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STATEMENT OF WITNESS

STATEMENT OF WILLIAM PAUL GORMLEY

DATED THIS DAY OF 2008

I, WILLIAM PAUL GORMLEY, declare that this statement is true to the best of my knowledge and belief and I make it knowing that if it is tendered in evidence at the Inquiry, I will be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

1. The Inquiry has disclosed a number of documents to me. Where I make specific reference to a document in my statement I have given the number of the relevant page.

2. I am a Consultant Anaesthetist at the Mater Hospital in Belfast. On the night of 26/27 April 1997 I was the Senior Registrar on call for anaesthetics at Craigavon Area Hospital (CAH). My role was to provide emergency anaesthetic cover for general surgery, an epidural service for maternity and cover for patients in intensive care including resuscitations, as well as to be on call for the Accident and Emergency Unit (A&E) for any emergencies.

3. I commenced my shift at around 1300 on 26 April 1997 and I worked through until 0900 on 27 April. I cannot recall what time I was called to attend to Mr Hamill in A&E. It would have been somewhere between 0200 and 0400 but I have not recorded the time in my notes. I was called to assess a person admitted with head injuries. I may have been given other information at that stage but I cannot remember it now. I cannot recall who called me down but I assume it would have been the Senior House Officer (SHO) in A&E.

4. I cannot recall the other staff who working that night. I cannot remember whether Mr Charles Fee was on duty and I do not recall a nurse by the name of Maureen Hagan. I have no recollection of who was in A&E when I arrived to

examine Mr Hamill. I remember I was told that Mr Hamill had been assaulted outside a pub but I was not told any further details.

5. I have refreshed my memory from my notes which are contained at page **38670**. These notes are part of the CAH inpatient notes for Mr Hamill.

6. I can recall there being blood on Mr Hamill's face but I cannot recall if he was actually bleeding or how much blood there was. The document headed *"Nursing Care Plan"* which commences at page **38665** is a form that I assume a member of the nursing staff completed, rather than a doctor. I have not made any entries on that document but I note it mentions that Mr Hamill had blood on his face. The phrase "*bloody ++ head + face*" indicates that his head and face were very bloody. The plus signs indicate the amount of blood present. I do not know who made that entry or any other entry on that document, including the note "*attacked by group, hit on head by ?? bottle*". I do not recall whether Mr Hamill had any injuries to indicate he had been hit on the head with a bottle or a sharp instrument.

7. Mr Hamill was unconscious and I assessed his consciousness using the Glasgow Coma Scale (GCS) as 5 out of 14. This is recorded on my notes at page **38670**. The GCS is a means of assessing a person's consciousness through eye movement and response to verbal command and pain. The lowest rating is 3 out of 14 for a completely unresponsive patient, and the highest rating is 14 out 14 for someone who is orientated and alert. The document headed *"Inpatient follow-up and Outpatient Notes"* contained at page **38669** records a rating of 3 on the GCS. I can confirm this document is not in my handwriting.

8. I have been asked to explain the difference in the two GCS ratings given for Mr Hamill on 27 April 1997. One explanation is that the scale can fluctuate in a patient over time. Another possible explanation is that, because I do GCS assessments quite often, I was able to stimulate Mr Hamill more and so get a greater response, which would mean he gained an extra point or two. However, I do not believe the difference between 3 and 5 out of 14 was clinically important in this situation.

9. I do not recall what Mr Hamill's oxygen saturation level was when I first saw him and I have not written it down in the notes.

10. After assessing Mr Hamill using the GCS I then intubated him. This procedure involves putting a tube into a patient's trachea to assist breathing. In order to insert the tube, a laryngoscope is used. This is essentially a torch with an angle on it used to line up the three angles in the mouth: the oral, pharyngeal and tracheal. Once these are lined up there should be a clear view of the vocal chords and a tube can be inserted. In order to insert the tube the patient's muscles must be completely relaxed. If is patient were not relaxed they might struggle and prevent the tube from being inserted.

11. My notes at page **38670** record that I administered 400mg of Thiopentone before commencing the intubation. This drug is an induction agent which is really an anaesthetic. It is used because, even though a patient is unconscious, when the airway is stimulated it can result in a very high rise in blood pressure and pressure in the brain which can make a head injury worse. Because I had rated Mr Hamill as 5 out of 14 on the GCS it was wise to use an anaesthetic agent to obtund any peaks in blood pressure and pressure in the brain.

12. Referring to the notes I see I also gave Mr Hamill 100mg of Suxamethonium which is a muscle relaxant. In the case of intubation it is used to relax the muscles in the larynx and vocal chords so that a tube can be inserted more easily. This drug is given as part of a standard protocol when a person is giving some response.

13. I cannot now recall whether I had any difficulty in opening Mr Hamill's mouth in order to intubate and I cannot recall what his breathing was like before we started. In my notes at page **38670** I have written the abbreviation *"IPPV"*. This stands for Intermittent Positive Pressure Ventilation which means that either a bag or a machine was used to breathe for Mr Hamill. To "bag" a patient means putting a mask over the face and squeezing a bag to deliver oxygen to help breathing. I would have started manually with a bag and, if I was able to "bag"

Mr Hamill, I would not have been too concerned about the jaw because I knew I would soon be administering the muscle relaxant to relax it. I would normally note jaw clenching if it meant I could not "bag" the patient, and so the fact I did not make a note indicates that the jaw did not pose a problem.

14. I have also recorded *"RSI"* on my notes at page **38670**. This abbreviation stands for Rapid Sequence Induction, induction meaning to put someone to sleep. When a person is admitted to hospital in an emergency and there is a high chance that the stomach is full, the induction must be done quickly to minimise the time in which a patient could regurgitate something from their stomach and aspirate that in their lungs. RSI describes a protocol for putting a patient to sleep in an emergency situation where there is a risk of aspiration.

