph and a chest X-ray. T
intravenous cannula was inserted.

Note: The foregoing series of tests are part of a basic screening for a patient who may well be undergoing an operation. The insertion of an intravenous cannula allows drugs to be given into a vein or a 'drip' to be established.

The blood test results at page 6 dated 5 August at 1302 were essentially normal, apart from elevated blood urea which would be indicative of a degree of kidney dysfunction but with the normal creatinine also recorded, this would not appear to be severe.

The notes record that the doctor receiving was 'Urwin LASRADO '.

Dr/Squadron Leader LASRADO is known to me to have been, at that time, a trainee in Orthopaedic Surgery. He is now a consultant.

Mrs LAKE was admitted, presumably to E3 Ward, on 5 August 1998 at 1300. It was recorded that she was previously well but had fallen, and a diagnosis was made of 'FNOF', a common abbreviation for fractured neck of femur.

On page 52 the notes record that she had a 'MI 3 YEARS AGO, NO RESIDUAL ANGINA, °DM ° COAD ° hypertension'.

These are abbreviations for Myocardial Infarction - a heart attack, diabetes mellitus, chronic obstructive airways disease and high blood pressure. The ' °' means 'no' or 'none'.

It was recorded that she had had varicose veins 25 years previously.

Signed: M FARQUHARSONROBERTS
2004(1)

Signature Witnessed by:

Before going to the ward she underwent a series of blood tests, a full blood count, liver function tests, clotting screen. Blood was taken for cross matching for possible subsequent transfusion. She underwent an electro-cardiograph and a chest X-ray. The notes also record that an intravenous cannula was inserted.

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It was recorded that she had had varicose veins 25 years previously.

It was recorded that she was possibly being treated with Aspirin Allopurinol (a treatment for gout), Co-proxamol (a painkiller) and a 'heart tablet'.

A clinical examination was carried out, which included recording that she had shortening and external rotation (turned out) of the left hip. However, pulse was recorded as being 72 beats per minute, but as being regularly irregular.

Note: A regularly irregular pulse would be indicative of, for example, 2 beats then a gap followed by 2 beats then a gap etc.

Otherwise the examination was normal, apart from a possible mass being felt in the abdomen.

The X-ray was recorded as showing 'Garden IV subcap NOF'.

Note: This refers to a classification of fracture necks of femur, the Garden classification, this implies that the head is completely separated from the neck.

It is recorded that she was to undergo a consent for operation, to undergo an hemi-arthroplasty.

The note was signed by a 'K TRIMBLE', a Senior House Officer in Orthopaedics.

Note: Karl TRIMBLE is known to me, he is now a trainee in Orthopaedics who should, to the best of my knowledge and belief, within a couple of years, become a Consultant.

Note: The system then pertaining at Royal Hospital Haslar was that each weekday afternoon there was a Trauma List, for emergency operating. It would appear that Mrs LAKE was put onto that Trauma List, undergoing her operation at the earliest possible moment. This would be in her best interests. It is known that the outcome from patients with fracture neck of femur is better the earlier they are operated on.

Mrs LAKE then underwent an operation. Regrettably, the notes I have been provided with of

the Operative Record are poorly photocopied. I am unable to read the Anaesthetic History Record or the Operative Record completely.

On page 57 the surgical operation notes record that at 1430, Mrs LAKE underwent a left cemented hemi-arthroplasty.

Note: A hemi-arthroplasty is the thigh half of a total hip replacement. As the head of the femur will die because of the loss of blood supply, it is replaced by means of an artificial head and neck which are inserted into the hollow tube of the bone and cemented into place using a substance known as 'polymethylmethacrylate'

The notes record that Mrs LAKE underwent a Hardinge approach to the left hip.

Note: There are a variety of methods/incisions to approach the hip, the Hardinge being one of the more common.

It was recorded that an extra small stem was inserted with a 43mm head.

Note: The operation was undertaken by Squadron Leader LASRADO. There is no record of my having being involved in this, despite being the Consultant under whom Mrs LAKE was admitted. However, Squadron Leader LASRADO, as a Specialist Registrar in Orthopaedics, would be expected to be able to make clinical decisions and undertake treatment as appropriate.

The nursing notes on page 161 record '1900 Ruby returned from theatre to E3 Ward safely after having a left hemi-arthroplasty ..... She has compression bandages insitu for leg ulcers. Admission completed with the help of Ruby's daughter . Ruby is on a nimbus mattress.....'

It is recorded later that she had a settled night and made minimal use of the PCA.

PCA is Patient Controlled Analgesia. I have reviewed the records with regard to narcotic analgesic dosage. In this context a narcotic analgesic is either morphine or diamorphine.

