Pulmonary

HAMPSHIRE CONSTABULARY

OPERATION
ROSEMEER

CONFIDENTIAL
UNAUTHORISED
DISCLOSURE
PROHIBITED

Code A

Volume 2

Witness list
Witness statements

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Code A

No comment.

Was it slackness?

No comment.

Was it deliberate?

No comment.

Chris?

Again Code A reminded you what the General Medical Council states about medical records and record keeping. Now as a doctor 'you must keep clear, accurate, legible and contemporaneous records which report the relevant clinical findings and decisions made, information given to patients and any drugs or other treatments prescribed'. That's Good Medical Practice, Page 2. And he also pointed out the GMC booklet Withholding and Withdrawing Life Prolonging Treatments, Page 30, where it specifically states that 'the decision making process should be recorded'. With these documents in mind, if we look at the medical notes, which is BJC/45 Page 24, over an eighteen day period, so from the 26th of March 1999 (26/03/1999) to the day that Code A died on the 30th of April that year, you've made one entry. Is that satisfactory?

No comment.

Is that complying with the conditions set by the General Medical Council?

Code A

No comment.

If you don't make notes, how can another doctor pick up the records in your absence and see any plans or treatments that you put into place?

No comment.

I notice another doctor has made entries on the 7th of April 1999 (07/04/1999) and the 12th of April 1999 (12/04/1999). It's Code A isn't it?

Yeah.

Code A

Uh-huh. He's managed to make notes on both occasions and he's a Code A Why has a Code A Code A not got time to make notes?

No comment.

How could Code A pick up these notes and know what you were trying to achieve for Code A Code A

No comment.

Code A

He couldn't could he?

No comment.

We'll go on to ward rounds. Again the way we see it the ward rounds give an opportunity for the doctors and nurses to review a patient, discuss the patient (somebody coughs) and decide upon further treatment, changes to treatment and, as such, they were an integral part of your duties at the War Memorial Hospital weren't they doctor?

No comment.

We're going to see explanation as to how you conducted your ward rounds and the role that you saw ward rounds playing in the care and treatment of the patient obviously, specifically in the care and treatment of Code A How often did you conduct your ward rounds?

Code A

No comment.

I think it was basically accepted that you went to the hospital every day, so would you do a ward round every day?

No comment.

Code A

How did weekend work differ from the norm?

No comment.

What was your routine on the weekend?

No comment.

If I show you the exhibit we referred to earlier, which is the calendar printouts from March and April, you can see that Code A was admitted on the 26th of March, so obviously you've got the 27th and 28th as the weekend, then you've got the 3rd of April and the 4th of April another weekend, and then you've got the 10th of April and the 11th of April as the next weekend and then she died Code A days after that on Code A, so she's there for one, two, three weekends excepting that you say 'somehow you know where you were on one weekend when you couldn't go to the hospital', that leaves another two weekends when, presumably, the pressure of your work wasn't as great so perhaps you could have made fuller notes, so why didn't you?

Code A

No comment.

Point number 9 you acknowledge the nursing transfer note taken on the 26th of March, it reports that Code A to be mobile from chair with assistance of two people, to be walking short distances with a zimmer frame and only

requiring Paracetamol as required for analgesia'. Yet in your initial note on the 26th, in your entry on that medical note you state 'Not weight bearing'. Can you explain the difference?

No comment.

Code A in that transfer note, writes: "Mobile from bed to chair with assistance of two people and to be walking short distance with a zimmer frame," but you seem to contradict that by saying: "Not weight bearing."

Code A

No comment.

Did you perform any tests on Code A to establish that she couldn't weight bear?

No comment.

Were you given that information from somebody else?

Code A

No comment.

Did Code A give you that information?

No comment.

If anybody had given you that information, would you have checked it yourself to make sure that that information was correct?

Code A

No comment.

Part of your sole entry in the medical notes states 'plan sort out analgesia'. You seem to believe that this was to ensure that Code A had adequate analgesia, anticipating that she would be in pain particularly where pain relief was considered such a prominent part of the Care Plan for a patient, it would be considered good practice, would it not, to take and document a full pain history, which would include current analgesic use and response to it?

Code A

No comment.

Why didn't you therefore record pain history in your clerking?

No comment.

Why doesn't the word 'pain' appear in your clerking?

No comment.

And again I ask you, you recorded Code A to be 'not weight bearing' and prescribed regular Morphine, which was at odds wasn't it with the transfer note assessment written on the same day of transfer, so it was written in the morning by Code A saying that 'she was mobile with help and only required Paracetamol,

PRN as required', but you prescribed her regular Morphine, why was that?

Code A

No comment.

Why did you not record where the pain was, what the pain was?

No comment.

What were the possible explanations you considered for Code A s increasing pain (somebody coughs) in your diagnoses?

No comment.

Now we know that Code A had had a hip operation, what examination did you undertake of Code A 's leg and surgical wound?

Code A

No comment.

Well it's likely, is it not, that if Code A did have pain it could be coming from the hip itself. Is that right?

No comment.

Is it also likely, or possible, that if she had pain it may be associated to a wound infection?

Code A

No comment.

If that was the case, was prescribing Oramorph appropriate?

(Pause) No comment.

If she had picked up a wound infection doctor, would antibiotics have been appropriate?

No comment.

Did you consider that she may have had a wound infection?

Code A

No comment.

Did you run any tests to check this out?

No comment.

Did you consider prescribing antibiotics?

No comment.

At what basis did you; on what basis did you consider that regular Morphine was required rather than the Paracetamol?

No comment.

Code A

Doctor perhaps you could tell us about your experiences of looking after patients who have undergone surgical repair of their fractured neck of femur with regard to their usual analgesic requirements, are you able to help?

No comment.

Did you in fact note that Code A had been on Paracetamol?

No comment.

And did you note that she did not seem to be in pain prior to transfer having had a settled evening on the 25th?

Code A

No comment.

Well we know, don't we, that you've written in her notes 'no previous medical history, significant medical history', so you, presumably, have you read something there, or spoken to somebody about her?

No comment.

Where would you have got that information from otherwise?

No comment.

You didn't know the patient did you?

Code A

No comment.

Well with that in mind, how did you know that she was in pain?

No comment.

And what was that pain related to?

No comment.

It's possibly, isn't it, that a patient can suffer on transfer from one hospital to another?

Code A

No comment.

Was that the case with Code A ?

No comment.

It's not recorded in her notes anywhere is it?

No comment.

And you can't tell me whether an infection had set in or not?

No comment.

Is that because you didn't carry out the required tests?

No comment.

Well none of the above is evidence is it?

Code A

No comment.

There's nothing written down there as to where the pain was coming from, what type of pain it was, whether it was a pain from the hip, whether it was a (inaudible) pain?

No comment.

Did you carry out a full assessment on Code A ?

No comment.

Code A

Paragraph 12 doctor relating to the Morphine. Did you prescribe the Morphine as a result of your own assessment of Code A or was it as a result of a request by Code A Code A the nurse?

No comment.

(Pause) Page 106 there's an entry, I don't know if it's by Nurse Code A or not, but it says, it's dated the 26/03, it's quite an empty note – 'Admitted to Dryad Ward for rehabilitation and gentle mobilisation. In Haslar she was mobile with a zimmer frame and two nurses short distances

and apparently transferring satisfactorily. However transfer has been difficult here since admission', this is the date that she came in, 'she has complained of a lot of pain for which she is receiving Oramorph regularly now with effect'. On Page 85 are the same hospital records (pause) dated the 26th again. It says Code A experiencing a lot of pain on movement', and underneath 'nursing action' it says 'give prescribed analgesia and monitor effect', 'give prescribed analgesia and monitor effect'. On Page 80 (pause), again under 'nursing action' on the same date, number 4 'give prescribed analgesics, night sedation and monitor their effectiveness'. What do those entries tell us doctor?

Code A

No comment.

Because you, in your statement, tell us that 'it was the nurse that was advising, advising you to prescribe analgesia'.

No comment.

Now you're indicating in your statement, are you not, that 'it was the nurse that was advising you to prescribe Oramorph'?

No comment.

Well you had seen the patient on the 26th?

No comment.

You had presumably examined the patient when she came into the hospital, or when you first saw her in the hospital.

No comment.

That is part of your Job Description isn't it to see the patient promptly?

Code A

No comment.

Did you then regard that the patient should have Oramorph when you first saw her?

No comment.

Are the nurses taking the lead in prescribing analgesics then?

No comment. (Somebody coughs)

Code A

You've written it in that statement that 'it was the nurses who were advising you to prescribe Oramorph'. So the line of events here is that you've seen, as far as I can understand now, you've seen Code A when you've written her up on the 26th and you haven't prescribed Oramorph then only until the nurse comes to you and advising it. Is that right or not?

No comment.

Because if we've got it wrong, if I've got it wrong let us know because this is your opportunity to tell us what actually happened there.

No comment.

Code A

Well when you write there that 'the nurses are advising you about prescribing Oramorph', where were you when the nurse was telling you this?

No comment.

Having been told that, did you go back to examine the patient?

No comment.

Did you go back to examine the patient to find out where the pain was coming from?

Code A

No comment.

Well then that straight away leads on to another question, did you just prescribe Oramorph without seeing the patient again then?

No comment.

What was the timing between you seeing the patient and you prescribing Oramorph and you being spoken to by this nurse who was advising you prescribe analgesia?

Code A

No comment.

Any questions Code A?

You have been a doctor for a number of years and a GP for a number of years, fully qualified, experienced and then you became a Code A and you've done that for a number of years. So in your experience doctor, what normally happens to pain after an operation?

No comment.

Code A

I mean the way I see it at the moment is that Code A Code A has had an operation to fix her hip, the actual fracture of the hip must have been extremely painful and the idea of the operation to fix it is to make her feel better. So after the operation one would expect, wouldn't one, that the pain would subside, it might be gradually but it will be progressively. Would that be normal?

No comment.

Yet her pain is reported to have increased. Why?

No comment.

What examination did you make, and what steps did you take to find out what was causing that pain?

Code A

No comment.

Bearing in mind that the lady had an operation, I assume several things could be going wrong there could be an infection in the surgical wound, maybe something went wrong with the actual hip operation itself. Surely part of your job would be to find out what was going wrong with that lady?

No comment.

And not only find out what was going wrong, but take steps to fix it.

Code A

No comment.

Now if it was beyond your ability to do this, why didn't you then move in and ask a Code A and take advice?

No comment.

Did you do anything at all to find out what the underlying cause of this pain was?

Code A

No comment.

That's all.

Code A

The starting dose, the starting dose of Morphine doctor and it's subsequent increase prescribed by you were in keeping in the guidelines from the BNF, but in view of Code A Code A 's advanced age did you consider using smaller doses, say for example 2½ milligrams four hourly?

No comment.

Why didn't you use a smaller dose?

No comment.

Okay. I think Code A this might be a good time to stop this tape because 38, 39 minutes we're on that. Do you want to add to anything, or clarify anything doctor?

Code A

No thank you.

I'm just trying to change the tapes over.

Sorry.

The time now is 1417. I am turning the machine off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF

RESTRICTED

DOCUMENT RECORD PRINT

RESTRICTED

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AG

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/04/2006

Time commenced: 1425 Time concluded: 1509

Duration of interview: 44 MINUTES Tape reference nos.
(→)

Interviewer(s): Code A

Other persons present: Code A - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the interview with Code A Code A the time by my watch is 1425. Doctor can you just confirm that the people in the Interview Room have remained the same?
	They have.
	Yeah. And we haven't discussed the matter for which you are being interviewed for?

Code A A

We have not.

And I will remind you that you are still under caution, and the purpose of the break was to, it was a little bit of a comfort break and we were looking for an exhibit. Okay?

Thank you.

Everybody happy?

(Pause nobody makes comment)

(Somebody coughs) We were talking, we were asking you 'why you didn't consider prescribing a smaller dose of Morphine from the outset'. Now doctor nausea and vomiting can occur in about half the patients commencing on Morphine. Is that right?

Code A

No comment.

And is it, generally it's a temporary affair and it settles after a few days?

No comment.

Now the fact that Code A vomited could have, may have represented the fact that she had just commenced Morphine. Is that right?

No comment.

Code A

Or maybe that her dose had just been increased?

No comment.

However your response to Code A 's vomiting doesn't seem to make sense. If you believed that her pain was severe enough to require Morphine, then commencing a regular antiemetic would be seen as an appropriate response would it not?

No comment.

But instead of going down that line, you discontinued the Morphine and commenced Code A on Co-dydramol. Is that right?

No comment. No comment.

Code A

Which is a combination I think, isn't it, of Dihydrocodeine and Paracetamol?

No comment.

How do you respond to that?

No comment.

Code A

If you have then considered, at that stage, that the Co-dydramol would be sufficient for Code A S pain, why didn't you commence it regularly initially?

No comment.

We've discussed the Analgesic Ladder earlier on today. My understanding is that you start at the bottom and work upwards, but in this case you seem to have started higher on the Analgesic Ladder and worked down. Is that usual?

