MR KERR: Mr Patel, please, page 85.

DR UMANG PATEL

Examination in chief by MR KERR:

Q. I wonder, Mr Patel, if you would be good enough to tell us your qualifications for the record?

A. MB, BCH sorry, I have a bachelor of medical from Saint Andrews in Scotland and I have an MB BCH from Manchester and then I qualified as a surgeon from England which was another exam and I have a doctorate of medicine.

Q. Now, in May of 1997 were you a specialist registrar at the Royal Victoria Hospital?

A. Oh yes, I was.

Q. And on Thursday the 8th of May 1997 were you on duty and working in ward 39 at the hospital?

A. Yes, I was.

Q. And could you just tell my Lord what is ward 39 in the hospital?

A. Ward 39 and ward 40 are the two neurosurgical wards in the Royal Victoria Hospital in Belfast.

Q. On that day did you see Robert Hamill from [redacted]

A. Yes, I did.

Q. And had he been a patient at the hospital for some days being treated for head injuries?

A. Yes, he had been, my Lord.

Q. Throughout the period can you say had he remained unconscious?

A. Yes, he had remained unconscious throughout the period, until I saw him.

Q. And at 5.03 pm on the 8th of May did you pronounce life

extinct?

A. Yes, I did.

Cross-examination by [redacted]:

Q. Is ward 39 distinct and different from the Intensive Care Unit?

A. Yes, it is.

Q. Is it the case that Mr Hamill had initially been in the Intensive Care Unit and then been removed to the neurosurgical ward?

A. Yes, he came to the Intensive Care Unit and he was transferred to ward 39, to the neurosurgical ward.

Q. Can you tell us when that was?

A. I think it was two days later, but I'm not sure. [After referring to notes]: Yes, he was transferred on the 29th of April at 1.00 pm.

Q. Into your ward?

A. Into the ward, yes.

Q. And did he then come under your care?

A. Well they are under our care in the Intensive Care Unit as well, but jointly with these.

Q. Had you had dealings with him then from his original admission?

A. My dealing with him was really from the Monday, which was the 4th, I had been on holiday the previous week.

Q. That was your first contact was the 4th of May?

A. As I recall.

Q. Under whose care was he?

A. He was under the care of [redacted], the consultant neurosurgeon.

Q. You described yourself as a specialist registrar?

A. Yes.
Q. What speciality?
A. Neurosurgery.
Q. Neurosurgery. Had there been a sudden and unexpected deterioration in his condition on the 8th of May?
A. Yes, there had been.
Q. Up until that time was the view that he was being treated for a relatively minor brain injury?
A. Yes, it was, that was the view.
Q. In what way did the sudden and unexpected deterioration manifest itself?
A. Well, I was asked to see him urgently on the ward. At the time it just happened on that day that once a month we have a meeting --
[redacted]: Sorry, I have a little bit of difficulty hearing you.
THE WITNESS: On that very day, my Lord, once a month we have an audit meeting with the consultants as well as the specialists all together, it just happened that we were all on that ward in that room and we got an immediate message to come and see him because he had become cyanosed, which means that he had become blue, suggesting that his oxygenation level was very low. And also that his temperature had gone quite high, which it had been for quite a number of days, and his blood pressure was almost unrecordable, so really it was an emergency and really more or less most of us left the room to assist him with the problem.
[redacted]: At what stage of the day was this?
A. This was in the afternoon, approximately I would say 3.30, quarter to four, something like that.

Q. And about three minutes past five you pronounced life extinct?

A. That's correct, yes.

Q. And certainly there had been nothing in the previous days that gave you any cause to expect such a sudden deterioration, was there?

A. I think we were looking for, we knew that he was irritable, I mean in normal terms, in other words agitated and restless and we see that after head injuries where patients are starting to recover from their coma it's not unusual. Having said that, he was probably one who was more agitated than one would probably like him to be and consequently he was requiring some medication to really control this. In addition I would say that we were also looking for any other sources that might be disrupting or causing more agitation than one should be and so we were looking for sources of infection and so on. So I think that was the case really with him and so in some ways we felt he was restless and agitated but perhaps a little bit more than we would normally see.

Q. Had he in fact been clinically progressing in terms of his coma scale?

A. As I see through the notes I would say that he had been progressing but his changes would probably be very subtle.

Q. And what was that in the sense of the coma scale?

A. Yes.

Q. What had it progressed to?

A. Well it had progressed to approximately 6 to 8 at the times it has been recorded, it was almost 8 on a coma score of 50.