On page 50 there is mention of two doses at 1135 and 1215 hrs of 3mg of morphine given while she was in the accident and emergency department.

On page 55 there is mention of two doses of 2mg of morphine given during the course of her operation.

She appears to have been given one dose of Diamorphine . On page 128 it is recorded that she received 2.5 Diamorphine at 1300 hrs 5/5/98.

Page 155 is the PCA prescription for morphine and nursing observations. A total of 60 mg was prescribed on 5 August 1998, but the records available to me do not include the print out from the PCA machine which would record how much was actually self-administered. There is no second or third PCA prescription.

Mrs LAKE was next seen by a Medical Officer on 6 August 1998, when a Ward Round was undertaken by 'MJ '. This was recorded on the clinical continuation sheet at page 60.

Note: A Ward Round implies that the doctor and nursing staff went and visited each patient on the ward.

I do not know the identity of ' MJ'.

The note recorded that Mrs LAKE was 'Well, eating and drinking'. She was to undergo a check of her haemoglobin.

Note: haemoglobin a measure of the red content of the blood. In this context, it would give an indication of how much blood she had lost during the operation or as a result of the original fracture.

She was to undergo a check X-ray,

Note: a check X-ray would be to ensure that the inserted hemi-arthroplasty was in the correct position.

It was recorded that her intravenous infusion, (the drip feed) was to be stopped.

Haemoglobin was subsequently reported as being 11.8,

Note: this would be in normal range.

A review by the House Officer on the 6th August 1998 records 'patient vomiting - green, no bowel movement today, no abdo tenderness, lost 1ltr fluid', [at this point in the notes there is a horizontal arrow pointing to the right, implying 'over the course of'] (10 hours [word(s) illegible, possibly 'prescribed'].

'SOB-O2 sats 98% on 02 - claims it is normal'.

Note: SOB is an abbreviation for shortness of breath, O2 sats refers to the saturation of oxygen in the blood, measured by a device called a pulse oximeter.

It is recorded that Mrs LAKE denied any pain or discomfort. It is noted that she had a raised white count, which would possibly be indicative of infection.

It was also recorded that her jugular venous pressure was raised by 3cm and that, on listening to her chest, she had 'basal crackles'

Note: This would imply crackling sounds heard through a stethoscope at the lung bases, that is at the bottom of the chest.

A diagnosis was made of fluid overload associated with left ventricular failure and/or infection.

The House Officer stopped her intravenous infusion for a period of 8 hours to restrict her fluid, ordered antibiotic treatment and for her to have a urinary catheter to monitor the fluid outflow.

She was given two different antibiotics - one Gentamicin, solely to cover the insertion of the catheter.

Note: Insertion of a urinary catheter can give rise to a transient bacteraemia (bacteria in the blood) and at that time it was common to give an antibiotic to prevent this having any untoward affects.

Mrs LAKE was also started on a treatment with another antibiotic 'Augmentin'

Note: Augmentin would be appropriate treatment either for a urinary tract infection, ie an infection of the urine or for a chest infection.

She was also treated with anti-emetics,

Note: anti-emetics are drugs to stop her vomiting.

Mrs LAKE was referred for physiotherapy on 6 August 1998. She was assessed by a physiotherapist who recorded (on page 16) that Mrs LAKE had had a fractured neck of femur on 5 August 1998 and undergone L cemented hemi-arthroplasty'.

Past medical history recorded 'MI 3 years ago (myocardial infarction, heart attack). She is recorded as suffering from Gout. She is recorded as being treated with Aspirin, Co-Proximol and Allopurinol.

Social history records:

'Widow, lives alone, previously independent + self-caring. Previously only able to walk approx 100 yards before rest due to Arthritis'.

It is recorded:

'Awaiting chest X-Ray currently unwell'.

The nursing notes at page 161 record: 'Ruby had a fully assisted bed bath this morning. She remains of her PCA and IVI and has been commenced on oral analgesia to wean her off the PCA. The District Nurse was contacted about the bandages on her bilateral leg ulcers..... Ruby's daughter will bring in her District Nursing notes so that we can confirm the aetiology of the ulcers'.

Mrs LAKE was next seen by a House Officer at 11pm.

It is recorded on page 62 'urine output in past hours 4mls. Patient dry. Patients IV fluids stopped this pm - restarted 2200 hrs at 18?'

She was also recorded as being given oral fluids.

At 2 o'clock in the morning it was recorded urine output 32mls an hour, patient asleep.