15. The reference to *"preoxy"* on my notes at page **38670** is to preoxygenation, which is part of RSI and involves giving the patient 100% oxygen through the mouth before intubation. This fills the lungs with oxygen and affords the anaesthetist more time in which to insert the tube.

16. My notes also state *"Chord seen"*. This refers to the vocal chords. It appears that when I inserted the tube I was able to get a clear view of Mr Hamill's vocal chords. I do not recall if there was anything in Mr Hamill's airway at this point but, if there was, I would have used a suction unit to remove it. If there was a lot of vomit present I would normally note this but I have not done so in this case.

17. I have also noted that 20mg of Vecuronium was given. This is a longer-acting muscle relaxant which lasts for around 20-30 minutes. Suxamethonium is used initially in an emergency situation where you need the patient to be fully relaxed quickly in order to intubate because it acts faster than Vecuronium. Suxamethonium acts within a minute whereas Vecuronium normally takes a couple of minutes to take effect.

18. The entire intubation process from start to finish probably would have taken around 3 minutes. The process I used to intubate Mr Hamill was a standard procedure for anyone admitted with a head injury in emergency circumstances.

19. I have been asked whether Mr Hamill could have been intubated at the scene of the assault. I understand that some paramedical staff are trained to intubate patients but to the best of knowledge they are not allowed to administer anaesthetic drugs. This means that ambulance staff would probably only attempt to intubate a person if they were totally unconscious and unresponsive.

20. I also wrote in my notes at page **38670** *"Head held in line: collar on"*. This is a reference to the precautions taken in relation to any possible neck injury. It is assumed in the case of all head injuries that there is also a neck injury until it is proven otherwise. I would have fitted a stiff neck collar and someone would have held Mr Hamill's head during this procedure to prevent aggravation of any neck injury.

21. The notes also say a chest x-ray was taken and my reference to *"NAD"* means there was nothing abnormal seen.

22. I have also written *"Cervical spine, C7 T1 not clearly seen"* in my notes. *"C7 T1"* is a reference to cervical 7 and thoracic, a junction of particular bones in the neck. If this junction is clearly seen on a neck x-ray, one can be fairly certain that there is no a neck injury but, if the junction cannot be seen, you cannot be sure. I have noted that this junction was *"not clearly seen"* on Mr Hamill's neck x-ray. A CT scan would probably have been needed to see whether there was actually an injury to the neck.

23. The notes state *"CT scan not working. Therefore transferred RVH"*. The CT scanner at CAH was not working that night. If Mr Hamill had been given a CT scan at CAH I would have accompanied him in order to look after his ventilation. If the CT scanner had not been broken, the normal procedure would have been for Mr Hamill to have a CT scan which would have been sent to the neurosurgeons at RVH. They would have made a decision on whether it was necessary to transfer Mr Hamill that night. Given that the CT scanner was broken, the decision to transfer Mr Hamill would have been made by the

surgical staff at CAH. I would not have made the decision. I cannot recall who the surgeon on duty was that night.

24. I am not sure what time Mr Hamill was transferred but it would have been somewhere between 0400 and 0600 on 27 April 1997. I am almost completely certain that I travelled in the ambulance with Mr Hamill to RVH. At that time it was the responsibility of the referring hospital to provide the anaesthetic cover during an ambulance transfer. A nurse would always have travelled in the ambulance with the doctor too. I would have called the Consultant to come in to cover for me whilst I accompanied Mr Hamill in the ambulance.

25. Upon arrival at RVH, I would have given a verbal handover to either the anaesthetist on call there, or the anaesthetist in the Intensive Care Unit (ICU). I think we transferred Mr Hamill directly to the ICU. Sometimes a letter is handed over on transfer if there is time to write it beforehand, but I am not sure if I did this in this case. I do not think I made any notes or completed any documents whilst at RVH. After transferring Mr Hamill, I think the ambulance would have dropped me and the nurse back at CAH.

26. I have been asked to comment on the medications listed on my notes at page **38670**, and those listed on the document headed *"Medications"*, contained at page **38666**. I believe the latter document would have been completed by one of the nursing staff. This document lists drugs that were ordered for Mr Hamill and next to the first three drugs is written *"Ordered by Dr Gormley"*. Scoline is the first drug listed on page **38670**. This is another name for Suxamethonium. Intraval Sodium is listed next and is another name for Thiopentone. The third drug is Deprivan, another anaesthetic drug that is sometimes used when a patient's blood pressure has started to rise. This drug is not recorded on my notes at page **38670**. I am not sure why this is so but it is likely I just forgot to note it down. The Deprivan would have been administered any time after the other two anaesthetic drugs had been given, but I cannot recall the time. In my notes at page 38670 there is a reference to Mr Hamill also being given Vecuronium. This is not recorded in the notes at page **38666** and I am not sure why this is the case.

27. The document contained at page **38678** entitled *"Head Injury Chart"* was probably completed by nursing staff in A&E. This chart is used to plot and monitor the observations of a patient with a head injury. I have not made any entries on this document.

28. I have seen a document headed "Casualty Slip" which is contained at page **38973**. I do not recognise this document or the handwriting on it.

29. I do not recognise the document contained at pages **72741** to **72775** which has a cover sheet saying, *"Copy of all notes in patient's chart relating to Mr Hamill's attendance on 27 April 1997"*. I also do not recognise the signature at page **72763**.

30. I do not recall seeing any of Mr Hamill's relatives at CAH or speaking to the police at any time about this case. After Mr Hamill was transferred to RVH I had no further involvement in his care.

SIGNED:

WILLIAM PAUL GORMLEY

DATED: