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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: LORD, ALTHEA EVERESTA GERADETTE

Age if under 18: O.18 (if over 18 insert 'over 18') Occupation: COMMUNITY GERIATRICIAN

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: A LORD Date: 27/01/2006

Further to my statements regarding Gosport War Memorial Hospital. I have been asked to clarify the following points.

In regard to the patient Ruby LAKE and my statement dated 15th March 2005 and the entry on page 74 of Mrs LAKE's medical notes, JR/19A , where I have written.

4) It is difficult to know how much she'll improve but I'll take her to an NHS continuing care bed at GWMH next week.

This is a complicated medical case where I would not be optimistic with her prognosis. Additionally because prior to admission she had lived alone but had required support, before she could be discharged account would need to be taken not only of her medical condition but also the level of support available for her which would need to be the same or greater than before admission.

I have been showed Mrs LAKE's prescription sheet page 366 & 367 of BJC/67 and asked to explain the drugs.

As required prescriptions:-

Oramorph 10mg/5mls, orally 2.5-5mls four hourly dated the 18th August by Dr BARTON. This is a strong pain relieving drug administered once on the 18th August 5mgs and two on the

Signed: A LORD Signature Witnessed by:

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19th August 1998 both 10mgs.

Temazepam 10-20mgs orally, one at dated, dated 19th August 1999 by Dr BARTON. This was never administered, sleeping tablet.

Regular prescriptions:-

These were all prescribed by Dr BARTON on the 18th August 1998 and are as on transfer from Haslar Hospital . Digoxin 62.5 micrograms, orally, one tablet in the morning. This tablet shows an irregular heart rate. Slow K, orally 2 tablets twice a day, a potassium replacement tablet. Bumetanide lmg, one tablet taken orally in the morning a diuretic Allopurnol 100mgs one tablet in the morning to prevent attacks of gout.

Daily review prescriptions. These prescriptions are for drugs that the patient requires depending on their conditions but where the dosage can be adjusted according to the patients condition.

Diamorphine 20-200mgs subcutaneous in 24 hours. This is an injectable pain killer to be given over a twenty four hour period via a syringe driver.

Hyosine 200 - 800 micrograms again subcutaneously in 24 hours. This reduces secretions in the throat.

Midazolam 20-80 milligrams subcutaneously in 24 hours. This is for anxiety.

All three drugs have been prescribed by Dr BARTON. The prescriptions are undated but the form has no available space on it. This is intentional so that the administrator of the drug can decide when to start it.

These three drugs are suitable to be administered simultaneously via a syringe driver.

As a consultant in charge of the patients on Dryad Ward I would have as part of a fortnightly

ward round reviewed patient prescription sheets. The drugs that were prescribed to Mrs LAKE were appropriate. To prescribe within a specified range was appropriate, and was standard practise at that time for these drugs in this instance.

There was a stage in mid to late 1990's when Haslar was admitting and operating on acute orthopaedic patients. These patients were transferred to Gosport War Memorial Hospital as we had the bed capacity. As such our work load increased. To ensure that the out of hours doctor was only called when necessary a practise evolved of prescribing within a given dose range to ensure that patients received the appropriate level of medication.

I never had any concerns regarding Dr BARTON's prescribing practises. I would of in my role as a consultant changed or altered prescriptions as appropriate to the patients condition.

Dr BARTON would have usually accompanied me on the Dryad Ward rounds. I would have visited each patient and made a note on each patients medical record. A ward round is a review of the patient condition and treatment by all health and social care professionals involved in that patient.

My role as a Consultant Geriatrician at Gosport War Memorial Hospital was to provide support to the Clinical Assistant by way of ward rounds. Furthermore I was always contactable for advice or if necessary to review a patient. If I was contacted by the Clinical Assistant or the nursing staff in this way I would expect them to make a note of this on the medical record.

I also carried the overall responsibility for the care and management of the patients on the ward.

We also ran Clinical Assistant teaching programme in Elderly Medicine which was a monthly evening session which was attended by all the Clinical Assistants in the department and Consultants in the department. These were held at QA Hospital and started in 1997 and ran for six years. It was topic teaching and a presentation by a Clinical Assistant for discussion.

Queen Alexandra always transferred the patient notes and x-rays with the patient to Gosport

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War Memorial Hospital. This was a complete set.

Haslar Hospital did at one time only send a transfer letter and x-rays with the patient. Although at some stage, I can't recall when, they sent the notes with the patient.

Signed: A LORD
2004(1)

Signature Witnessed by:

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