No comment.

Do you consider this was the appropriate way for you start prescribing her pain relief?

Code A

No comment.

In Paragraph 4 to 8 of your statement, you make reference to Code A 's Medical Records. Were these Medical Records available to you at the time?

No comment.

Did you read them?

No comment.

Paragraph 20 referring to Code A I believe. I quote: "I am unable now to say that he saw Code A in the

course of that week." I understand that Code A conducted weekly ward rounds. Is that right?

No comment. (Somebody coughs)

Code A

If he had seen a patient on his ward round, would you expect to see a record and the notes of that visit?

No comment.

Or was he regularly seeing patients without recording it?

No comment.

If this was the case, did you ever raise that as an issue?

No comment.

Code A

Did that impact on your ability to provide proper care and management of the patients?

No comment.

In particular Code A

No comment.

We'll go back to the Co-dydramol. Code A received that for about three days. You note, this is in Paragraph 21, you note that 'the nurses recorded that Code A

Code A was in a lot of pain when she walked to the physiotherapist'. Your response to that was to prescribe Morphine Sulphate, abbreviated to MST, 10 milligrams twice a day on the 31st of March 1999. Now this is eleven days after Code A 's operation, and Code A has asked you some questions on this line before. After such a length of time post operation, would it be unusual for pain severe enough to require such a strong opioid to be present?

Code A

No comment.

If Code A was in such severe pain that it required Morphine, why didn't you search for the reason why she was getting this pain?

No comment.

Where doctor, in all these records, have you evidence that you considered, examined or documented the possible reasons why Code A 's pain was so problematic?

No comment.

I don't think you have have you, I can't find any?

No comment.

You write: "I believe I would have reviewed Code A Code A ." Why is that written in such a way?

Code A

No comment.

It reads to me as if there is some doubt there in your mind: "I believe I would have reviewed Code A " To my mind, the way I read that, it leads to a suspicion that you might possibly have been prescribing without seeing the patient.

No comment.

Was that the case?

No comment.

Were the nurses prescribing?

No comment.

Paragraph 24 'still having pain on movement'. What was wrong with her?

Code A

No comment.

At Haslar she was marked up for 'possible Compartment Syndrome Haematoma', problems along that line. Did you consider looking for evidence of pain that might fit with this?

No comment.

Code A

Did you consider that her pain may be relative for something along those lines?

No comment.

With regards to Compartment Syndrome, would your knowledge have extended to that?

No comment.

I understand Compartment Syndrome is something that will occur quite quickly postoperative, definitely orthopaedic. If a doctor had considered that as an option would you have considered that it may not be Compartment Syndrome by the time you see her, but there might still be a problem with her haematoma.

Code A

No comment.

Have you any questions on that Code A

Do you know what Compartment Syndrome is?

No comment.

Have you had any dealings with that complaint?

No comment.

Code A

How many times have you come across that complaint before?

No comment.

Is it easy to diagnose?

No comment.

And what are the symptoms of Compartment Syndrome?

No comment.

Would there be a swelling of the leg?

No comment.

Could it be as simple as something like big leg / little leg, whichever way you look at it she's got one little leg and one big leg: "There must be something wrong with that leg but I don't know what it is." Was that the case?

Code A

No comment.

And if you didn't know what it is, what should you have done?

No comment.

Code A

Did you consider the haematoma side of things then doctor?

No comment.

If I had a headache doctor and I took Aspirin for it and the headache didn't clear, what's written on a packet of Paracetamols or Aspirins?

No comment.

Isn't there some sort advice that 'if symptoms persist please consult a doctor'?

Code A

No comment.

If giving analgesia to a patient isn't working and you cannot understand why, what the problem is, shouldn't you have sought advice or help?

No comment.

If a headache persisted, especially if it's my headache and I went to see a doctor, I'd like the doctor to try and find out what was causing that headache and then to stop it.

No comment.

So what did you do about this lady's leg?

No comment.

Was it just your answer just to keep ramping up the opioids?

No comment.

Code A

It's almost like a cover job, a bosh job, just so the pain doesn't show then we don't have to worry about what's causing it. Is that the case?

No comment.

On the 6th of April, nineteen, seventeen days after Code A Code A had had her hip operation, you doubled the MST to 20 milligrams twice a day. So seventeen days after the operation her pain is still increasing, is that right?

No comment.

Code A discussed earlier on, isn't decreasing pain post operation the norm?

Code A

No comment.

Why didn't you conduct a thorough review of the cause of this unresolving and increasing pain?

No comment.

Code A

Did you consider that she may have a wound infection?

No comment.

Where is the evidence, or record that you actually sort out this possibility on the 6th of April 1999 (06/04/1999)?

No comment.

If you had considered infection, why then did you increase the Morphine as opposed to commencing an appropriate antibiotic course?

No comment.

And I will ask you again about did you consider another possible cause for Code A s pain, i.e. that she may have had a large haematoma?

Code A

No comment.

I believe that haematoma and Compartment Syndrome as well are associated with severe pain that responds poorly to analgesics, and haematoma can also become infected. (Somebody coughs) Did you consider referring Code A Code A to an Orthopaedic Surgeon?

No comment.

Did you consider a second opinion at all?

Code A

No comment.

(Pause) Do you consider Code A that you had enough time to properly treat this patient?

No comment.

I mean I think you've said earlier on that 'the pressure of work in the hospital was severe and it was causing you to not get the opportunity to record notes etcetera'. I think you say that 'you had a choice to make write less notes or don't take proper care of the patients'. Well if I show you exhibit BJC/89 and that's the Admissions Book for Dryad Ward and Code A was admitted on a Friday so if we go, and we know that patients aren't normally admitted over the weekend are they? So let's go back say to the 22nd of March, well I'll tell you what let's go back to the 16th of March because a patient was admitted on the 16th, two patients were admitted on the 16th. The next patient is admitted on the 24th, that's a Wednesday, and then the next patient is Code A who is admitted on the Friday. No more new patients are admitted to Dryad Ward until the 9th of April, which was another Friday and that was Code A days before, or Code A days before Code A died. And one of the things you're telling us I believe, or leading us to believe was that the amount of patients coming onto the ward prevented you from properly looking at the other patients or recording on the other patients. Is that correct?

Code A

No comment

And what I'm saying to you there is look you only had one other patient that week on that ward. In actual that patient died the day after Code A came into the hospital, so if you're looking at it coldly there was a bed there, which presumably wasn't filled until the 9th. Do you understand that, am I reading that right?

No comment.

So it was one less patient if you know what I'm saying?

(Silent)

So if we look at that we go from the 27th of March, the day after Code A came in, which was the weekend, and that was the day that this other patient had died, so we go from the 27th, one, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, it's practically two weeks, it's thirteen days before we get another patient admitted into that ward. That doesn't look as if that's a full on filling up of the ward does it with new patients?

Code A

No comment.

With the lack of new admissions, then would not a patient that's on the ward who is in a lot of pain actually be flagged up as somebody that would need attention?

No comment.

Because all new admissions will have to be initially examined and clerked, which we've spoken about. With the lack of those then surely more time could be given to somebody like Code A who is in so much pain?

Code A

No comment.

How much time did you give her?

No comment.

Can you give me a reason why you couldn't afford her some time?

No comment.

There was a Microbiological Report in the notes dated the 9th of April 1999 (09/04/1999) revealing that the wound swabs had grown the bacteria Staphylococcus, which is sensitive to antibiotics, (inaudible), Flucloxacillin and Penicillin, but you prescribed Ciprofloxacin as an antibiotic. Is that right?

Code A

No comment.

Was that an appropriate antibiotic to prescribe in the circumstance then?

Code A

No comment.

(Pause) Paragraph 29 says that 'On the 7th of April the nursing staff recorded that the fracture site was red and inflamed and Code A was seen by me, with my indicating that she should be commenced on the Metronidazole and the Ciprofloxacin and I anticipate that I was concerned Code A was developing an infection and should commence these antibiotics even in advance of the results of the swabs'. Did you make any referral, or consult with anybody over this?

Code A

No comment. (Somebody coughs)

Okay. Paragraph 30 'Code A saw Code A the same day in the course of what I anticipate was a ward round, and noted specifically that she was still in a lot of pain and was very apprehensive. He also recorded the fact that the Morphine Sulphate had been increased to 20 milligrams twice a day the previous day. He advised that Flupenthixol, a minor antidepressant, should be given and he wrote up a prescription for Flupenthixol on her drug chart accordingly. He also asked that an x-ray of Code A Code A s hip should be undertaken as movement was still quite painful and there appeared to be a 2 inch shortening of her right leg. I am unable now to say what the x-ray demonstrated as there is no report available in the medical records provide to me'. So from that you note that Code A has asked for x-rays, is that right?

No comment.

Well bearing in mind the date of that is now (pause) the 7th of April and was this not an opportunity that was open to you, an option that you had had to ask for x-rays?

Code A

No comment.

Were you entitled to send the patient for x-rays?

No comment.

You were the person with responsibility on a day-to-day basis. Why hadn't you considered x-rays before now?

No comment.

She had been in your care for approximately eleven days and according to you her pain was increasing. Is that correct?

Code A

No comment.

Is it common to refer a patient back to the x-ray department after such surgery?

No comment.

Did you attempt to review the x-rays at all?

Code A

No comment.

Because I can't find it in the records and there seems to be no follow-up to that. Is that right?

No comment.

You're Code A has asked for a patient to be x-rayed. Do you not consider that that is a flag to you to source the pain?

No comment.

So obviously the fact that Code A has asked for x-rays, he must be thinking along the lines, surely, that there's something wrong with her leg, her hip (somebody coughs). Is that right?

Code A

No comment.

Was it not one of your responsibilities in your Job Description to follow a line, or was it your responsibility to follow a line that the Code A was taking?

No comment.

Well I'm assuming that if the Code A writes something in the hospital notes, you aren't going to ignore the doctor are you?

Code A

No comment.

Was it not your responsibility to ensure that the x-rays were done and then viewed?

No comment.

You have got day-to-day responsibility for the medical management of a patient haven't you?

No comment.

If the Code A asked for something to be done, is it not your responsibility to ensure that that is done?

Code A

No comment.

Well the notes say, from the nursing notes, 'that the x-ray was arranged for three o'clock the following day'. Do you agree with that?

No comment.

You saw Code A on the 8th and the 9th (someone coughs) and so for at least the next two days, and yet you make no mention of the x-rays. Why not?

No comment.

Code A

In actual fact you make no mention of anything because there is nothing recorded by you in your notes. That's correct isn't it?

No comment.

When would the x-rays normally be available after being taken doctor?

No comment.

Do you want to ask any questions?

(Inaudible)

In paragraphs 34, 35 and 36 you know that the nursing entry on the 10th of April reports that 'Code A was leaning to the left', and this raises the possibility that Code A Code A may have had this cerebrovascular accident, a stroke. Now bearing in mind that's what you recorded the cause of death as, when did you carry out a medical examination including a neurological examination to support that view?

Code A

No comment.

Did you carry out such an examination?

No comment.

Surely if you had have done you would have recorded that as a significant event?

No comment.

Code A

Presumably when you examine the patient you look at the Nursing Records, or speak to the nurses. Did you consider it possible that she may have been leaning to the left because of pain from her right hip?

No comment.

Would that be a normal thing for a patient to do to avoid the right hip and lean to the left?

No comment.

(Pause) Were you aware, at that stage, that Code A had complained of pain on the stitch line to surgical wound?

Code A

No comment.

Well I say to you that it was available for you to be aware of because it's in the nurses' notes.

(Silent)

Did you consider that doctor?

Code A

No comment.

Paragraph 33. (Somebody coughs) The Nursing Records for the 9th of April 1999 (09/04/1999), twenty days after her operation report that 'Code A was distressed when put onto the commode and so she was catherised. Her urine was very concentrated and she wasn't drinking'. Is it right that even though the Morphine dose had not been increased, when people don't drink and they become dehydrated the Morphine metabolises, accumulates as if the dose of Morphine had been increased? Was that something you considered doctor?

Code A

No comment.

Where did you record and why you were prescribing Morphine for Code A and the effects that the drugs would have on her?

No comment.

Did you feel that you had the necessary experience and skill to prescribe those medicines to patients suffering from such ailments?

No comment.

Did you ever raise concerns about your workload and role requirements with anyone?

Code A

No comment.

In particular the Code A ?

No comment.

Because of the lack of documentation from your part, it is difficult to know if you considered Code A may have been experiencing problems due to septocemia, toxcemia from an infection, or from the increase in her blood levels of Morphine (inaudible) or both. Now did you consider any of those problems doctor?

Code A

No comment.

I think it's quite relevant that they've given the comments regarding her wound.

No comment.

Well did you record any findings?

No comment.

Did you, in fact, have any findings?

No comment.

On the 11th of April Code A was less well, drowsy, unrousable at times, irritable and with her wound showing

signs of possible infection despite the fact that she had had five days of antibiotics. Why was she not reviewed by the doctor on call?

Code A

No comment.

Why didn't you refer Code A then Code A Code A ?

No comment.

Was any patient ever referred back to another hospital like Haslar, or the QA?

No comment.

Could Code A have been referred back to the other hospitals?

Code A

No comment.

Were any patients ever transferred?

No comment.

Was there any particular reason why Code A shouldn't have been transferred?

No comment.

Code A

Okay.

Paragraphs 37 and 38. You clarify that 'you probably saw Code A on the 12th of April 1999 (12/04/1999)'. The 12th of April is the Monday.

No comment.

Given your comments there (somebody coughs), there would have been quite a change in Code A s condition over the weekend wouldn't there?

Code A

No comment.

Bearing that in mind, what medical assessment of Code A Code A did you then undertake?

No comment.

How did you exclude any causes of Code A s deterioration that would have been potentially reversible with appropriate management?

Code A

No comment.

For instance the septicaemia from the infected hip wound?

No comment.

Excess opioid...

Code A

No comment.

...because of the increasing dehydration, or some other medical problem doctor?

No comment.

Well why weren't even basic observations such as Code A Code A 's temperature not taken?

No comment.

The antibiotics were discontinued on the 12th of April. Why was that?

Code A

No comment.

Now one option is that you may have considered the wound infection had cleared. Did you?

No comment.

Or was it because Code A was deteriorating?

No comment.

You considered that 'on the 11th of April Code A was drowsy as a consequence of her infection', Paragraph 40. This suggests that you did consider an infection, that it

was at least a factor of Code A 's deterioration. Was that right?

Code A

No comment.

Because if that is right, why didn't you consider it appropriate to use antibiotics that were known to be effective against the bacteria isolated from the wound?

No comment.

Remember we saw the sensitivities available for the month of April?

No comment.

(Pause) We all make mistakes doctor, but is there a reason why there seem to be a few here?

Code A

No comment.

Well given that Code A was not considered to be terminally ill, why were intravenous fluids not considered appropriate to correct Code A 's dehydration?

No comment.

I think we've already established, from what you wrote, that 'you considered infection was the problem'. So why weren't intravenous antibiotics considered appropriate?

Code A

No comment.

(Someone coughs) On what evidence then do you concluded that Code A 's deterioration was due to an irreversible medical problem?

No comment.

(Pause) Paragraph 39 doctor. Given that Code A had been receiving the MST 20 milligrams twice a day and you say, do you not, in your statement: "I consider this increase in medication to be a reasonable one in view of her condition at that time." Can you therefore describe exactly to me the steps and the calculation you undertook in order to conclude a dose of Diamorphine, 80 milligrams over 24 hours subcutaneously was an appropriate dose for Code A Code A ?

Code A

No comment.

Now I am going to show you this blown up section from the BNF and it deals with equivalent doses. That indicates, doesn't it, that the equivalent dose from the MST to Diamorphine subcutaneously was 15 milligrams. Is that right?

No comment.

Code A

You were prescribing her 20 milligrams every 12 hours of MST. Is that correct?

No comment.

If you look at the chart here and you'll seen Morphine Sulphate every 12 hours 20 milligrams, and equivalent Diamorphine subcutaneous infusion dose would be 15 milligrams every 24 hours. Is that right?

No comment.

And these are guidelines in the BNF aren't they when prescribing?

Code A

No comment.

Yet you started her on 80 milligrams, she was started on 80 milligrams of Diamorphine. That represents, doesn't it, the four to six fold increase in dosage.

No comment.

(Somebody coughs) Why, why did you start at such a high dose?

No comment.

If the equivalent dose of Diamorphine is 15 milligrams to what she was getting in MST, why did you have her started on 80 milligrams of Diamorphine?

No comment.

Is that down to you, or is it down to the nurses?

Code A

No comment.

But ultimately it must be down to you because you're the prescribing doctor aren't you?

No comment.

What guidelines were given to the nurses when you were giving that prescription?

No comment.

(Pause) Should you review doses regularly doctor?

Code A

No comment.

Particularly with elderly patients?

No comment.

And particularly with the strong opioids? Are they likely to need the lower, or less frequent doses?

Code A

No comment.

What allowance did you make for Code A 's age when you were prescribing the Diamorphine?

No comment.

Did you make any allowance for her level of dehydration?

No comment.

Again you see there is no fluid chart available is there?

No comment.

Code A

Well how did you know what her fluid levels were then?

No comment.

Why was Midazolam considered necessary?

No comment.

And 20 milligrams every 24 hours?

No comment.

Code A actually reduced that Diamorphine to 40 from the original 60, is that right?

No comment.

Did that often happen, did he often reduce your doses?

No comment.

Code A

Code A was noted 'as being drowsy'. What tests do you make to ensure the Diamorphine isn't the cause of that drowsiness doctor?

No comment.

Now tell me if I'm right here, is there a practice within the hospital on other wards to carry out a simple test on the pupils to establish that?

No comment.

Code A

If the pupils are a normal size, does that equate to likely to be not too much Morphine?

No comment.

If the pupils are pin-points would that equate to too much Morphine, so therefore reduce the dose?

No comment.

If the pupils were pin-points and it wasn't pain controlled, would you then look at considering different analgesia?

No comment.

Are these simple tests ones that you would apply?

Code A

No comment.

If you did that, is there evidence anywhere?

No comment.

On Page 41 of the notes shows Code A s entry in relation to the prescription. I'll show you that (pause).

(Inaudible) I'm not sure what it is.

But it's, there is an, there is an entry by Code A ..

Code A

(Inaudible – mumbles)

...dated the 12th. 'Now very drowsy. Regarding the Diamorphine infusion established reduce it to 40 every 24 hours. If pain occurs up it to 60. Able to move hips without pain, but patient not rousable'. Now that is a clear instruction, isn't it, to the nursing staff? Do you think that's a good example of how you should instruct the nursing staff and the medical staff? It's quite clear isn't it?

No comment.

Code A do you want to make anymore questions on that?

No. I would like to, if I can, go pop back to Point 26. I didn't want to interrupt you. Paragraph 26 isn't it?

Code A

While Code A is looking for that doctor, the transfer letter concludes: "For any further information please contact the ward." Signed by Code A Did you ever seek such further information?

No comment.

You make the point that '40 milligrams of Diamorphine was not seemingly successful in relieving Code A 's pain as she was in some discomfort when attended to'. But isn't that unusual for someone who had undergone repair of a fractured neck of femur with it done on a hip screw?

No comment.

Code A

Would that not flag up to you that an orthopaedic review should be sought?

No comment.

And yet despite that open invitation from Code A Code A you didn't take it up?

Code A

No comment.

Code A

Yeah it's Paragraph 26 of your statement: "I would not have seen Code A over the course of the weekend 3rd/4th of April," it's obviously because you're not on duty. (Tape recorder buzzes) Oh.

INTERVIEW COMES TO A SUDDEN END.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AH

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/04/2006

Time commenced: 1514 Time concluded: 1531

Duration of interview: 17 MINUTES Tape reference nos.
(→)

Interviewer(s): Code A

Other persons present: Code A - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the interview of Code A Code A the time by my watch is now 1514, the date is the 4th of April 2006 (04/04/2006). Doctor can you just confirm that we have just changed, had a break to change the tapes and we haven't spoken to you during the interim?
	I can confirm that.
	Thank you. And the same people are still in the room are they not?

Code A

I can confirm that.

Good, okay. I will remind you that you are still under caution and I think I'll hand you over to Code A as he wants to ask you some questions.

Thanks. We were talking about Paragraph 26 and in fact Paragraph 25 as well in your prepared statement doctor. Paragraph 25, I'll read it: "The following day the 2nd of April, Code A was now noted as having a small wound on her arm. She continued to have Morphine Sulphate, 10 milligrams twice a day, but on the 3rd of April it was again noted that she still continued to have pain on movement even with the Morphine Sulphate." And then you've put: "I would not have seen Code A over the course of the weekend the 3rd and 4th of April, but anticipate that I would have reviewed her condition again the following Monday, the 5th of April." You were obviously not working on the Saturday and Sunday, but what cover was arranged for weekends?

Code A

No comment.

And who would cover for you?

No comment.

And any doctor that would be covering for, i.e. locum, how would they know what to treat...

Code A

No comment.

...because of the lack of notes?

No comment.

There's a lack of care or treatment plans as well isn't there doctor?

No comment.

Also because of your lack of notes, that's why you would say: "I anticipate that I would have reviewed her condition again on the following Monday, the 5th of April," isn't it doctor?

Code A

No comment.

Because you can only 'anticipate' because you've made no notes.

No comment.

Would it be normal for you to have bank holidays off duty?

No comment.

Because this weekend was actually the Easter weekend and the 2nd of April was Good Friday and the 5th of April was

Easter Monday. Would you have been working those days?

No comment.

Code A

Who would have reviewed Code A on Easter Monday then?

No comment.

So am I right in thinking there's possibly, a possibility of chance that she hasn't been seen possibly since the 1st of April?

Code A

No comment.

But of course we can't make a judgement on that because there are not notes are there?

No comment.

All right.

(Pause) Doctor you admit to poor note keeping I think in your written statements and, but even with the episodes considered potentially serious and significant by you regarding your patient Code A you make not entry in her medical notes. As Code A said 'even on a weekend when you're not presumably time pressured to the same extent'. Do you agree with that?

Code A

No comment.

What is your duty of care to your patients?

No comment.

Did you feel competent or incompetent in performing the role of Code A ?

No comment.

Were patients in your care exposed to unnecessary risks at all?

Code A

No comment.

(Pause) (Somebody coughs) Bear with me doctor I'm going to ask you some more questions in a moment. (Pause) Doctor this case, this patient a 92 year old lady, she's very independent, she's a Code A she's been a Code A for 40 years and she's lived alone I think for 40 years, but certainly living alone at the time that she was in hospital when you came into contact with her, she's a non-smoker, she enjoys a brandy and ginger ale every morning, this is all information available to you from her Medical Records. She takes no drugs and has no other health problems. Unfortunately for her on the 19th of March 1999 (19/03/1999) she has a fall and breaks her hip. Prior to this she is considered active, she speaks well but is a little deaf,

she's marked up as 'no breathing difficulties', regarding eating and drinking she's got a small appetite. Unfortunately on the 19th of April because of the accident she wasn't able to clean and dress herself at that time. She feels the cold a little bit, likes to keep warm. Her normal life involved walking her dog, which she loved and doing the garden. She sleeps a lot, always falling asleep in her chair. She had no problems apart from she liked to urinate most mornings at about 4 o'clock. She was alert on the 19th of April and understands everything, even though she is a little deaf. She goes into Haslar Hospital where she's correctly diagnosed as having this broken neck of femur and with regard to the fact that patients of that age there is an (inaudible -somebody coughs) for them to be operated on and she is operated on the next day, thus increasing her risk of survival.

Code A

No comment.

She makes reasonable progress at Haslar and despite the fact that she has to have Diamorphine before and after the operation, her only pain control after that was Paracetamol as required and she didn't have that very much. She comes to Haslar, sorry Gosport War Memorial and you start off her treatment with Oramorph because you say that 'she was in pain', which I think we've shown is not adequately recorded. Increasingly her analgesic is increased and increased and increased until eventually she is on Diamorphine by a subcutaneous syringe driver. On the 6th of April she's seen by you and the MST was increased,

which is the Morphine Sulphate. Code A visited her and it says in the nursing notes 'if necessary once Code A is discharged home (how she is adament about not going to a nursing home) he will employ someone to live in', going on to explain that 'she has been incontinent with urine a few times over the weekend, I have spoken to her about a catheter and she was going to think about it, or using pad in pants'. So up to the 6th of April she's considering going home. Code A is under the impression obviously that she is going home and he is making arrangements for her to be looked after. Presumably the nurse doesn't contradict this at all and makes a note of it.

Code A

No comment.

On the Medical Certificate of Cause Of Death you've put 'approximate interval between onset and death of 48 hours', so that's the Code A So you're saying, are you not, that 'she'd reached the terminal phase 3 days before, Code A days before she died'. Is that correct?

Code A

No comment.

From the moment she came into Gosport War Memorial Hospital doctor to the moment she died, did you properly seek to establish why she was in pain?

No comment.

A 92 years old lady who looked after herself, she only had a home help that came in once a week. Did you consider what was causing her pain?

No comment.

Code A

Do you want to ask any questions Code A?

Have you finished then?

Yes.

At this point (coughs) I'll just go over this very quickly. I'm not going to ask a question, but will make the point about 'note keeping' doctor. On Code A s admission to the Gosport War Memorial Hospital on the 19th of March until the time she died, which I believe was the 12th of April,...

Code A

The 13th.

...the 13th of April. That's twenty-four isn't it?

(Silent)

There is one page of clinical notes made, which is four entries, only one of those by you, two by Code A and the last one was just confirming death, but one page over all that time. Now in the ward we don't think, it doesn't appear to be that busy doctor but Haslar Hospital, which

has an Accident and Emergency, on the 20th of March alone is a page of clinical notes. The clerking that was a page. On the 21st of March is a page-and-a-half of clinical notes and so it goes on. How can one hospital, and doctors at one hospital have time to make such comprehensive notes and you don't have time at the Gosport War Memorial, the Cottage Hospital.

Code A

No comment.

Would you agree that these, which are in the file JR/14, the Haslar notes, these clinical notes and the clinical continuation sheets that's how the notes should be made?

No comment.

(Pause) Can you give any reason for your lack of notes?

No comment.

(Pause) Is there anything else you want to ask?

I really make that point again though doctor and that's Code A Code A came into your hospital under your care and seemingly up until then recovering from a dynamic hip screw replacement operation but (pause), and regularly apparently complaining of pain and you start at a level of analgesic prescribing, which is upped and upped to, as I say, eventually going on to Diamorphine, but never

establishing what the cause of that pain was. Do you accept that?

No comment

(Pause) I can almost compare it doctor to an engine rattling in a car and turning the radio up so you can't hear it, there's been not attempt to find the cause of the rattle, the cause of the pain, there must be some reason?

No comment.

Code A

(Pause) Is there anything you want to add doctor?

No thank you.

Is there anything you want to clarify?

No thank you.

Do you think we have misunderstood anything...

No comment.

Code A

...that you want to make clear to us?

No comment.

Code A is there anything you would like to say?

Code A

No thank you.

Well the time by my watch is now 1531 and I am going to turn the machine off.

INTERVIEW CONCLUDED – TAPE MACHINE WAS SWITCHED OFF.

Code A

You say that 'you probably went to the hospital maybe up to three times a day'. What, did you do three ward rounds, or a ward round each time you went, or just one in the morning, or one in the afternoon, or one in the evening?

No comment.

Who do you conduct your ward rounds with?

No comment.

Did you conduct them with Code A ?

No comment.

What role did Code A play in the ward rounds?

Code A

No comment.

What was the purpose of the rounds?

No comment.

We've already discussed that it appears that you really, perhaps, should have been making more notes than you had, it that not one of the purposes of the ward round?

Code A

No comment.

Ideally perhaps you should have been writing a proper Care Plan down for the patient, and if the patient was sticking to the Care Plan and there were no significant changes and the patient was on a plateau or maybe slightly improving, then perhaps we can understand you not making any records of the ward rounds, but we've already explained that at some stage you jump from treating her with Paracetamol, the previous hospital treating her with Paracetamol and you jump two steps on the ladder up to strong opioids and you hadn't recorded that. So did anything else happen to Code A on those ward rounds that you failed to record?

Code A

No comment.

How long would they take?

No comment.

Did the nurses accompany you on the ward rounds?

No comment.

Did they have an input into the rounds?

No comment.

Code A

Again we've already established that Code A Code A possibly saw the patient more than most, at least as per the (inaudible) maybe that worked out in practice I don't know, but would she have gone on the ward round with you to see your patients?

No comment.

How often did the Code A conduct the ward rounds?

No comment.

I believe the Code A in this case was Code A Code A How often did he conduct his ward rounds?

Code A

No comment.

Did you accompany him when he did his ward rounds?

No comment.

I think you'll agree that in the Job Description one of your requirements was 'to accompany the Code A on his or her ward rounds'. Did you do that?

No comment.

Code A

Did the Code A ward rounds differ from yours at all?

No comment.

In your first 'prepared statement' you say that 'you went to the ward, uh went to the hospital on most days'. If that was the case during Code A 's stay, why didn't you make entries in her medical notes?

No comment.

Code A has just been discussing that with you, and we can only find one entry in the medical notes with your name on it, that is dated the 26th.

Code A

No comment.

I'm going to show you, we've printed off from 1999's calendar, I'm going to give this an exhibit reference of...

GJQ/HF/16.

Thanks. We've printed off a calendar for you to have a look at and it shows the calendar months of March and April of 1999 and if we look there I've written down – 'Admitted to Dryad Ward', and that's when Code A came to the hospital when you first

saw her, and on Code A is sadly the day she died. While you are looking at that I'll ask you, you visited the hospital first thing (somebody coughs) in the mornings (somebody coughing) around seven-thirty (0730) is that correct?

Code A

No comment.

Is it also correct to say that you visited at lunchtime most days?

No comment.

And am I also correct in saying that you used to visit in the evening after seven o'clock?

No comment.

I've got that from Pages 3 and 4 of your 'prepared statement' and this is what you've previously told us doctor. Did I tell you that Code A was admitted to Dryad Ward on Friday the 26th of March 1999 (26/03/1999) and died on the Code A Code A as I've shown you on those calendar months. Going on your daily routine that gives you, if my maths are correct – it won't be far out even if it isn't, that gives you forty-seven opportunities to have seen her and then to have recorded entries into the Medical Records. Doctor how many entries did you record?

No comment.

As we've referred to earlier the answer is there for all to see isn't it? It's just the one brief note on her transfer dated the 26th of March 1999 (26/03/1999). Can you explain to us now why there's only that one entry there out of a possible forty-seven?

Code A

No comment.

The Bank Holiday was over the weekend of the 2nd to the 5th of April. What are you doing that Bank Holiday?

No comment.

The reason I ask that is because you say in your statement, paragraph 26, this is the statement relating to Code A and I see you've got a copy of it in front of you, that 'you would (somebody coughing) not have seen her over that weekend'. Is that correct?

Code A

No comment.

Well I'm intrigued by that because I believe the start of the statement says that 'At this removal of time we had not recollection of a patient'. Is that correct?

No comment.

Code A

If you have no recollection of that patient, how do you know that you wouldn't have seen her over that weekend?

No comment.

If you had have been recording every day, every time you saw her you were recording and then you could say: "I obviously didn't see her over that weekend because look I haven't recorded anything," I could perhaps understand that, but that's not the case here is it?

No comment.

Code A

There's an absent of your notes every day, is that right?

No comment.

You don't remember the patient do you?

No comment.

And your notes don't indicate that you were away do they?

No comment.

So how do you know that you wouldn't have seen her over that weekend?

Code A

No comment.

How can you tell, from looking at those notes that we provided you with copies of, that you did not see her over that weekend?

No comment.

Have you, to establish that, have you referred to a diary of some sort to come to that conclusion?

Code A

No comment.

Where is that diary?

No comment.

Looking at that month in March in front of you and the month of April in front of you, it's pretty black and white isn't it the amount of days that she was in the hospital for under your care, under your daily management, your medical management, do you feel that you satisfactorily achieved the standards required of you...

Code A

No comment.

Code A

...(a) with the care and treatment of Code A, and (b) with the note recording of Code A.

No comment.

If you weren't available on a particular day, would Code A do ward rounds on her own?

No comment.

Code A?

I'm still talking about the lack of notes that Code A Code A's talking about and (inaudible – mumbles) it's seven years since Code A died, and you mention in your 'prepared statement 'after this removal of time you cannot remember the patient', so really you'd be like a new doctor looking at the notes. Now with all the time that's been available for you to look at these notes now for this enquiry and to compile your 'prepared statement' you still struggled. So how would a new doctor, when Code A was alive, pick up those notes fare on a busy ward round?

Code A

No comment.

He or she would have no chance would they?

No comment.

Code A

The lack of notes are just so significant.

We'll move on to Code A their assessments and responsibilities. Code A play an integral part in the care and treatment of the patients don't they doctor?

No comment.

We think that it's essential for you to have the opportunity to offer an explanation as to how the role and the function of a Code A was performed in respect of Code A We are seeking an explanation of any concerns you may have raised and to whom. Did you have any concerns on how the Code A supported you at War Memorial Hospital?

Code A

No comment.

If you did, when and how did you raise these concerns?

No comment.

Were you comfortable that you knew how to raise concerns should you have needed to?

Code A

No comment.

Code A

Who was the Code A responsible for the care and treatment of Code A whilst she was a patient at Gosport War Memorial Hospital?

No comment.

I think we've established haven't we that it was Code A? What did you understand Code A Code A's responsibilities to be?

No comment.

Did you leave all responsibility to him?

No comment.

Did you depend on him?

No comment.

Code A

What was your relationship with Code A.

No comment.

...in a work capacity?

No comment, no comment.

Did you have a good working relationship with him?

No comment.

(Coughs) Did you ever consult with him about Code A Code A ?

No comment.

Code A

Well you've made 'no comment' to those questions, so in the absence of not knowing the answer to them, is there any reason why you didn't or couldn't consult with him?

No comment.

As we've mentioned you had up to forty-seven opportunities to write in those notes going on what (inaudible) you're the one who's told us how many times you would go to the hospital. Code A saw Code A on the 7th. I think it was the 7th or the 9th of April was it?

7th and 12th.

Code A

7th and 12th of April and yet he managed to write two entries. How many opportunities would he have had to see Code A ?

No comment.

Code A

I understand he did his ward rounds once a week, is that right?

No comment.

If you would have wanted him to see Code A, could you have asked him to have a review of her...

No comment.

...outside of the ward round routine?

No comment.

Did you ever ask him to?

No comment.

What was his involvement in the care and treatment of Code A?

Code A

No comment.

Code A any questions.

None.

Okay. We will move on to pharmacy. Pharmacy prescribing and administrating controlled drugs, specialist subjects. We seek explanations as to how

you were involved in the pharmaceutical prescriptions, your level of training, your understanding of the drugs you prescribed and their uses. How did you ensure that you were up-to-date on the knowledge that you had in respect of pharmaceutical issues doctor?

No comment.

What pharmaceutical training had you received at the time of Code A 's admission to the hospital?

No comment.

Code A

How would you know what drugs to prescribe to a patient?

No comment.

How would you learn about new drugs that were available for administration?

No comment.

Code A

How would the pharmacy at the War Memorial work in relation to the availability/suitability of medicine and drugs?

No comment.

Code A

Going back to the: "How would you know what drugs to prescribe to a patient," it's easy for us to sit here and assume that you knew what drugs to prescribe, well I say it's easy to assume that, but when we spoke about the Analgesic Ladder it looks on paper, at least, that you may have made some terrible error in going from Paracetamol up to strong opioids in one full swoop. Did you have a good working knowledge of drugs available to you at that time?

No comment.

Do you see how it looks without an explanation, it looks as if you perhaps didn't. I don't want to be impertinent, but I'm just saying that's how it looks in black and white.

No comment.

Code A

(Coughs) And this is an opportunity for you to put us on the right path.

No comment.

How many pharmacists worked at the War Memorial in 1999?

No comment.

Code A

Did they have a pharmacy there at that stage?

No comment.

What is the BNF?

No comment.

We've already shown you the BNF haven't we and we gave it an exhibit reference.

BNF 2001 is CSY/HF12.

Thank you. And my understanding doctor is that that is the bible for the prescribing of drugs isn't it?

Code A

No comment.

And would you have had a copy of that available to you in 1999?

No comment.

I believe most doctors have always got a copy of that, a current copy of that available haven't they?

No comment.

How often would you refer to it?

Code A

No comment.

Similarly there are two other publications, one is the MPF, which is similar to the BNF but this is for nurse prescribing, it's a nurse prescribers formulary. Are you familiar with that doctor?

Code A

No comment.

Do you ever refer to that?

No comment.

We'll give that a reference number won't we? What number are we up to now?

GJQ/HF/17.

Thanks.

And this will be GJQ/HF/18.

Yeah. So number 18 then is another one, which is the PCF/2, which is the Palliative of Care Formulary. Are you familiar with that at all?

Code A

No comment.

I mean do you refer to those still now those three documents?

No comment.

Code A

Were any of the drugs used in Code A s treatment new or seldom used?

No comment.

We've shown you the green Palliative of Care book and the Wessex Protocol within it, and the Wessex Protocol on the documents from Gosport. What's the purpose of the Wessex Protocol in relation to prescribing medicines?

No comment.

Code A

Is it not, I don't say simple matter, but the concept is that you start off low until pain control is achieved. Is that how it works?

No comment.

Chris have you got any questions to ask?

Just really to clarify about the Palliative of Care handbook sometimes referred at the Wessex Protocols as some people haven't heard of it. This one we're showing you is the fifth addition, it's from the Countess Mountbatten House at (Inaudible) University. This is in association with all the Wessex

Specialist Palliative Care Units. I think that's where it's probably got the name of the Wessex Protocols, but we've got the book here for you to see. Are you familiar with it?

No comment.

Well I think that's another opportunity that we (inaudible – mumbles). Is there anything that you want to clarify or add to doctor?

Code A

No thank you.

No. Code A

No thank you.

No. The time by my watch is now 12, 1139 and I am turning the machine off.

INTERVIEW CONCLUDED, TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AE

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/04/2006

Time commenced: 1147 Time concluded: 1227

Duration of interview: 40 MINUTES Tape reference nos.
(→)

Interviewer(s): Code A

Other persons present: Code A - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	The time by my watch is now 1147. Doctor this is a continuation of interviews with yourself. Because we've had a bit of a comfort break and we've just done some tidying up of the documents, can I just ask you to confirm that the same people are still in the room?
Code A	They are.

Code A

Thank you. We've had no discussions about the matters for which you are being interviewed while the tapes haven't been running?

No.

Thank you. Because there has been a little bit of, a bit of a gap I will remind you that you are under caution, you do not have to say anything but it may harm your defence if you do not mention, when questioned, something which you later rely on in court. Anything you do say may be given in evidence. Now I think we've gone through the explanation of the caution. Would you like to go through that again or are you happy, you are confident that you know what it means?

Code A

Thank you.

Yeah. We've just had a, as I say, little comfort break and we've just tidied up the exhibits. Even though the exhibits have just been removed from the table there, you can see that they're still in this box beside me and beside Code A Code A If you want to look at any of those exhibits during the course of this interview, I want you to feel free that you can have access to them. Do you understand that?

Thank you.

You're welcome. (Coughs) Prescriptions doctor. When you prescribe medicines you have a requirement to

complete different parts of a prescription chart. We are going to seek explanations as to how you, as the Code A Code A, was involved in prescribing medicines and what protocols you followed. We would like you to describe the process undertaken in the prescribing and administering of controlled drugs. Can you detail to us the purpose of, what the purpose of each part of the controlled drug chart is, and if we show you a copy of another, again this is an exhibit we've used before CSY/HF/10 (pause whilst Code A hands Code A exhibit) thanks, and you can see that that is the Fareham and Gosport Primary Care Trust Prescription sheet. Obviously the first page is taken up with notes for the prescriber. The second page would have a box for the Consultant's Name, Analgesia Drugs Sensitivity is obviously the patient's personal details. The first box there is Once Only And Pre-medication Drugs. What would go into that box there doctor?

Code A

No comment.

Underneath that you have a section, which says As Required Prescription. What would you write into there?

No comment.

The booklet folds out and you have another section called The Regular Prescription. What would go there?

Code A

No comment.

Code A

And on the back of it is for nursing use and that's Exceptions To Prescribed Orders. Can you explain how you would use that chart in prescribing drugs to a patient, for a patient?

No comment.

When you prescribe drugs to a patient, do you consider certain factors? Would they, for instance, involve fluid charts, observation charts, weight charts, etcetera. (Coughs)

Code A

No comment.

When you prescribed drugs for Code A did you give consideration to what was recorded on those charts?

No comment.

Code A

Because I've gone through the records for Code A and I can't find those charts for that patient.

No comment.

Can you explain why there don't seem to be any of those charts available?

No comment.

Code A

As previously stated you were responsible for the day-to-day medical management for Code A Given the absence of those charts was it not your responsibility, one of your responsibilities to ensure that they had been undertaken?

No comment.

Should they not have been available for any other doctor to consider on the occasion of being called out to Code A Code A in your absence?

No comment.

(Pause) We've already gone through the calendar month there and Code A was in for several days. Are we saying that at no time was here blood pressure taken?

Code A

No comment.

Was she ever weighed?

No comment.

How would you know if her weight was going up or down?

No comment.

(Coughs) How would you know whether she was properly hydrated?

Code A

No comment.

Was any record being made of her fluid intake?

No comment.

What about her nutritional intake?

No comment.

Doctor I've just shown you the blank prescription sheets there. What is the difference between 'once only drug', 'as required drug' and 'regular drugs'?

Code A

No comment.

Why are ranges of drugs prescribed for patients?

No comment.

How should a prescription chart be completed?

No comment.

Can you tell us what a Proactive Prescribing Policy is?

No comment.

We know it's something that you told us about in your 'prepared statement', (coughs) was there a policy for it?

No comment.

If there was a policy, how did it come about?

Code A

No comment.

What was its purpose?

No comment.

Who authorised the policy?

No comment.

On Page 134 of the War Memorial notes (pause whilst locating notes)...

I think it's 134.

Code A

It goes on to telephone prescribing. Can you explain what 'telephone prescribing' is?

No comment.

You see on Page 134 at the top, I think the drug is Metoclopramide and you see it's got a 'pp' on it, 'pp Code A and it's prescribed on the 28th of March,

'pp Code A' and then it looks like your signature underneath it. Is that an example of telephone prescribing?

Code A

No comment.

It looks as if you weren't there when the drug was prescribed.

No comment.

Is that your writing in the header there under 'Drug'?

No comment.

What is the purpose of a doctor on call?

No comment.

There was, I understand there was probably a 'locum' available. Did you ever use, or pay for the locum out of hours GP covering service?

Code A

No comment.

One you've prescribed a drug, who administers the drug?

No comment.

Is it the nurses that administer the drug?

Code A

No comment.

Can any nurse administer it?

No comment.

What training do the nurses have in administration of drugs?

No comment.

Each ward has a drug register. What is the purpose of the 'drug register'?

Code A

No comment.

What has to be recorded in them?

No comment.

Now why have there been drugs prescribed but not administered?

No comment.

I'm going to show you Page 123 (pause). Page 123 is Oramorph and it was prescribed on the 26th but it wasn't administered until the 31st. Can you explain why that was?

No comment.

Code A

Did you let nurses prescribe drugs?

No comment.

Oramorph was presumed to be making Code A sick and thus it was stopped on the 28th of March. Why was the prescription not cancelled?

No comment.

The Oramorph was stopped on the 28th of March, as we've said, because it was causing the nausea. To counteract the nausea you then prescribed Metoclopramide but that was continuing until the 31st of March. Why was that?

Code A

No comment.

(Inaudible) prescribed MST to Code A Morphine Sulphate I understand that is isn't it?

(Silent)

And yet on the 31st of March (mobile phone interfering with tape) and the 11th of March she was given doses of Oramorph. Can you explain that?

No comment.

Code A

After she received the dose of the 11/04 Code A is recorded as 'being very drowsy / un-rousable at times'. Did you consider, at all, that this could have been due to the two analgesia being given that morning?

No comment.

Any questions on that Code A?

If I could take you back to the topic area before prescriptions. When prescribing drugs doctor to a patient, Code A has covered some of it but do you consider that it is important to consider different factors about a patient before you prescribe those drugs?

Code A

No comment.

Would you consider conditions of the patient, they may still be suffering from heart problems, or be alcoholics. Would that have any bearing on what you prescribe?

No comment.

What about allergies?

No comment.

And their weight or age?

No comment.

And hydration?

No comment.

The Proactive Prescribing Policy, which you've mentioned previously, was this your policy?

Code A

No comment.

And what authority did you have to introduce such a policy?

No comment.

Code A mentioned 'telephone prescribing'. Am I right in thinking that a doctor would give instructions to one nurse on the phone and then, again, to a second nurse on the phone confirming what's been said?

No comment.

Then one nurse can make an entry on the records countersigned by the second nurse?

Code A

No comment.

And then the doctor would come in later and sign it?

No comment.

If there's such a system as 'telephone prescribing', which we know there is, what was the need of a Proactive Prescribing Policy?

No comment.

Was it just a bid to stop being phoned at night?

Code A

No comment.

There's also mention of 'doctors on call'. Is that just for the purpose of 'telephone prescribing', or should they actually be attending?

No comment.

Talking about the drugs then doctor, Code A s already mentioned that Oramorph was prescribed on the 26th of March and this has been signed by you, and this is Page 123 of BJC/45, and it would appear that it wasn't administered until the 31st of March, that's five days doctor. Does that mean she didn't need it in those five days?

Code A

No comment.

The notes from Haslar that you have had access to indicate that Code A was on Paracetamol only', and that would suggest to me that possibly she didn't need

Oramorph. The fact that you've prescribed Oramorph on the 26th and she hasn't been given it until the 31st would also indicate she doesn't need Oramorph. Why did you prescribe it?

No comment.

Is this laziness?

Code A

No comment.

You should be attending I believe it's five sessions a week, and in previous statements you've said that 'you can attend up to three times a day at the hospital', that's a possible fifteen visits between the 26th of March to the 31st of March, or anywhere between twelve and fifteen visits you could have had. Couldn't Oramorph have been prescribed at a later date?

No comment.

Code A

Did you see Code A on any of those visits (noise from drilling in background overriding what is being said).

No comment.

For the purpose of the tape somebody is now drilling outside the Interview Room. In fact can I just leave the room...

Code A

Yeah.

...and see if I can get that stopped.

It sounds as though it's upstairs Code A It's Code A

Could you remind me of the last question Code A asked? If you can't don't worry.

Code A

Sorry I can't.

(Inaudible)

What was the last question? Can you ask the last question again?

Sorry I found the drilling rather off-putting with all that noise. (Laughs) I think you asked: "Couldn't the Oramorph have been prescribed at a later date?"...

Code A

Prescribed at a later date.

...and you then said something but I'm afraid I, the drilling meant that I couldn't catch it.

I'm wracking my brains, I think I may have asked: "Was this laziness?"

Code A

That's right, thanks.

Code A

Over to you.

Yeah okay. Right doctor 'syringe drivers'. Now the use of a syringe driver is normally dictated by a doctor. We understand there are different reasons for employing a syringe driver. We seek an explanation as to why a syringe driver was utilized, utilizing this case in particular and the way in which you would (inaudible). Can you tell us what training had you had in the use and deployment of syringe drivers?

Code A

No comment.

Can you explain what a 'syringe driver' is?

No comment.

Can you explain why they are used?

No comment.

Can you tell us what type of patients are most suitable for syringe drivers?

No comment.

I understand that the patient or the family, or maybe both, should be spoken to prior to a syringe driver being used. Who would take that responsibility on?

Code A

No comment.

How does the syringe driver work?

No comment.

Obviously it's used for administering drugs. Who prepares the drugs for administration via the syringe driver?

No comment.

There are different styles and sizes of drivers, do you know why that is?

Code A

No comment.

Do you know which one was used mostly on Dryad Ward?

No comment.

If I show you this which is exhibit CSY/HF/8, which is one we've used before, and we believe that was a poster that was on the wall in Dryad Ward. Can you confirm that?

No comment.

Is that the type of syringe driver that was being used at the time?

No comment.

Code A

Code A

Code A

Code A

Code A

RESTRICTED

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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED MARINE CONSULTANT

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: Code A Date: 17/03/2004

I am the above named person and I live at the address overleaf with Code A I now live on the Isle of Wight prior to that I lived in Alverstoke.

I make this statement in relation to Code A who was born on the Code A Code A and died on the Code A. Code A was Code A she was Code A Code A were from a family of two children. Code A died at the age of 76 from a stroke. Code A died at a reasonably young age, my Code A was 52 but had been involved in a serious accident and my Code A died at the age of 58, I don't know why.

I am not aware of any family illness or history from that side of my family.

Code A taught at a small private school and later got married at about the age of 26 to Code A Code A Between them they ran a market garden in Meon, Hampshire. Code A had no children and sadly Code A died in 1958 from cancer and the effects of mustard gas in World War I. Code A never remarried.

After the death of Code A sold the business and moved to Code A Code A This was to be the house she lived in for the rest of her life.

I would describe Code A as a fit, healthy and active person all her life. She was quite tall and of slim build. I do not recall any health problems she suffered from until she was in the late stages of her life. Code A was still driving a car to the age of 90.

Signed: Code A Signature Witnessed by:

RESTRICTED

The first time I recall Code A being ill was when she suffered from Rymes disease. She was in her late 80's and was admitted to the Queen Alexandra Hospital in Portsmouth . Code A was in hospital for about three weeks. I was told by a doctor that she would never be the same again. However in a very short time she was back walking the dogs and driving her car. She did not seem to suffer from the ill effects having left hospital.

I was one of the people who had most contact with Code A She was always able to hold a conversation and was fully aware of her surroundings. Due to the fact that Code A was such an independent person she did become miserable when she had to give up driving. She would have help around the home but was adamant that she wished to remain there and would not have a live in companion.

In mid March 1999 Code A had an accident, where she fell over outside the Post Office in Stubbington . She was admitted to the Haslar Hospital on the 19th March 1999 (19/03/1999) where she had an operation on her right hip. I visited her in hospital and although she was in some pain the physio's at the hospital had got her sat up and moving. I was impressed at the level of care that she got at Haslar. Code A seemed ok in herself, she was still lucid when she spoke.

On the 26th March 1999 (26/03/1999) Code A was transferred to the Gosport War Memorial Hospital . I do not know why she was moved, I think it was because of a lack of staff at Haslar. I think Code A was on Dryad Ward, although she had a private room. I fully expected Code A to be discharged from the GWMH and hopefully to return home.

I visited Code A four or five times whilst she was at the GWMH. On my earlier visits she had other friends with her and was speaking with them quite happily. I also spoke with Code A and she seemed fine. She told me that she rarely saw any doctors or physio's. I spoke to the staff and expressed my concerns about this. I was told that Code A was to uncomfortable to be moved and had told the staff to go away on several occasions.

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Just prior to the Easter weekend in 1999, I don't recall the exact date, but it would have been about the 1st April, I visited Code A with some chocolates. She was again able to hold a conversation and I recall saying to her "Code A it's time to get you out of her", Code A replied "If the old horse doesn't get out of the stable she never will".

