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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: TURNBULL, BEVERLEY ANNE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: STAFF NURSE

This statement (consisting of 9 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: B A TURNBULL Date: 27/02/2006

I am Code A and I live at an address known to Hampshire Police.

I am currently employed by Fareham and Gosport Primary Care Trust as a Staff Nurse on Dryad Ward at the Gosport War Memorial Hospital. I qualified as a State Enrolled Nurse in 1967 and my Nursing and Midwifery pin number is 67K3210E

I did my training at Queen Alexandra Hospital in Cosham Portsmouth

Between 1967 and 1972 I worked at the Gynaecological Unit at St Mary's Hospital Portsmouth, then left nursing for a year for a year.

Between 1973 and 1974 I worked as a Community Nurse at Cosham Health Centre leaving there due to maternity leave.

In 1976 I recommenced my career working 20 hrs per week, covering weekend day shifts at the Redcliffe Annexe in Gosport. This was a geriatric unit of GWMH situated a short distance away.

This was the first time I had worked caring for the elderly who were long term stroke patients and as such did not require a great deal of medical care, but did require basic nursing care. There was no medical staff attached to this unit. The patient's own GP would attend the Annexe and administer any medical care, at the request of the nursing staff.

At this time it was the practice for the SEN's to take charge of the ward so when I was on duty I would be responsible and work with an Auxiliary nurse. A Sister being in overall charge of the unit.

Between 1978 and 1981 I again left nursing due to maternity leave.

In 1981 I resumed nursing again and returned to the Redclyffe Annexe.

In 1984 I began working 20 hrs per week on a night shift 2015 - 0745 hrs.

Between 1994 and 1995 I took a conversion course to become a State Registered Nurse and subsequently became a Grade D Staff Nurse.

The patients in the Annexe were not there to recuperate but to be given palliative care until they died. Some had been resident for up to ten years. Some of these required pain relief but I do not recall any of them requiring opiates

Around 1986, the method of staffing changed and a Staff Nurse was required to work at the unit. The number of patients also doubled, to eighteen or twenty. These were still dealt with medically by their own GP's.

Sometime after 1986 I cannot remember specifically when, a local GP, Dr BARTON , was appointed to take responsibility for all patients at the Annexe. If we had a problem with a patient during the night we would contact her practice and she or another Dr would give advice over the telephone or indeed attend.

I have no idea what the procedure was during the day although I do recall seeing Dr BARTON doing her ward rounds sometimes, when I was going off duty.

It was around this time that I noticed the use of syringe drivers on the ward. This is a battery driven device used to administer over a 24 hr period, strong narcotic analgesic to patients.

An analgesic is a pain killer. The type of drugs being administered were Diamorphine a strong opiate and Midazolam is a sedative drug.

The result of the usage of these drugs in the driver was that the patient became heavily sedated, unrousable and died.

I was very concerned with this practise because I felt that it was being used on patients who had not presented any symptom of pain.

All of the patients under the care of Dr BARTON were prescribed in this way. She set the parameters of the amount of drugs and it was at the trained nursing staff's discretion as to when increases were given, depending on the patient's increased level of pain.

My concerns were that patients were going straight on to the strong drugs without weaker analgesics being tried on them to keep them comfortable. This is what usually happens. The stronger drugs are normally prescribed when the weaker ones fail. This procedure is known as the Analgesic Ladder.

I was aware that other members of the nursing staff also had their misgivings about the use of Syringe Drivers. I spoke with both Sylvia GIFFIN and Anita TUBBRITT regarding it.
During 1991 there were a number of meetings which I attended in relation to the use of Syringe drivers on our unit. I have retained all the correspondence and minutes I had at the time, including one attended by the Hospital Manger Mrs EVANS.

I and other members of trained nursing staff voiced our opinions regarding the continued use of the stronger drugs being administered from the outset of patient care.
Mrs EVANS stated she would arrange some training in the use of syringe drivers; however as a SEN this did not affect me as I did not set them up.

Following those meetings I was still unhappy and I am aware that Sylvia GIFFIN contacted the

Royal College of Nursing regarding the matter. I believe she held a meeting at her home with an RCN representative.

I recall attending a meeting called by Dr LOGAN. He and the medical staff sat like a panel opposite the nursing staff. Their general tone was highly condescending, talking to us as if we did not know what we were talking about and that we did not understand the properties of Diamorphine. I felt very vulnerable and did not believe that anyone was listening to us.

I remember a policy was going to be drawn up to formalise procedures, but to my knowledge this never happened.

I felt that my colleagues and I had been labelled as trouble makers. There was a definite atmosphere between the night and day staff at Redclyffe Annexe.