Page 162, night time nursing record - 6th August records:
'Unsettled start to the night. Hypotensive with poor urine output given 500mls of haemaccel stat, iv fluids increased, venflon resited L elbow, decreased SOB + BP. Urine output remains between 30-33 cc per hr since 02:00. O2 sats 99-10% with O2 via nasal cannula, BP @ 06:08 129/70. Co-Proxamol required twice with [word indistinct possibly 'fair'] effect. No nausea overnight. Drains remain in situ. Slept for short periods only'.

Note: hypotensive means low blood pressure, haemaccel is a fluid give intra-venously, technically a plasma expander, used to raise blood pressure, venflon is a proprietary intra-venous cannula

On the 7 August 1998, it was recorded that she was seen on the Ward Round by 'MFR',

Note: It is common practice for consultants to be referred to by their initials. MFR was a commonly used abbreviation in Royal Hospital Haslar at the time for myself.

The notes written by the Houseman on page 62 record 'looks better today, urine output 30-40mls per hour, awaiting repeat hip X-ray for House Officer review later'.

She was subsequently seen by the House Officer at 2.30 pm, who recorded on page 63 'seems better today....'.

It is recorded that she had 'bilateral basal crackles',

When seen at 1345 by the House Officer it was recorded that she still had a poor urine output after a fluid challenge,

Note: I assume that the doctor thought this probably due to reduced kidney function .

Note: I cannot explain the apparent discrepancy in the times recorded apart from the fact that the notes were written in 24 hour clock and perhaps the House Officer had miswritten 1345 meaning to write 3.45.

It was recorded that this had been discussed with the Senior House Officer, 'TRIMBLE' and that she was to be given 60mg of Frusemide.

Note: Frusemide is a diuretic. This causes the kidneys to push out more fluid.

On the 7 August at 1500 the nursing notes at page 162 record that she had undergone an X-ray'. She remained on bed rest until after her X-ray this morning. She had assisted bed bath.....

The physiotherapy notes on page 17 record that:

'Chest X-ray okay' (checked by Squadron Leader Lasrado). Mobilised bed [to] chair [with] frame + 2. Managed well [with] encouraged. It was recorded that the plan was that she should 'continue to [mobilise] over [weekend] [with] nursing staff, review Monday'.

1900 the nursing notes on page 163 record that:
'Ruby's fluid intake and output has continued to be monitored. IVI fluids have been stopped in the later part of the afternoon. Ruby was given 500 ml of Haemaccel, about 1400 together with a washout of her catheter. At present, urine seems to be draining well. Her bowels opened a small amount. Became breathless on movement from commode to bed. Was given to some O_2 through mask..... After a period of time doctors informed of situation.'

Later nursing notes on the same page record that:
'Awake frequently through the night. Urine output tailed off start of shift.... bowels open x 3 large watery stools. Full bed bath given this morning [dressing] to L-hip changed. Open area noted, in crease of buttock, surrounding area appears fragile. Nursed side to side O_2 used intermittently throughout the night when [short of breath] with effect. Analgesia given x 1 with effect, no nausea overnight.

However, at 7am nursing notes record that she was complaining of nausea but with no vomiting.

On 8 August 1998 nursing notes on page 163 record:
'All care given, assisted wash, bowels open +++ diarrhoea x 2, specimen sent. Ruby remains very breathless. Pressure areas poor, sacrum broken in sacral crease, difficult to apply any form of dressing due to diarrhoea.....'

Note: medical notation uses '+' signs to indicate severity, size etc. The scale ranges from + to +++, the latter being the most extreme or largest etc.

Later the same day the nursing notes on page 164 record:
'Attempts made to nurse Mrs LAKE on her side, unable to tolerate this at all, much more comfortable sitting up in bed due to breathlessness.... Pressure areas unchanged. Very poor

fluid intake'.

The evening of the 8th August nursing notes on page 164 record that:
'Pyrexial at start of shift - paracetamol given with effect. Paracetamol given with effect. Apyrexial for remainder of night. Agitated at times. Buttocks continue with open areas Opsite applied. [Complaining of] nausea, Cyclizine given with slow effect. Vomited 50mls bile, reluctant to stay on her side. Urine output good overnight, fluid input poor. Remains hypertensive [short of breath] at times O2 therapy with good effect'
The House Officer was asked to review Mrs LAKE. The note records that this was on the 8 August at 0020 i.e. twenty past midnight.

Note: From the context, I believe, that this was probably in the early hours of the night of 9th August.

Page 64 of the notes record: 'asked to see Mrs LAKE re: reduced urine output (20-30mls per hour)'.

On examination, he found the jugular venous pulse was raised and she had again bilateral basal crackles.