Code A did not seem to be getting anywhere and told me again that she was not seeing any doctors or getting any physio.

This point was again made in a letter from her financial advisor, Code A of Blake, Lapthorn Solicitors . In a letter dated the 9th April 1999 (09/04/1999) Code A stated that Code A was terribly depressed and had not seen a doctor. This letter obviously added to my concerns.

I phoned the hospital and spoke to a member of staff, I don't know who but it was a woman. This phone call would have been on the 10th or 11th April 1999 (10/40/1999), (11/04/1999), I said "She is an old lady please make her as comfortable as you can". The lady said words to the effect that she would.

On the 12th April 1999 (12/04/1999) I visited Code A in hospital, she was quite unconscious and I was unable to rouse her. I stayed for 2 or 3 hours and asked to see a doctor. When I saw him he told me there is nothing wrong with Code A she is on too high a dose of morphine. I believe the name of this doctor to be Code A

The doctor told the nurse to reduce Code A diamorphine , he said she would be all right. When I left at about 1800 hours my aunt was still heavily sedated.

I got home and at about 2200 hours Code A received a phone call from the GWMH saying Code A Code A was conscious. Obviously we took this to be good news We were told Code A had been given sips of water.

At around 0130 hours on Code A I had another phone call to say that Code A

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Code A had died. Given the nature of the previous call this came as a shock.

The cause of death was shown as Cerebrovascular accident and signed by Code A Code A was later cremated at Portchester.

With regard to Code A my concerns are as follows:

1. The lack of treatment and care whilst at the GWMH. I feel she was somewhat abandoned.
2. The levels of morphine she was prescribed, especially with the comments made by Code A Code A

I have always had concerns about Code A death. I only came forward when I heard about others expressing the same concerns. I have had a chance to review Code A medical notes.

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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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: PSYCHIATRIC Code A FOR

This statement (consisting of 15 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: Code A Date: 02/03/2006

I am Code A and I am a Code A in Older People's Mental Health at Moorgreen Hospital Southampton.

My GMC registration number is Code A

My MPS number is Code A

In 1983 I qualified as a BM (Hons) at Southampton University.

In 1989 I further qualified as MRC Psych with the Royal College of Psychiatrists

I have Section 12(2) Approval under the Mental Health Act 1983

I was entered on the Specialist Register on 21/5/96

Between 1986 and 1990 I was on the Wessex SHO and Registrar Rotation in Psychiatry

Between 1984 and 1986 as Senior House Officer I held the following posts

Obstetrics and Gynaecology

Paediatrics

General Audit Psychiatry

Signed: Code A Signature Witnessed by: Code A

RESTRICTED

Geriatrics

Between 1990 and 1994 I was on the Wessex Senior Registrar Rotation in Psychiatry

Between 1995 and 2003 I was a Code A in Older Peoples Mental Health in Fareham and Gosport

Between 2001 and 2003 I was Psychiatric Tutor for Fareham and Gosport

From 2003 to the present I am a Code A in Older People's Mental Health in Eastleigh.

I am Code A for the locality of Eastleigh, Test Valley South and the locality.

I have the Code A for Resuscitation in the Hampshire Partnership Trust.

I am Code A of the Senior Medical Staff Committee

I took the Code A lead in developing and introducing Multidisciplinary Assessment in Fareham and Gosport. This involves doctors, CHMN's OT's Psychologist, Physiotherapist and Social Workers with the aim of appropriate professional assessment from entry to the service.

I have taken the Code A in developing the assessment tool for new referrals.
This form is broad and detailed and fosters holistic and comprehensive assessment.

I am a Consultant mentor and a Consultant Appraiser.

I have been asked to detail my involvement in the care and treatment of Code A. From recollection and referral to her medical notes (Exhibit Reference BJC/45) I can say that between 1997 and 1999 I was known as Code A and working in Older Peoples Mental Health at St Christopher's Hospital in Fareham.

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On page 144 of the notes dated 11/11/97 which is a standard assessment form regarding mental state and practical support, I have written.

HOME/HOSPITAL.DV.NO

Consultant Code A

16/2/07

Code A

GP: Code A
Jubilee Surgery
Titchfield
01329 844220

Date referred: 4/11/97

Date Seen: 11/11/97 By Whom: Code A Where: Home

Reason for Referral:

DV requested on patient who is depressed and becoming increasingly frail. She has just had to stop driving. She has said she would rather be dead than carry on like this. Code A is an intellectual lady who is still very with it but who does not want to socialise. She has failing eyesight and hearing. She has a one eyed rescued greyhound which she walks 3 times a day. She is on Prothiaden 25 mgs at night, Losec and Gaviscon. GP is asking if there is a more appropriate antidepressant and that CPN follow up might be helpful.

Professional Visiting CON (Consultant)
CPN means Community Psychiatric Nurse

On page 145 of the notes I have written

History of Presenting Complaint

Depressed mood.

Stopped driving 2/12 years ago: poor eyesight, depressed since

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↓ enthusiasm, wants to sleep all day, no diurnal variations

Appetite → little interest

Can see no future

Takes a taxi to go out

Used to enjoy sewing/reading- unable to do now.

Family History

Parents: M + heart dis 56yrs

+ Means died

M = Mother

F = Father

F + brain tumour 50 yrs

Sibs: 1 brother + 10 yrs ago CVA

Mental Disorders;

Fa mental hosp after fall. Fa means Father

Upbringing:

Occup. History: Teaching

Locksheath Fa fruit grocer. Fa means Father

Nanny/governess. Little warmth

Marital History: (husband, age etc)

Code A

Previous personality

Always busy "express parcel delivery" initials EPD

Brandy every morning

Smoke not now

Past Medical History

Loss of sight L eye poor sight Rt eye physical health otherwise good. Deaf, tonsils & bunions.

This means operations on Tonsil and Bunions

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Past Psychiatric History:

Nil

Social Circumstances

Finance: No worries

Home: Pleasant home 40 years

Support: domestic help weekly gardener ↓ social contact

Current Medication:

Domperidone 10mg Mane

Serc 16 mg

Was on Prothiaden- not taking now

Mental State:

Appearance and Behaviour: pleasant, cooperative, articulate

Speech: normal rate and form, little spontaneous

Mood: depressed, hopeless

Thought content: Nil abnormal

Delusions/Hallucinations Nil abnormal

Suicidal Ideas: No Suicidal Risk: NO

Insight: Good

Main Psychiatric Problems

Depressive Illness relating to failing physical health & loss of independence

Immediate Management:-

Restablish antidepressant

⟶ Citalopram 10 mg mane

Follow up:

Signed: Code A

Signature Witnessed by: Code A

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CPN - Support & counselling Minimal CPA

1/52

Page 148 is The Mini - Mental State Examination

Orientation	Points	Score
1. Date?	1	0
Day?	1	1
Month?	1	1
Year?	1	1
Season?	1	1
2. Country?	1	
County?	1	5
Town?	1	
Street?	1	
House No/Name	1	

Registration

3 Name 3 objects then ask the patient all Three after you have said them. Give One point for each correct answer Repeat the answer until the patient learns all three

3 3

Attention & Calculation

4 Serial sevens. Give one point for each Correct answer. Stop after five answers Or spell word backwards. 5 5

Recall

5 Ask for names of three objects learned

Signed: Code A

Signature Witnessed by: Code A

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	in Question 3. Give one point for each correct answer	3	2
Language			
6	Point to a pencil and watch. Have the Patient name them as you point	3	2
7	Have the patient repeat, "No ifs or buts"	1	1
8	Have the patient follow a 3 stage command "Take the paper in your right hand. Fold the paper in half. Put the paper on the floor	3	3
9	Have the patient read and obey the Following "CLOSE YOUR EYES"	1	1
10	Have the patient write a sentence of his/ her own choice (the sentence should contain a subject and should make sense ignore spelling errors when scoring)	1	0
11	Ask the patient to copy the overlapping pentagons, give one point if all sides and angles are preserved and if the intersecting sides form a quadrangle	1	1
Total		30	27

A score of between 27-30 is normal, but a score below 26 would indicate a problem.

On page 150 of the notes I have written on a History Sheet

Signed: Code A

Signature Witnessed by: Code A

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18/11/97 "Called to review had forgotten appt

Citalopram 10mg- tolerating

→ continue

CPN support

Could ↑ citalopram

I have signed that entry.

↑ means increase

↓ means decreased

→ means going to continue

Diurnal variation describes mood change during the course of a day. In depression the mood is typically worse in the morning and then improves.

SERC is a tablet of Betahistine Dihydrochloride and is used in the treatment of dizziness, vertigo or tinnitus

Domperdole is used for sickness/ nausea

Prothiaden is an anti depressant

2/12 means 2 months

+ means dead/died

CVA means Cerebro Vascular Accident (Stroke)

On page 170 of the notes is a letter I have written to Code A s GP, Code A dated 12/11/97.

Dear Code A

Re: Code A

Code A

Signed: Code A

Signature Witnessed by: Code A

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Thank you for asking me to see this woman whom I visited on the 11th of November.

History: She said that she had been suffering from depressed mood over the last couple of months although I suspect it has probably been present for longer than that. She stopped driving two months ago because of failing eyesight and feels that she has been depressed since that time. She has lost all interest she previously enjoyed and feels that she just wants to sleep all the day. There is no diurnal variation in her mood. She has little interest in food. She can see no future for herself and has had fleeting suicidal ideas but says she would not act on these. In addition to the driving, she is now unable to do sewing and reading which she used to enjoy and this has compounded her feeling of depression.

Family history: Her mother died of heart disease at fifty six and her father of a possible brain tumour at fifty. He was in a mental hospital for some time after a head injury. She had one brother who died ten years ago of a stroke. She was born in Locks Heath and her father was a fruit grower. She was brought up by nannies and a Governess and said there was little warmth in her childhood. She did some teaching work after she left school because she felt bored. She Code A in 1932 aged 25. Code A was a Fruit Grower and she said they had a Code A Code A They had Code A and Code A She has lived alone since that time.

Previous personality: She said she has always been a busy person who has had great enthusiasm for life. She drinks a brandy every morning and she does not smoke.

Past medical history: She has lost the sight in her left eye and has poor sight in her right eye. There is no history of glaucoma. She also has poor hearing.

Past psychiatric history: Nil

Social circumstances: She has no financial worries. She has been in her present home for forty years and has domestic help and gardener weekly. She has lost contact with many of her friends in recent years.

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Current medication: Domperidone 10mgs in the morning

Serc 16mgs bd

She has been on Prothiaden 25 mgs although she has not taken this for some time

Mini mental state examination: Score was 27 out of 30

Mental state examination: Appearance and behaviour - She was a pleasant cooperative articulate woman. Her speech was normal in rate and form although there was little spontaneous speech. Her mood was depressed and hopeless. There was no evidence of formal thought disorder, delusions or hallucinations. She had fleeting suicidal ideas but I do not think she poses a suicide risk at the present time. Her insight is good.

Diagnosis: This lady is suffering from a depressive illness related to failing physical health and loss of independence.

Suggested management: I felt it would be beneficial to try and re-establish her on an anti-depressant. I felt on balance an SSRI would probably have less side effects although she may be troubled by nausea. I have therefore started her on a very small dose of Citalopram 10mgs in the morning with the hope that she will be able to tolerate this and we can then build up the dose. I will see her again in weeks time to see how she is tolerating this and I will ask our CPN to call in and offer her support and counselling.

I would be grateful if you could sign and return the enclosed DV form.

Yours sincerely

Code A

On page 168 of the notes dated 12/11/97 I have written a letter to Code A

Signed: Code A

Signature Witnessed by: Code A

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Christopher's Hospital.

Dear Code A

Re: Code A

Code A

I wonder if you might call in and see this lady who has become depressed over the last couple of months. Her physical health is failing and she is losing her independence. She has become socially isolated and I think would benefit from psychological support. I started her on an antidepressant but I am not sure she is going to be very keen on taking tablets for any length of time.

Many thanks for your input.

Yours sincerely

Code A

On page 166 of the medical notes dated 25th November 1997 I have again written to Code A Code A

Dear Code A

Re: Code A

Code A

I called to see this lady again on the 18th of November. She had in fact forgotten the appointment we had made. She is taking Citalopram 10mgs in the morning and was quite sick for the first twenty four hours but has been tolerating it since. I have asked her to continue with that and she will be seen by our CPN Code A shortly

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

Continuation of Statement of: Code A

Yours sincerely

Code A

Citalopram is used for the management of depression.

CPA is Care Programme Approach Supervision.

SSRI means Selective Serotonin Re - uptake Inhibitor and is used in the management of depression.

This lady remained under my care whilst she was being seen by Code A until discharged.

I did not personally see her again.

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: SPECIALIST REGISTRAR

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: Code A Date: 25/01/2006

I am a Specialist Registrar in Anaesthetics at the Birmingham School of Anaesthesia. I live at the address stated overleaf.