Q. What had it started at?

A. Sorry?

Q. What was it initially?

A. It had started on the ward. It had started really at about 5, 5 to 6.

Q. And had he begun to move his limbs and he was then breathing unaided, is that correct?

A. That's right, yes.

Q. From a relatively early stage?

A. I think, meaning he did require --

[redacted]: He did require what?

THE WITNESS: Oxygenation with the aid of canula, which is a tube which is in his - or a face mask.

[redacted]: Did that continue to be the situation?

A. Yes, it did, I mean as far as I can see from the notes. But because he was so agitated it was sometimes difficult to make sure that he had the canula in his nostrils, which is the way that oxygenation is given in some patients, otherwise -- (speech interrupted).

[redacted]: He was breathing spontaneously but you were assisting it with oxygen?

THE WITNESS: That's right, yes, but he was maintaining saturation quite well.

[redacted]: Had he in fact been subjected to two CT scans?

A. Yes, he had.

Q. And was the first at 8.00 am on the day of arrival at the Royal Victoria Hospital?

A. I don't know whether it was 8.00 am but certainly it was on the first day, yes.

Q. Is it correct that that showed no obvious brain injury?

A. That is correct.
Q. And indeed was there a further CT scan on the 30th of April?
A. That's correct.
Q. And was that described as essentially normal?
A. Well I don't know, this is the report of the consultant himself, who reports it. He says
"There has been no significant changes since the previous night".
So, and then he says:
"There is again some prominence of the subarachnoid space of the frontal lobes",
which is to suggest there is this extra space in front of his brain, which can mean little or nothing really or sometimes it can mean that he might have some, perhaps a childhood anomaly or bleed or something that was never really detected.
EW to CH at 12.00

Q133 [redacted]: Did Mr. Fannan produce a commentary on this case? A Yes, he wrote the discharge summary.

Q134 In that discharge summary did he comment on the further CT scan that again there was no obvious focal abnormality? A That's right. That's correct.

Q135 And indeed did Mr. Fannan proceed in that commentary to say that his death was an extremely unexpected outcome? A That's correct.

Q136 Did he conclude that it was felt this man sustained a relatively minor head injury? A That was his conclusion.

Q137 So in terms of his sudden and unexpected deterioration you mentioned his temperature rose substantially. How high did it rise? A It rose to 40 degrees but he had had a temperature for a number of days.

Q138 Did it rise at one stage to 42 degrees which is 170 degrees Fahrenheit? A It perhaps may have done but I haven't seen all the letters.

Q139 Would that be consistent with a drug-induced difficulty? A I'm not an expert on these things but it could be consistent.

Q140 Had he been obtaining dosages of drugs? A Yes, he had been.

Q141 On that day, the 8th of May, had he been given an injection of Chlopromazine? A You will have to forgive me, my Lord, because the notes are all scrambled up.

Q142 I think the original notes are in court. - [Handed.] This is the 8th of May. I don't know whether that's a signature that has been crossed off. Yes, he did receive it on the 8th of May on two occasions.

Q143 In what dosages? A The first one was 50mg through a nasogastric tube. It doesn't say a time. The second one was given at 10 past 3 and he received 100mg intramuscular.

Q144 What is that drug for? A Chlopromazine is a drug used for sedation. That's one of its effects.

Q145 Was it shortly after 10 past 3 that the alert was raised as to this man's condition? A I think my recollection would be perhaps about 3.30 or something like that when I was first called.

Q146 We now know that at 10 past 3 he had been given 100mg of Chlopromazine, is that correct? A That's right.

Q147 Might that induce a very high temperature?
A It might but I'm not an expert to say that and whether it would do that immediately I'm not an expert to say that either.

Q148 Did Mr. Fannan raise the prospect that he might have been suffering from septicaemia? A Yes, he did.

Q149 What would be the relevance of that?

A Septicaemia means that a person has bacteria in the bloodstream, he's very sick. Essentially he would have a high temperature and a drop in blood pressure. That would be of significance. He would be peripherally shut down and he would become cyanosed, as he was.

Q150 [redacted]: He became blue in other words. A Blue, my Lord, yes.

Q151 [redacted]: Did Mr. Fannan also postulate that he might have suffered a pulmonary embolism? A Yes, he did.

Q152 What is that? A When patients are immobile so to speak in hospital for a number of days there is a chance that they can develop because of stasis of the circulation the formation of clots. Usually it starts off in the leg and if one of these breaks up it goes into the right side of the heart and from the right side blood is pumped to the lungs and immediately you get a blockage of the blood supply to that part and the patient can be extremely unwell as a result.