Note: The significance of a raised jugular venous pulse combined with the basal crackles is that it is indicative of cardiac failure. Cardiac failure is a term used to describe the situation when the heart cannot fully pump all the fluid it is required to. This leads to fluid accumulating in the tissues, such as the lungs, giving the basal crackles, and to back pressure in the circulation, causing the jugular venous pulse to be elevated.

The notes record that the Houseman discussed matters with the Duty Senior House Officer 'TRIMBLE' and following this he was to give 20mls of Frusemide and to monitor the urine output hourly.

On 9 August the nursing notes on page 164 record that:

'Full bed bath this morning [seen by] Flight Lieutenant TRIMBLE. IV fluids recommenced. Venflon patent initially, extravasated at 1215 hours to be resited, fluid and diet intake remains minimum.

Note: Venflon, as previously noted, is a cannula or tube inserted into a vein. Extravasated means that it is not sited within the vein, therefore, a new cannula has to be inserted.

The note continues for the 9 August. (page 165)
'Vomited x 2 this morning. Mobility improved. Walked around bed with Zimmer frame and assistance. Sat up for one hour. Unable to tolerate. Nursed on side, always rolls onto back. Hip dressing changed.....

On 9 August 1998, Mrs LAKE was reviewed by the Senior House Officer when it was recorded (page 64):

'Urine output much improved...'

Reference is made to her fluid balance, i.e. the amount of fluid taken in by her and given out. I find the note internally contradictory, implying that despite the increased urine output she had taken in 3 litres more fluid than she had passed.

It was noted
'Problems:
poor mobility
SOB
Diarrhoea'.

Note: SOB is an abbreviation for shortness of breath.

It was recorded that she was to have her haemoglobin checked and a sample of her stool was to be sent for culture and sensitivity

Note: Cultures and sensitivity means that some of her stool was to be sent to the laboratory to see if any disease causing bacteria were present to see if her diarrhoea was a result of an infection and if so to ascertain which would be the appropriate antibiotic to treat it.

The note then records that she was seen again on 9 August 1998 by the Senior House Officer who recorded (page 65):

'slow progress.
nausea,
diarrhoea yesterday
poor mobilisation'

It was recorded that her urine output was good, the wound was 'fine'.

Note: I assume that the wound referred to was the surgical incision.

It is recorded that an intravenous infusion was to be restarted and she was be observed.

She was seen again at 1700 (5pm) the same day and the results of blood tests were available. These appear to have been essentially normal.

On 10 August at 6.30 am the nursing notes (page 165) record that:

'Restless night again. Temazepam given but vomited up.....
She was recorded as having had further episodes of diarrhoea.

Later the same day, the nursing notes record:

'All care given this morning. Area between buttocks remains moist and broken. Cream applied. No further diarrhoea. [Seen by] SHO. ECG performed, bloods and chest X-ray, antibiotics

changed to IV as unable to swallow large tablets.

'Ate a small amount of ice cream at lunchtime. Urine output good. Ulcers need redressing today both legs...'.

On 10 August, she was reviewed by the House Officer, (page 66) recorded:

'patient unwell,
vomiting/diarrhoea
drowsy
denies pain
orientated in place and time'

It was recorded that her pulse was raised at 120 beats per minute and was irregularly irregular.

It was recorded that she was to undergo an electrocardiogram, continue intravenous fluids with a fluid balance chart, and her management was to be discussed with my Senior House Officer.

The electrocardiograph was recorded as showing 'sinus tachycardia'.

Note: Sinus rhythm indicates that the heart was beating normally. This contradicts the earlier clinical finding of an irregularly irregular pulse. Tachycardia is a fast heartbeat.

It is recorded that she was to undergo a full blood count, investigation of her blood urea and electrolytes and the cardiac enzymes, a chest X-ray and blood cultures.

Note: The cardiac enzymes would be to test for the after affects of a heart attack, blood cultures in case she had had an infection.

She was seen later the same day, and it was recorded (page 67).
'patient rouseable, denies pain/(shortness of breath) palpitations.

Further [history] unobtainable'.

On examination she was recorded as being drowsy, with a pulse of 90 but regular with ectopics.

Note: Ectopics imply an extra beat of the heart in addition to the normal rythmn.

She was recorded as having inspiratory palpitations at the base of the left lung.

An electrocardiograph was recorded as showing ectopics with a sinus arrhythmia and an elevated ST segment in V4.

Note: an electrocardiograph traces the electrical activity of the heart. This is recorded on a number of leads, one of which is V4. The significance of a single elevated ST segment on the trace is probably slight, but could be indicative of her having had myocardial infarction or heart attack.

It is recorded that she was possibly dehydrated, possibly had had a myocardial infarction, or possibly had a chest infection.