My medical education was undertaken at Newcastle Medical School between 1989 - 1994.

I hold the following qualifications;

Bachelor of Medicine, Bachelor of Surgery, University of Newcastle Upon Tyne July 1994

Diploma In Immediate Medical Care, Royal College of Surgeons Edinburgh March 1999

Diploma of Fellow, Royal College of Anaesthetists, London February 2003

My previous employments were as follows;

Royal Army Medical Corps Short Service Commission September 1991 - February 2002

Pre Registration House Officer, Surgery/Orthopaedics Cambridge Military Hospital, Aldershot August 1994 - February 1995

Pre Registration House Officer, Medicine, Duchess of Kent Hospital, Catterick. February 1995 - August 1995

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Senior House Officer, Accident & Emergency, Palmerston North Hospital, New Zealand August 1995 - February 1996

Professionally Qualified Officers Course, Royal Military Academy, Sandhurst February 1996 - June 1996

Regimental Medical Officer, 4th Royal Irish regiment, Omagh, Northern Ireland June 1996 - August 1998

Code A Anaesthetics, The Royal Hospital Haslar, Gosport August 1998 - August 1999

Senior House Officer, Anaesthetics, Portsmouth Hospitals NHS Trust August 1999 - November 2000

Clinical Fellow, Paediatric Intensive Care, Birmingham Children's Hospital November 2000 - June 2001

Clinical Fellow, Anaesthetics, Birmingham Children's Hospital June 2001 - August 2001

Clinical Fellow, Liver Anaesthesia, Queen Elizabeth Hospital, Birmingham August 2001 - January 2002

Senior House Officer, Neonatal ICU, Royal Wolverhampton Hospital February 2005 - August 2005.

As stated above I was a Code A in Anaesthetics at The Royal Hospital Haslar from August 1998 to August 1999. One of the Consultants I was working under was Code A Code A

I have been asked if I recall a patient named Code A. I have no memory of this patient.

Signed: Code A

Signature Witnessed by:

RESTRICTED

I have been shown a copy of her patient notes marked JR/14.

Pages 68 and 69 of the notes bear a handwritten note dated and timed 20/3/99 1200. The note is written by me and relates to an Anaesthetic Pre Op Assessment. I would have been aware that the patient was due to have an operation, my duty as the anaesthetist was to examine the patient and ensure that she was properly prepared and fit for the theatre. The entry reads as follows (with explanations in brackets);

20/3/99 1200

Anaesthetic Pre Op Assessment.

92 year old lady for DHS HIP. (Dynamic hip screw)

Admitted yesterday PM.

Previously well - nil major medical problems.

Fell 19/3/99 @ 1500 hrs. Ate tea & toast b'fast 19/3/99.

*Nil oral fluids since. Nil IV fluids. (Patient had had no drinks or fluids since breakfast the day before)

Analgesia: Voltarol 50 mg given & Paracetamol 1g. Nil else. (Pain relief medication)

Concerns 1. Nil fluid intake in > 24 hours

2. Nil urine output since yesterday's fall. (I was worried that the patient was dehydrated)
3. Use of NSAIDS on empty stomach, elderly patient with hypovolemia. (Non Steroidal Anti Inflammatory Drugs - Voltarol, aspirin etc. Hypovolemia is low circulating levels of plasma in the blood)
4. Minimal analgesia.
5. IV access LACF from paramedic only. (The Paramedics had put a drip in, other than that no other intravenous fluids had been given)
6. Nil blood sugar analysis .

Plan

1. Hartmans 1000 ml stat (a fluid used to re-hydrate)

Signed: Code A

Signature Witnessed by:

RESTRICTED

2. 16 G cannular sited L wrist (this indicates the type of needle to be used and where it should be located)
3. Cyclizine 50 mg + Morphine 2 mg IV - titrate to response (Cyclizine combats the effects of sickness)
4. BM stick.
5. Stop Voltarol.
6. Delay theatre until better resuscitated.

1400 Reviewed

1. Hartmans finished
2. BM 4.0 (Blood sugar level - low)
3. Start 1000 ml 5% Dextrose 2°
4. Morphine 2mg → pt hallucinations □ nil further episodes.
5. Pt - pu'd : taken away before dipsticked.

→ for spinal GA @ 1430 hours.

I have then signed the entry as Code A Anaesthetic.

Page 40 of the notes shows the record of Intravenous Fluid Prescription and Administration. On the 20/3/99 the patient had been prescribed 1000ml of N.Saline by Code A This had not yet been administered. As I felt that the rate was too slow I crossed it off and signed it. I then wrote in a prescription for 1000ml of Hartmans with 5% Dextrose at a 2 hourly rate. The Dextrose was to help with the blood sugar level.

Page 38 is the as required prescriptions record, Code A prescribed Cyclizine either Intramuscularly or Intravenously at 50mg, the chart shows that I administered the first dose at 1200 on 20/3. I have signed the entry.

Also on the same page Code A prescribed Diclofenac as an anti-inflammatory pain killer, I note that it was given once at 2300 on 19/3. I did not consider this as appropriate in this patient's circumstances as she had neither eaten nor drank, consequently there was a possible risk of kidney or stomach damage.

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Page 36 shows the Once Only Premedication Drugs. I have written the first entry, I initially wrote CYCL (for Cyclizine) by mistake which I have crossed out. I then wrote up MORPHINE at 2mg IV. This is dated and timed 1200 20/3/99. The record shows that I administered that amount at the same time. I have signed the entry.

Pages 73 to 78 of the notes are pink cards which relate specifically to the operation. I have written on only page 73 which is entitled Operation Record. This page is written up as an assessment by the anaesthetist prior to an operation, in this case I have written the following:

Assessed by Code A Grade Code A Where E6 Date 20/3/99.

History

Anaesthetic

GAs 60 years ago - tonsils; hernia (this means General Anaesthetic history)

Medical

1. Nil asthma; SOB; MI; Chest pain (Shortness of breath, heart attacks)
2. H.H - takes Gaviscon - after evening meal - nil regurgitation.
3. Pagets Disease - LBP (Lower back pain)

Current Health

Nil URTI (No cough/cold)

MEDICATIONS

Gaviscon

Allergies / Anaesthetic Hazards

Nil food/drink allergies

Premedication

/ (none)

Signed: Code A

Signature Witnessed by:

RESTRICTED

Nil by Mouth

Food B'FAST 19/3/99 (Her last meal)

Drink H20 B'FAST 19/3/99 (Her last drink - water)

Examination

Airway: Two front crowns

Intubation Assessment: Grade 1

(This relates to placing a tube into her lung, grade 1 is good)

Respiratory

Chest Clear

Cardiovascular

HS 1 + 11 (Normal heart sound)

ECG

1 X PAC (Premature Atrial Contraction)

Volt. Criteria LVH nil strain (Voltage Criteria for left ventricular hypertrophy)

This suggested long standing high blood pressure.

Other

/ (Nil)

Investigations

Hb 12.2 Na 138 K4.0 U 7.9 Cr 100 BM 4.0

These are normal blood results

Techniques Discussed/Warnings

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Spinal (She was told that she would have a spinal anaesthetic, one of the benefits would be better post op recovery)

Assessment For Anaesthesia

I have circled Urgent and under ASA Status 2. The ASA Status is basically a grading system for the patient's fitness to go to theatre, in this case Code A was relatively fit for surgery.

Under Comment I have written;

NIL ORAL FLUIDS FOR 24h.

* NIL IV fluids since admission 24 hours

Needs FLUIDS ++,

This shows that she had neither drank nor been given IV fluids since admission and we needed to increase her intake.

I have then signed for all of the entries and dated it 20/3/99.

This would have been written at the same time as my note on page 69.

Page 74 of the notes is the reverse of page 73 and continues the documentary anaesthetic input for the operation. As I was a junior Doctor under training I would expect to have written this page up as well, however I see that it has been written by the Code A Code A. This indicates to me that I was not present during the operation. His recorded notes indicate that the procedure was without any noted incident, in other words from an anaesthetic point of view it was straightforward with no complications.

My dealings with Code A can be summarised as such:

She came into Haslar at 1530 19/3/99 as an emergency via ambulance having fallen at home, she was diagnosed as having a broken right neck of femur which required urgent. I saw her at 1200 the following day to assess her for the theatre, it was apparent that she had not been given

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the fluids previously written up by Code A I was concerned that she had insufficient fluids and pain relief, pus her blood sugars were low. She was dehydrated and had not passed urine (there does not appear to be a fluid chart for 19/3/99 but page 62 shows a Pre - Operative check list and indicates that she last passed urine at midday 19/3/99).

I removed the prescription for Voltarol (Diclofenac) as it was not suitable for her condition. At that time I did not feel it was safe for her to go to theatre. She was given more fluids and better pain relief. I saw her again at 1400 by which time she had improved sufficiently enough for me to write her up for her spinal anaesthetic for 1430.

I do not appear to have had any further dealings with the patient Code A

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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: Code A

Age if under 18: OVER 21 (if over 18 insert 'over 18') Occupation: DOCTOR

This statement (consisting of 6 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: Code A Date: 04/01/2006

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

I am at present a Specialist Registrar, Emergency Medicine at the Prince of Wales Hospital, Randwick, Sydney Australia.

I enlisted in the British Army in July 1995, my service number was Code A I retired from the army on the 2nd August 2005 in the rank of Major.

I qualified as Doctor in 1998 at the University of Nottingham. I hold the following qualifications,

Batchelor of Medical Science (BMedSci)
Batchelor of Medicine (BM)
Batchelor of Surgery (BS)
Member of the Faculty of Accident and Emergency Medicine (MFAEM)

In August 1998 I was employed as a Pre Registration House Officer in Medicine at Frimley Park Hospital.

In February 1999 I was employed at The Royal Hospital Haslar in Gosport Hampshire as a Code A Code A in surgery and orthopaedics. At that time my rank was Code A

In March 1999 at The Royal Hospital Haslar I was Code A to Code A

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Code A and Code A, in that capacity I took part in a ward round each day, some days with the Senior House Officer and Registrar, but most days with the entire team, including the consultant.

I have been asked to detail my involvement in the carer of Code A. I do not recall this patient but from referral to entries in her medical notes (Exhibit reference JR/14) I can state that on page 82 of the notes on 22 March 1999 I have written,

"WR Code A

-poor oral fluid intake

Apyrexial

- Needs check Hb today

Code A

Hb 11.1 Na 134

Wbc 8-02 K 4.9

Plat 2/6 Urea 10.9

Creat 115"

These are blood test result readings.

Apyrexial means normal temperature.

WR Code A means Ward Round with Code A (Code A

On page 83 of the notes dated 24 March 1999 I have written,

WR Code A:

- Skin V.thin & Fragile lower legs

Need to Elevate

Do not use teds

-Would benefit from Code A for Rehab"

Signature Witnessed by: Code A

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GURNEY "150"

Code A was a consultant in elderly medicine to whom patients that it was felt would need a period of rehabilitation to recover function post- operatively were referred.

I have further written,

"Dear Code A

Many thanks for reviewing this pleasant 92 year old lady who was admitted on the 19th March having sustained a sub-trochanteric fracture of to R femur, having been pulled over by her dog. She was previously well, with no significant past medical history, living alone and independently with no Social Service input. She was transfused with 3 units of blood, but has otherwise made an unremarkable post - op recovery. She has proved quite difficult to get mobilised, and her post op rehabilitation may prove somewhat difficult . Additionally the quality of her skin, especially her lower legs is poor and at great risk of breaking down. Code A Code A would appreciate your advice regarding her rehabilitation and consideration of a place at GWMH.

Yours Sincerely

Code A

This last entry being a formal referral letter to Code A summarising the case at that stage and requesting that she be transferred to the Gosport War Memorial Hospital.

On page 85 of the notes dated 25 March 1999 I have written,

"WR Code A

- R leg ↑ swelling

Signed: Code A

Signature Witnessed by: Code A

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Continuation of Statement of: Code A

Skin tissue- paper thin& very fragile

Haematoma developed& broken down

Dress æ Gelonet

Elevate

- Ready for GWMH when beds available

Needs Great care of skin

& warn GWMH of skin state

Code A

↑ means increasing

Æ Means, with

Gelonet is a type of dressing

A Haematoma is a swelling.

A Sub-Trochanteric Fracture is a fracture of the hip just below the neck of the femur.

Teds refers to compression stockings used to prevent the formation of clots in immobile patients.

In the original notes my signature is accompanied by the number Code A my bleep/electronic pager number.

Signed Code A

Signature Witnessed by: Code A

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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: Code A

Age if under 18: (if over 18 insert 'over 18') Occupation:

This statement (consisting of 4 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: Code A Date: 14/12/2005

I am Code A I live at an address known to Hampshire Police. I have been employed as a Matron at the Chichester Nuffield Hospital since November 2003.

In September 1989 at Manchester Royal Infirmary I obtained the qualification of Registered General Nurse.