Soon after the Annexe joined the main hospital and the patients from there joined Dryad Ward. The sort of patient remained the same as I have previously described and the Dr responsible for them remained Dr BARTON. The Consultant I believe was Dr REID .

However as time went on the type of patient admitted to the ward began to change. There were more patients on the ward for assessment and as a result of Orthopaedic procedures. There was a more multi disciplinary input, for example, Physiotherapy and Occupational Therapy. The patients were able to express their needs more clearly and we had more people admitted for rehabilitation.

I would read the notes of each of my patients to determine what I needed to do for each one. The other nurses would do the same. Each nurse had access to the patient's medical notes.

I am familiar with the term ANC-All Nursing Care. This indicates that the patient is unable to do anything for themselves, in respect of ADL, Activities of Daily Living, i.e. feeding washing etc. This would not specifically indicate that the patient is heading for the end of their life.

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I am also familiar with the term TLC- Tender Loving Care. This indicates to me that the patient is nearing the end of their life and should be made as comfortable as possible.

The term I am happy for staff to verify death indicates that Dr BARTON was happy for nurses to verify the death of a patient in her absence during the night.

I have been asked to detail my involvement in the care and treatment of Enid SPURGIN . I do not recall this patient at all but from referral to entries in the medical notes (Exhibit Reference BJC/45) I can say that on page 106 of those notes dated 26/3/99, night I have written,

"Requires much assistance with mobility at present- due to pain/discomfort. Oramorph 10mgs/5mls given 2315 & 5mgs at 0650" I have signed that entry B TURNBULL.

I can cross reference this with entries in the Dryad ward Controlled Drugs Record Book (Exhibit Reference JP/CDRB/24 where on page 47 of those notes at 2315 on 26/3/99 I have witnessed Staff Nurse Anita TUBBRITT administer 10mg Oramorph in 5mls and at 0655 on 27/3/99 I have again witnessed Anita TUBBRITT administer 5mgs of Oramorph in 2.5mls both to Enid SPURGIN.

This is further cross referenced on page 125 of the notes where Anita TUBBRITT has initialled at the 2200 column on 26/3/99 and also in the 0600 column on 27/3/99.

On page 114 of the notes, which is a nursing care plan regarding continence, I have written on 26/3/99

Problem - Maintaining Urinary Continence, Due to poor Mobility
Desired Outcome - To maintain Urinary Continence
Evaluation Date - Daily
Nursing Action - Assist with use of slipper pan. Enid will request when needed
I have signed that entry.

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On page 116 of the notes which is a nursing care plan regarding washing and dressing part of the ADL, Activities of Daily Living, I have written on 26/3/99

Problem - Enid requires help with washing and dressing
Desired Outcome - To try and maintain a standard of hygiene acceptable to Enid.
Evaluation Date - Daily
Nursing Action - 1) Offer Daily Wash
2) Apply Liquid Paraffin To Dry Areas
3) Report Any Changes To Skin To Trained Nurse
4) Ensure Privacy/Dignity At All Times

I have signed that entry

On page 120 of the notes which is a nursing care plan for Elimination (Constipation) I have written on 26/3/99

Problem - Enid May Be Prone To Constipation - Due To lack Of Mobility
Desired Outcome - To Try And Aim To Achieve Regular Bowel Actions
Evaluation Date - Daily
Nursing Action - 1) Encourage Adequate Diet & Fluids- 11/2 litres Daily
2) Record All Bowel Actions, Report Any Changes
3) Maintain Privacy/Dignity At All Times
4) Give Prescribed Aperients As Boarded And Monitor Their Effectiveness.

I have signed that entry.

On pages 80 and 81 of the notes which is a nursing care plan in relation to Sleeping, I have written on 26/3/99,

Problem - Enid Requires Assistance To Settle For The Night
Desired Outcome - To Try And Maintain Enid's Normal Sleep/Rest Pattern, And To Wake On Own Accord Feeling Refreshed.

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Evaluation - Nightly

Nursing Action - 1) Ensure Enid Warm/Comfortable In Bed

2) Offer Commode/Bedpan As Required

3) Offer Warm Night Drink

4) Give Prescribed Analgesics/Night Sedation And Monitor Their Effectiveness

5) Ensure Drink/Call Bell Within Reach

6) Ensure Privacy/Dignity At All Times

I have signed this entry

In a continuation of this care plan, I have written again on 26/3/99

Used slipper pan. Difficulty in moving. Slept long periods. Oramorph given as boarded for pain in hip.
I have signed that entry.

On page 81 on dates, 3/4/99, 4/4/99 and 5/4/99, I have signed blank entries. This indicates that nothing untoward happened during the night to warrant an entry.

On page 89 of the notes which is a nursing care plan in relation to dressings I have written on 4/4/99

Granuflex renewed to wound right calf. I have signed that entry. Code A