The notes record that she was to be given one litre of normal saline over 6 hours to be reviewed. This is struck through in my handwriting (page 68) and changed to 5% dextrose with my initials against it.

Note: I obviously intervened at this point, feeling that she was being given too much sodium, which would be likely to exacerbate her cardiac failure. 5% dextrose is effectively water, in biochemical terms.

Later the same day, written in my handwriting and signed by me, is a note (page 68):

'By Surgeon Captain FARQUHARSON-ROBERTS, for all necessary treatment and resuscitative measures'.

I have been asked to explain this entry. I have no memory of making it. I do remember that I had, as head of department, given instructions that for the avoidance of doubt, consultants direction and guidance as to the management of patients was to be recorded in the clinical records, preferably in their own hand when there was any possibility that it might be thought in the best interests of the patient for care to be modified.

She was seen at 2.30 pm by 'COLTMAN' who recorded (page 69) 'much improved, alert, bright and orientated'.

Chest X-ray recorded that she had a left side basal chest infection, with no evidence of cardiac failure.

It was recorded that she was to continue on Augmentin but at a raised dose.

The note continues:

'continue with therapy, observe fluid balance [overnight] prone to go into failure'.

The nursing record covering the night 10/11 August (page 166) records that:
'Ruby had a very unsettled night last night. She was incontinent faeces twice. Her stools were very loose. She remains on her Egerton Bed and she has been able to move and turn throughout the night. Her sacral area remains red but due to her incontinence this has been left uncovered and she continues to need to be kept off her sacrum. Her IVI continues as per regime. Her oral fluid intake has been poor overnight due to her confusion. Her catheter remains in situ, but she has been draining small amounts.....'

On 10 August the physiotherapy notes (page 17) record that:
'Appears unwell today ? MI ? Chest Infection'.

MI as previously noted is myocardial infarction and chest infection which would imply

pneumonia

It was noted 'on AUSC' that there was:
'decreased air entry at the left base of the lung with no added sounds. She was taught breathing exercises and coughing. 'Good strong cough'. Dry nil expectorated'.

Note: AUSC is an abbreviation for auscultation i.e. listening with a stethoscope.

She was reviewed on 11 August 1998 (page 69) by the House Officer and it was recorded '[patient] feeling nausea [and] abdo pain'.

'Spoken to Surg [eon] L[ieutenan]t COLTMAN (SHO)'.

It was recorded the plan of treatment was to give her further dextrose.

Note: I cannot read the rest of the note with certainty, but believe it to read: 'Further 1 litre dextrose/12hrs

Dose [word indistinct, possibly 'cyclizine'] as [word illegible]

Chase U&E results'

The physiotherapy notes (page 17) record that:
'the left base remains quiet and that she remained unwell.

On 11 August the nursing notes record that at 1420 (page 166).
'Full wash given this morning, bottom and sacral area very red and breaking down in cleft. Nursed on side all morning. Incontinent of faeces x 1. Dark, greeny stool. Complained of [word indistinct possibly 'sacral'] pain this morning then nausea. [Seen by] [word indistinct] IVI Dextrose 5% commenced at 1145 hrs. Cyclizine given on Drs orders. At 1210hrs started suffering with 'muscle spasms' /[word illegible] BP raised + pulse. Dr came to see ?reaction to Cyclizine. Tolerated v little food, although unwell at lunchtime. Bloods taken this morning,

now much better at time of report'.

On 11 August at 1930 the nursing notes record that (page 167):
'Mrs LAKE remains very sleepy. Doctors unable to re-cannulate after initial Venflon fell out. To encourage oral fluids. 1 x diarrhoea, small amount, urine output satisfactory. Difficult to nurse on side ? change bed tomorrow'.

She was seen on 11 August by 'COLTMAN' who recorded: (page 70)

'Much improved. Apyrexial, good urine output'.

Note: Apyrexial means that she did not have a raised temperature.

It was recorded that the blood results were normal and that she should be switched to oral Augmentin,

Note: oral means the drug will no longer be given intravenously or by injection.

It is recorded that she should be encouraged to drink fluids.

Later the same day (11.30 pm) urine output had dropped from over 100mls an hour to less than 50mls an hour and her jugular venous pressure was again raised at +4cms.

The Houseman recorded the impression that she was left ventricular failure. (page 71)

It was recorded that intravenous fluids should be stopped and she be given intravenous Frusemide and the notes record'[chest X-ray] tomorrow maybe useful to confirm failure'.

She was seen on a Ward Round by the Registrar the following day, who recorded (page 71): 'Much improved, has sat out today, not in failure [no further diarrhoea, developing sacral bedsore....'