Q153 Have you any explanation for the dramatic deterioration from apparently an improving clinical state to rapid death? A In this patient?

Q154 Yes? A I think I would agree with Mr. Fannan that it may well be that he was either septicaemic or that he might have had a pulmonary embolism.

Q155 Was there also the prospect that it could have been drug-induced? A I couldn't say that.

Q156 [redacted]: Sorry? A I couldn't say that, my Lord.

Q157 You couldn't say that? A I couldn't say that because I don't know.

Q158 I hadn't heard what you said. A Sorry, my Lord.

Q159 [redacted]: Is that a view Mr. Fannan expressed? A I don't know what he expressed.

Q160 Why would he be given Chlopromazine? A Perusing through the notes he had been given Chlopromazine on a number of occasions because he was quite agitated. Sometimes when patients are agitated to the degree where due to the moment and because they are unable to recognise the environment they might harm themselves and in order that they don't pull their tubes out you may well have to sedate them just enough to ensure that they get their treatment.

Q161 It's a powerful drug, is it? A It is a powerful drug. A psychiatrist would use it quite a bit in schizophrenia in doses of about 10 times the amount.

Q162 Is one of its side effects recognised to be respiratory depression? A I would say that, yes.

Q163 Were the sudden breathing difficulties and other problems consistent with that? A I know he had certain breathing difficulties; whether connected to the

Chlopromazine isn't something that I can say.

Q164 Returning to the fact that in neurological terms he suffered a minor head injury do you agree with Mr. Fannan that it was an extremely unexpected outcome that he died?

A I think if he has a minor head injury and if you have a complication like a pulmonary embolism then it would be unusual but, having said that, you can go for a routine operation in a healthy person and if you're immobile in bed for a few days you can get a pulmonary embolism and die as well, so equally that could be unusual in the sense that it is not necessarily always picked up. It can happen rather suddenly and it happens in a time scale approximately 10 days or so after.

Q165 From the time scale of this injury the normal expectation might have been recovery, is that correct?

A Yes, I would say that.

RE-EXAMINED BY MR. KERR

Q166 MR. KERR: Firstly, you have been asked to deal with the notes. If I can move into more general territory. This man was brought first of all to Craigavon and was unconscious and transferred to the Royal with a head injury, is that correct? A That's right.

Q167 He was unconscious during his time in the Royal as a result of the head injury, is that correct? A That's right.

Q168 [redacted]: Did he ever regain consciousness as far as you know? A No, I don't think he ever regained consciousness. When one talks about consciousness and unconsciousness there is a spectrum. It depends how you define it. If you were to say did he ever come to a time when he recognised his environment, in other words, "Squeeze my hand", one of the nurse's notes says "He did squeeze my hand once", but when patients are as unconscious as that it can be reflex, so I would say not.

Q169 MR. KERR: Can I deal with the drug that he was given on the day, Chlopromazine? Is it a regular and recognised treatment in relation to matters that he required for medical reasons? A It probably isn't necessary first line. Some people would use it as a first line drug. The first thing you would do is look for obvious causes. Has he got a tube which is blocked? People would use different drugs. In neurosurgery we tend to use drugs that don't sedate people too much because we are always concerned about their consciousness level and their breathing, so we would start off with drugs which would have less side effects and then go to the other drugs if required.

Q170 But this drug was given as a result of his treatment in hospital? A That's right, yes.

Q171 For example, a pulmonary embolism which you think may have occurred in this case? A That's right.

Q172 Is that a recognised difficulty that one has when someone is immobile in hospital? A Yes, my Lord.

Q173 Septicaemia, is that something that can occur in the same circumstances? A In an unconscious patient, yes, you can get an infection which can lead to septicaemia.

Q174 All of those are things which can and do occur in cases of people who are immbolie because of unconsciousness? A Yes, they do.

Q175 [redacted]: Would that show up in a post-mortem examination? Presumably a pulmonary embolism is heart failure? A Yes, my Lord.

Q176 What about septicaemia? A A pathologist would be able to tell you. It depends how quickly, for instance, some people might be septic and they would get ventilated and treated with antibiotics for a number of days. They get multi-system failure.

Q177 In a sense it isn't the septicaemia that would kill you, it's the effect it has on vital organs? A Yes, it's the effect it has.

Q178 You don't want to ask any questions arising out of that, [redacted]? I think we went further than re-examination.

Q179 [redacted]: No, my Lord.

12.15pm to EW