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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 Beverley TURNBULL 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 Code A

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 Redclyffe 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 Redcliffe 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 Redcliffe 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.

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 Geoffrey PACKMAN . I have some recollection of this patient due his sacral sores, and with referral to the medical notes (Exhibit Reference BJC/34) . I can say that that on page 63 of those notes which is a summary, dated 28/8/99 and nocte (night). I have written,

"Oramorph given as prescribed. Condition remains poorly & variable. Drinking well. Dressings remain intact" I have signed this entry.

Also on page 63 dated 31/8/99 nocte (night) I have written,

Appeared to have a comfortable night. Continues to pass tarry black faeces". I have signed that entry.

This would indicate to me that the patient was either on iron tablets or he was having an internal bleed.

According to the notes a Dr was not called out during the night but the information would have been passed to the day staff and I am sure a Dr would have been informed then. I see from the following page dated 1/9/99 that it is written that Dr REID a consultant was on the ward. I cannot see anywhere on the notes that this passing of tarry faeces was of such a concern that it was reported to a Doctor.

On page 64 of the notes dated 1/9/99 nocte (night) which is a continuation of the summary I have written,

"Incontinent of black tarry faeces on settling. Peaceful night. All care given. Syringe Driver satisfactory". I have signed this entry.

The syringe driver was not set up by me, I just checked to ensure that it was running correctly.

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The syringe drivers were set up by the day staff before we on night duty came on duty.

As I have previously stated the fact of the passing of tarry faeces would be verbally reported on handover to Sister HAMBLIN.

I notice that on page 83 which is a continuation of a nursing care plan in relation to bowel movements, which had been started on 23/8/99. On 31/8/99 nocte (night) I have written,

"Continues to pass large amounts of black tarry faeces".

There doesn't appear to be a fresh nursing care plan in place to address this issue.

On page 79 of the notes which is nursing care plan in relation to sleep, I have written on 27/8/99,

"Oramorph given as prescribed. Comfortable night. Not c/o any chest pain" I have signed that entry

C/o means complaining of.

Also on page 79 of the notes dated 28/8/99, I have written,

"Oramorph given as prescribed. Condition variable. Drinking well. Appears hydrated. Slept long periods". I have signed that entry.

I can cross reference both of these entries to page 172 of the notes which is a prescription chart where I have initialled that I have administered Oramorph to Mr PACKMAN at 0600 on 27/8/99, at 0600 and 2200 on 28/8/99 and 0600 on 29/8/99. These times are approximate only.

The prescriptions have been written up and signed by Dr BARTON, and as such I have administered what has been written up. This is to be given 4 hourly. There is a double dose given at night in order that the patient is not woken up to administer, thereby giving the patient uninterrupted sleep.

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I can cross refer this to the Dryad Ward Controlled Drugs Record Book (Exhibit Reference JP/CDRB/24) pages 54 & 55 .

On 27/8/99 at 2215 I have signed that I administered 20mgs Oramorph in 1ml to the patient Geoffrey PACKMAN witnessed by Staff Nurse Anita TUBBRITT .

On 28/9/99 at 0705 I have signed that I administered 10mgs Oramorph in 0.5mls to the patient witnessed by Staff Nurse Anita TUBBRITT

On 28/8/99 at 2310 I have signed that I administered 20mgs Oramorph in 1ml to the patient witnessed by Anita TUBBRITT. On 29/8/99 at 0635 I have signed that I administered 10mgs Oramorph in 0.5 mls to the patient witnessed by Anita TUBBRITT.

On page 81 of the notes which a nursing care plan for sleeping, on 2/9/99 I have written,

"Incontinent of weak tarry faeces on settling. Nursed on side. Peaceful night. Strong radial pulse. Opens eyes when spoken." I have signed this entry.

On page 85 of the notes which is a nursing care plan for Elimination - Urine, on 31/8/99 I have written,

"Catheter draining satisfactorily". BA TURNBULL