It was recorded that she be mobilised for the physiotherapy and encouraged to take oral fluids.

Her antibiotics were stopped as were her intravenous fluids.
On 12 August it was recorded:

'Urine output poor, early evening and night. It was recorded that she was seen by the House Officer and the IV fluids were stopped and 40 mg of intravenous Frusemide given with effect.

'Increased urine output. Commenced on O_2 via nasal cannula 2 litres. Remained agitated and restless throughout night, continually nursed onto side but continuous to move herself onto back. Sacrum and buttocks very red.'

The physiotherapy notes record that on 12 August:
'Appears slightly brighter today on AUSC good [air entry] no added sounds.

It is recorded that the treatment plan was to increase her mobility the following day 'if well enough. '

12 August, the nursing notes record that (page 167):
'Fair morning. Full wash given. Sat out for one hour. Bottom remains extremely red. New Electric bed awaited. Fluids taken in reasonable amounts. Urine output satisfactory. Awaiting antibiotic change to oral.
Would dressing left intact. No further oozing noted. Ulcer dressings to be changed this afternoon.

The nursing notes for the 'pm' period 12 August 1998 records that (page 168):
'Ulcers redressed as per District Nursing Plan. New bed arrived. One episode of diarrhoea. No other problems. Appears a lot brighter.'

The nursing notes for 13 August 1998 timed 7am record that (page 168):

'Ruby had an unsettled night overnight. She continues to be very restless. Her urine output has been satisfactory and her fluid intake has improved.

The physiotherapy notes for 13 August record that:
'Unable to mobilise at present due to chest pain'.

On 13 August she was referred to Dr LORD.

Note: I know that Dr LORD was at that the time, a Consultant in Elderly Care who visited Haslar on a regular basis.

The Referral reads: (page 72)

'Surgeon Captain FARQUHARSON-ROBERTS' compliments. He would be very grateful if you would assess this lady from the point of view of her future management. Mrs LAKE was admitted from A&E following a fall which resulted in [fracture] of the left neck of femur. She underwent a left hemi-arthroplasty on 5.8.98. Post-op recovery was slow with periods of confusion and pulmonary oedema. She also suffered vomiting and diarrhoea. Over the last 2 days, however, she has been alert and well and it is now our intention to work on her mobilisation.

Previously, she lived in a ground floor house, being visited twice weekly by the District Nurse for the past 4 weeks or so. The physio also visited her for the past 6 weeks or so. Thanking you in anticipation'.

The nursing note timed 'am' reads: (page 168)
'Assisted wash given this am. Hourly urine output satisfactory. Pressure areas remain red. Bowels opened this am [complaining of] central chest pain. O_2 4 litres per minute given by a nasal cannula. GTN [two tablets] given sublingual with effect. ECG taken. Reviewed by doctor - no further action required.'

Mrs LAKE was seen on 13 August by Dr LORD who wrote: (page 73)

'Elderly medicine'

Thank you. Frail 85 year old with:

1. Left cemented hemi-athroplasty of hip 5.8.98.
2. LBBB + LVF - improving
3. Sick Sinus Syndrome/AF.
4. Dehydrated but improving.
5. Bilateral buttock ulcers.
6. Bilateral leg ulcers.
7. Hypokalaemia.
8. Normochromic Anaemia.
9. Vomiting and Diarrhoea ? cause'.

Note: LBBB is a abbreviation for left bundle branch block, an abnormality of heart conduction, LVF an abbreviation for left ventricular failure a form of cardiac failure.

Note: Sick Sinus Syndrome is an abnormality of the heart. AF a term for atrial fibrillation, when the heart beat, instead of being in sinus rhythm (see above) is irregularly irregular.

Note: Hypokalaemia is low blood potassium. If it gets too low, it can affect the action of the heart. Normochromic anaemia is anaemia with normal amount of red haemoglobin in each of the red cells, but fewer than normal red cells giving an overall anaemia.

Dr LORD suggested that she have potassium supplements, be given oral hydration and 'stools culture and sensitivity and if not sent already'.

Dr LORD concluded 'it is difficult to know how much she will improve but I will take her on to NHS continuing bed at [Gosport War Memorial Hospital] next week.

The nursing note for 13 August annotated pm records that:
'Comfortable afternoon. Oral fluids taken and urine output. No [complaint of] chest pains. [Seen by] Dr LORD for transfer to Gosport War Memorial next week'.

In a letter dictated on 14 August and typed on 17 August (page 23), Dr A LORD FRCP, Consultant Geriatrician wrote to me saying:

'Thank you for referring Mrs LAKE, whom I visited on E3 at Haslar on 13 August 1998. She was admitted with a fractured neck of left femur and has had a cemented hemi-arthroplasty on 5 August. She is catheterised and diarrhoea and vomiting have been problems recently. Her appetite is poor and she is eating and drinking very small amounts. Her ECG show atrial fibrillation but also a variable PR interval, indicating a sick sinus syndrome, ischaemic heart disease and LVF have also been problems recently. 'Biochemically she is still dehydrated, hypokalaemic and has a normochromic anaemia.

'If the diarrhoea persists I would be grateful if stool cultures could be sent. Potassium supplements would also be required as she is on Digoxin in order to prevent Digoxin toxicity associated with hypokalaemia.

'Mrs LAKE also has problems with chronic leg ulcers and recently buttock ulcers as well, and overall she is frail and quite unwell at present. I am happy to arrange transfer to an NHS continuing care bed at Gosport War Memorial Hospital. At this stage I am uncertain as to whether there will be a significant improvement as, prior to this admission, Mrs LAKE lived on her own and was supported by her daughters.

With best wishes,

Yours sincerely'

Mrs LAKE was seen on a Ward Round by the Senior House Officer on the 13 August 1998 who

recorded (page 74):

'Thank you Dr LORD, stool [culture and sensitivity] no growth'.

It was recorded that she was started on Slow K.

Note: Slow K is a proprietary preparation of Potassium taken by mouth.

On 14 August the physiotherapy notes record that:
'Brighter today, sitting out. Walked short distance [with] a frame, managed very well'.

It was recorded that the plan was to:
'gradually [increase] distance walked as energy increases.

The nursing note for 14 August 1993 timed 0700 records that (page 168):
'Ruby spent a comfortable night. She was turned frequently to rest her sacrum. Her fluid intake and urine output has been satisfactory'.

The am nursing note for the 14 August records Page 168):
'Ruby has had a wash with minimal assistance. Fluid intake and urine output satisfactory. Bowels not open this am. No chest pain. Waiting for transfer to GWM next week. Walked with Physio into the middle of ward with minimal assistance'.

Mrs LAKE was seen on 14 August by me. (page 74) The note records:
'Well'.

Note: The next portion of the note is illegible.

The entry continues 'plan mobilise [transfer] to [Gosport War Memorial Hospital] next week'.

The nursing note for the 15 August 1998 at 0700 records that (page 169):

Ruby had some pain due to arthritis in her left shoulder overnight. She had paracetamol as charted to good effect. She was frequently assisted to turn and move up the bed to make her comfortable. She has been fully alert'.

The nursing note for 15 August for the period 'am' records that (page 169):
' Full assistance given with hygiene needs. Sacrum broken on both left and right buttocks + sacral cleft. [word indistinct] dressing [Hydrocolloid] applied. Still some loose stools for barrier creams to perineum to protect skin. Sat out in the chair for lunch. Now back in bed on right side. Left hip redressed. Would clean. [complaining of] pain in left shoulder/chest on inspiration. O_2 remains in situ. Doctors to revisit? muscular'.

She was seen on 15 August by the Senior House Officer who recorded (page 75) 'ISQ mobilised, Check K+ Monday'.

Note: ISQ is an abbreviation commonly used in medical notes for 'in status quo', i.e. unchanged. K+ is an abbreviation for Potassium.

There is a note in a different hand dated 15 August 1998 (page 75), indicating that she was being reviewed by a House Officer who recorded 'L-sided chest pain in ribs through to back - since being manhandled. Worse on coughing, tender over ribs'.

An electrocardiograph was recorded as showing no changes and it was recorded that there was no affect on her pain with 'GTN'.

Note: GTN is a glyceryl trinitrate which should have a beneficial affect if the pain was of cardiac origin.

The House Officer recorded that she was to have oxygen by nasal spectacles

Note: Nasal spectacles are like spectacle frames except these come over the ears and under the eyes and actually the catheters delivering the oxygen poke up each nostril.

It is recorded that the probable diagnosis was musculo-skeletal pain but the House Officer considered the diagnosis of pulmonary embolus or angina.

Note: pulmonary embolus is a blood clot travelling to the lung. This would follow a deep venous thrombosis such might follow a period of immobilisation in hospital.

Angina is pain of cardiac origin, i.e. from the heart.

It is recorded that she was to be given pain relief with codeine phosphate , have a chest X-ray in the morning and, the note is not entirely legible, but I believe to be observed at night.

It is recorded that she was to be considered to have a spiral computerised axial tomography, or a VQ scan or pulmonary angiography.

Note: VQ scan would be appropriate to diagnose pulmonary embolus I don't think the spiral CT or pulmonary angiography would be appropriate in the management of an 86 year old and these do not appear to have been discussed subsequently.

Nursing notes for 16 August 1998 at 0700 (page 170) record that:
'Ruby had a restless nights sleep. Her left shoulder pain increased at one point and an ECG was performed which showed no changes to her previously ECGs. She was seen by the SHO who requested U&E's bloods and [word indistinct] which showed a high Urea result. Her urine output was minimal overnight. Due to her previous fluid overload and her chesty cough the doctor wanted her to be reviewed today reference? IVI fluids needed. She was also being prescribed Codeine Phosphate for analgesia of her shoulder paid to good effect'.

The nursing notes on 16 August 1998 at 1900 (page 170) record that:
'Comfortable afternoon. O_2 Sat 96% on air.'

Note: This records the saturation of 96% of the bloods oxygen carrying capacity while breathing

air ie. without an oxygen supplement. That is entirely normal.

The note continues:
'Went out with family around the grounds. High in spirits on return. Legs redressed. Clips removed left hip. Wound leaking serious fluid distal end of wound, slightly open. Skin closure achieved with steristrips.'

Note: At the time of the operation, the incision was closed with clips rather that sutures, this is common practice.

On removal it would appear that the wound had not entirely healed and it was necessary to complete the closure with steristrips, which can be thought of as being a medical sticky tape.

The note continues:
'Good oral intake of fluids. Sacrum redressed with Kaltostat + Opsite for [world illegible] tomorrow'.

On 17 August 1998 the nursing notes (page 170) record that at 0700:
'Ruby had quite a good nights sleep after settling late and frequently calling out. Taking good amounts of oral fluids. Invests satisfactory due to go to Gosport War Memorial Hospital this week.'

Mrs LAKE was reviewed at 0840 on 17 August by the Senior House Officer [COLTMAN].

It was recorded (page 76) that she was well, had no chest pain, was mobilising slowly and awaiting transfer to the Gosport War Memorial.

On 17 August the physiotherapy notes record that:
'Bright, sitting out in chair independent (moving from sitting to standing)'.

It was recorded that she mobilised with a Zimmer frame and supervision and managed well.

At 2015 on 17 August the nursing notes (page 171) record that:
'Seemed confused this afternoon, reluctant to move herself around bed or from bed to chair. Phone call from Gosport Memorial Hospital to move mane'.

Note: Mane is commonly used notation in medical records for in the morning.

The note continues:
'to Dryad Ward, transport request has gone. Pyrexial 38.8° C at 1945 Paracetamol given.'

She was next seen on the Ward Round by the SHO [COLTMAN] on 18 August 1998 (page76) and it is recorded:

'Well comfortable [and] happy. Last pm spike temperature 38.5° C, now 37.3, mobilising well. Transfer to [Gosport War Memorial] today.'

It was recorded that her intravenous infusion was to be removed, oxygen to be stopped and she was to be transferred to the Gosport War Memorial Hospital.

On the 18 August 1998 the nursing notes (page 171) record that:
'Increase shortness of breath recommenced on oxygen therapy. Encouraged to expect expectorate a-Pyrexial. Sacral dressings changed'

On 18 August the physiotherapy notes record that:
'[Patient] [discharged]. Home safe [and] [independent].

There are no further records available to me. However, I felt it would be appropriate to review the prescription records with regard to drugs she was given while an in patient at Royal Hospital Haslar.

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In addition to the various drugs mentioned in the statement to this point, she was recorded as being given:

Ranitidine, Diclofenac and Metaclopramide on 5 August 1998, single dose only, at the same time.

Note: Ranitidine is an anti-ulcer drug, Diclofenac a painkiller which can cause ulcers and Metaclopramide to prevent vomiting.

She was also given Cefuroxime at the same time and, subsequently, an antibiotic.

Note: From the context in which it is prescribed I believe that it was used to prevent infection of her hemi-arthroplasty.

The foregoing appears to have been given in association with and part of her operative procedure.

She was also prescribed Augmentin an antibiotic, Gentamicin, an antibiotic, Ondansetron, a drug with which I am unfamiliar. Frusemide, a diuretic.

She appears to also have been given Caliparine, Allopurinol Aspirin, Bumetanide and Digoxin.

She was also prescribed Cyclizine, a drug used for the treatment of nausea.

She was prescribed, but never given Naloxone.

Note: This is a narcotic which paradoxically counteracts and cancels the action of other such drugs. It is thus used as an antidote to morphine overdose.

She was given Co-proxamol, a painkiller.

She was also recorded as being prescribed Temazepam, a night sedation which was given on 3 occasions but on the 14 August it was not given, the reason being given was 'asleep'.

She was also given Slow K, a preparation of Potassium.