In 1990 at Royal East Sussex Hospital I obtained an ENB 298 (A specialist course in nursing Elderly people)

In 1991 at Trafford General Hospital, Manchester I obtained an ENB 998 (Teaching and assessing in Clinical practice)

In 1993 I qualified as an NVQ assessor (D32/33) at the British Military Hospital, Rinteln, Germany.

Between 1997 and 1999 I obtained a Bachelor of Nursing degree at Dundee University.

Between 2003 and 2004 I obtained an Executive diploma in management, level 5 at the Chichester College of technology.

From 1989 until 1990 I was employed as a staff nurse at Manchester Royal Infirmary.

Between 1990 and 1992 I was employed as staff nurse at Trafford General Hospital,

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Manchester.

From March 1992 until March 2000 I was employed as an Army Nursing officer at various military hospitals including QE Military Hospital Woolwich. British Medical Hospital, Rinteln, Germany.

From December 1998 until January 2000 I was employed as Code A Orthopaedic ward, Royal Hospital Haslar .

Between January 2000 and January 2003 I was employed as Senior Nurse BUPA hospital, Havant, Portsmouth.

From January 2003 until November 2003 I was employed as Senior Nurse Chichester Nuffield Hospital, Chichester.

My Nursing Midwifery Council number is Code A

I have been asked to detail my involvement with the patient Code A dob. Code A I do not recollect this patient or the subsequent treatment that was administered.

I have been shown the medical records for this patient exhibit ref BJC/45 .

I can confirm that on page 20 of the notes I have written the transfer letter dated 26/03/99 which is as follows;

Dear Code A
Code A *was admitted to the ward on 19/3/99 following a fall.*

She went to theatre the following day and had a right dynamic hip screw.

Post operatively, she is now mobile from bed to chair with 2 nurses and can walk short

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distances with a Zimmer frame. She has no urinary catheter and although she is continent during the day, she has been sometimes incontinent at night.

The skin on her lower legs is paper thin so she is not to wear TED stockings. Her right lower leg is very swollen and has a small break on the posterior aspect. This has been steristripped. Her Consultant recommends they be elevated.

She needs encouragement eating and drinking but can manage independently.

Drugs have not been included as her only medication is analgesia (Paracetamol) PRN

For any further information please contact the ward.

Code A *RGN.*

To clarify a number of points that has been written in this letter

Right dynamic hip screw- This is a Fixation with a metal pin to a fracture of the right hip.

Urinary catheter - This is a tube inserted into the bladder to drain urine. In this patient's case she went to the toilet normally during the day; however she was prone to wetting the bed at night.

The skin on her lower leg is paper thin- The skin on this elderly lady's legs was like tissue and easily prone to tearing with the least contact. This is common in elderly ladies.

TED stockings - Transdermal Embollic Deterrent stockings are used to prevent blood clots in the legs. Her skin was so fragile the stockings were not applied.

The patient has been steristripped as a result of a rip to the skin at the back of her leg this was applied to close the wound.

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Needs encouragement - this means that she was physically able to feed and give her self drinks however she was reluctant or forgetful or depressed (there is a variety of reasons) to eat or drink unsupervised.

I can confirm that on page 18 of the medical notes I have written on a "Request for Transfer form" which was to transfer Code A from E6 ward, Haslar to Gosport War memorial Hospital on the 26/3/99.

I can confirm that on page 26 of the records I have written;

0930 hrs for transfer to GWMH this morning- This is self explanatory.

On page 27 of the records I have written the following entry;
22/3/99 Sat out by physios - Drinking + eating much better today. Continues on 1° Catheter measurements only small volume at 1500hrs. Oral fluids pushed. *Signature*

This means that the physiotherapists assisted her to get out of bed and put her into a chair by the bed.

Continues on 1 hourly catheter - this means that every hour usually on the hour a measurement was taken of urine that she had passed. This is done to assess kidney function and to ensure she is adequately hydrated.

Oral fluids pushed- this means that she was given fluids by mouth as often as possible.

I had no further dealings with this patient.

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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: Code A

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

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: Code A Date: 09/12/2005

I am Code A and am currently employed as a Night Sister in a local nursing home.

I started nursing in 1965 as a cadet nurse and trained for three years, qualifying at Hackney Hospital, East London in 1969. I worked on all wards until my qualification as a Registered Staff Nurse to the surgical ward.

My Nursing and Midwifery Council Number is Code A

I commenced employment as the Gosport War Memorial Hospital (GWMH) in 1988 as a Staff Nurse, retiring in February 2004 as a Code A (Code A at Dryad Ward, although I had been Code A since 2003.

I was responsible for twenty four hour care on Dryad Ward. I was also on a rota for the management at Redclyffe Annexe which was a fifteen bed unit for elderly mentally ill patients.

Redclyffe Annexe was a short distance from the GWMH and moved to the main hospital in 1994 when it became Dryad Ward.

I was responsible for the twenty four hour care of the patients on Dryad Ward and took on management roles when there were no managers at the hospital, ie, weekends and evenings. I was responsible for all staff on the ward with regards to training, hiring, discipline, staff rotas and leave issues.

Signed: Code A Signature Witnessed by: Code A

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My hours of duty were 0730 - 1615 or 1200-2030 hrs. I also worked every other weekend.

In 1999 my Code A was either Code A or Code A.

My position in 1999 was Code A

In 1999 syringe drivers were being used at the hospital. Syringe drivers are a device loaded with the patients prescribed drugs and administered subcutaneously, ie, under the skin, mechanically, over a twenty four hour period. This prevents peaks and troughs of pain in the patient. Syringe drivers were in use from about 1990.

Code A was a Code A who started at Redcliffe around 1989.

Prior to Code A's appointment each patients GP was responsible for their individual patients on the ward. She was at GWMH from 1989 onwards.

Code A visited GWMH at 0730 hrs Monday to Friday and see every patient on ward rounds before going on to her GP's practise. I would accompany her if I was on duty, if I was not she would be accompanied by the senior nurse.

Code A returned to the GWMH to check in and arrange to speak with patients relatives when she had finished her GP surgery, if required.

On her visits Code A prescribed the drugs required by each patient.

When patients were transferred to the GWMH they normally came from acute wards at local hospitals.

Acute wards cater for those patients with sometimes complicated medical issues, as opposed to continuing care wards.

Signed: Code A

Signature Witnessed by: Code A

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Dryad Ward was a continuing care ward.

Daedalus Ward at GWMH was a rehab/stroke ward.

Continuing care is that provided in order to ensure the patients return to either their home or on to a nursing or rest home or if they required palliative care ie, they were expected to die, to be looked after in a manner which would ensure a dignified death.

Daedalus Ward was for general rehabilitation and stroke rehabilitation of patients. Patients on Daedalus were given daily physiotherapy which was unavailable on Dryad Ward.

Code A was responsible as a Code A for patients on both wards. Her line managers were the Consultants.

Ward rounds were conducted on a daily basis. Code A would go round every patient and speak with them in order to assess how they felt that day. She would also read any reports from night staff as regards any change in their condition and if appropriate, change medication. She would always discuss this with nursing staff. There were occasions where she contacted a Consultant before amendment in medication or other issues.

When Code A was off on leave or for any other reason, a member of her practise deputised for her, however they never conducted ward rounds to my knowledge . In those cases I would do the ward round on my own although I sought advice on issues from Consultants. In any case I would speak with one of Code A s colleagues. I should say that they would attend GWMH prior to their morning surgery but it would be brief.

Code A returned almost every day and in any case was always available on telephone for advice or to discuss patient issues . She would return and address any newly admitted patients, talk with relatives when required and receive updates from nursing staff. I felt she was very good in this regard. She always tried to get to know patients relatives and to discuss the patients

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well being with them.

When necessary Code A would see patients in the afternoon or evening to reassess them. Dryad Ward held twenty beds, Daedalus twenty four. Dryad would have at least two trained nursing staff and four or five support workers. Daedalus had slightly more due to its twenty four beds.

The Consultants conducted ward rounds either once fortnightly, later once a week. On those occasions Code A and the senior member of nursing staff also attended. If Code A was not available none of her partners attended.

Ward rounds involve all the patients needs, not only their types and levels of medication. My duties were the administration of drugs, the doctors to prescribe them. If I felt that a patient was being adversely affected by a drug I would speak with the doctor. In some cases this would result in a decrease or cessation of a particular drug, in other cases drugs may be changed or the amounts increased.

If the doctor decided to change the type of drug or the amount to be given they would either come in at once or as soon as they could and write up the prescription. In exceptional circumstances and this was rare, authorisation to change types or levels would be given over the phone. The doctor would then have twenty four hours to write the prescription and sign it.

In the event of this happening with a controlled drug, two trained members of nursing staff would accept the doctors decision, enter it in the nursing notes and both sign that entry.

In Consultants ward rounds I would be a party to their discussions with Code A. They were always well conducted and I never heard any criticism by the Consultants of her.

I have today been referred to the police exhibit BJC/45 , this being medical notes of Code A Code A and who died at GWMH on Code A and specifically to page 104 of those notes. This states that I am the Code A in overall charge of the patient. The named nurse

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was Code A and the Consultant, Code A This is a standard form showing general personal information about the patient.

As the Code A I was in charge of all aspects of the patients care, with the exception of drug prescription.

My duties involved personal hygiene, nutrition and general nursing care.

Code A, as the named nurse, was junior to me. She conducted the day to day aspects of the patients care and supervised the hands on care, including the supervision of health support workers. Code A was an experienced nurse who I left to get on with her job. If she felt she needed advice she would speak with me and I would address any issues raised. If there were medication issues I would then consult a doctor.

My role was to be in charge of twenty beds, the named nurse may have had four to six patients to deal with. I also had my administrative role and I was kept very busy, however my priority was care of the patients as it should have been.

I was also continence advisor for the whole hospital. Any staff who had patients who had bladder or bowel problems would call me and I would attend, wherever in the hospital and advise regarding treatment or management of the problem.

As GWMH is almost all elderly patients I was also busy in this role.

The administration of drugs was done by a trained member of staff. This could have been me or another staff member.

I have viewed the prescription charts of Code A I can say that I never administered drugs to her.

I cannot recall this patient.

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

As regards the nursing notes, the only time I would make an entry in these would be if there had been a major problem with a patient, otherwise the named nurse would write them up. I made no entries in this case.

The patient had a fractured neck of femur. I believe she was admitted from Haslar Hospital on 26/3/99 for continuing care.

From the drugs charts I can say that (page 134) the patient was prescribed the following drugs by Code A

METOCLOPROMIDE 10mg 3 times daily. This is an anti nausea drug and uncontrolled.
SENA tablets 2 nightly. This is uncontrolled and an aperient ie, to loosen the bowels.
MORPHINE SULPHATE - initially on 10mg twice daily for six days until 5/4/99 when the does was increased to 20mg twice a day. This is a controlled drug given for pain suppression. It is in tablet form.
CIPROFLOXAIN 500mg twice a daily. This is uncontrolled and is an antibiotic.
METRONIDAZOLE 400mg twice daily. This is also an antibiotic.

There is no problem in patients being given CIPROFLOXAIN and METRONIDAZOLE together.

The patient, on 12/4/99 was prescribed DIAMORPHINE , I think it says 80mg over 24 hours. This is given in this case by way of syringe driver and is a controlled drug. This amount was a slightly increased dose but not dramatic.

HYOSCINE was prescribed but never given. This is an uncontrolled drug given to dry secretions in lungs.
MIDAZOLAM 20mg. This is an uncontrolled drug and is given to allay anxiety.
LACTULOSE 10ml orally. This is an aperient like Senna.
CICLOZINE. This is an anti emetic. She never received this drug.

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

When the doctor prescribed drugs they would not always be given until nursing staff thought they required them. They were prescribed on a 'PRN' basis as on page 131 of the notes. This meant whenever necessary.

I have been shown the ward Controlled Drugs Record Book, exhibit JP/CDRB/47 and referred to the entries therein. I made no entries in relation to this patient.

These drugs are held in a locked cupboard within a locked cupboard. Two trained members of nursing staff take the key from the senior member of nursing staff on duty and withdraw the prescribed amounts. Both nurses then sign the relevant entry and administer them. If not all of the dose of any given drug is used, what is left is discarded, ie, thrown down the sink.

The DIAMORPHINE and MIDAZALOM would be administered by syringe driver. The other drugs would be given orally.

As a Code A on the ward it was my duty to ensure that drugs were being given appropriately.

To summarise I was in overall charge of all nursing care on the ward as well as my administrative duties. I was answerable to my line manager who had overall responsibility for the hospital, with the exception of the doctors.

RESTRICTED

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: Code A

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

This statement (consisting of 7 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: Code A Date: 03/02/2006

I am Code A and reside at the address overleaf.

I am a Code A staff nurse, presently employed at the Gosport War Memorial Hospital, Hants (GWMH).

My nursing Midwifery Council number is Code A

I qualified as a State Registered Nurse (SRN) in 1972 at Hull Royal Infirmary.

I qualified as Code A about 1991.

My current responsibilities on Sultan Ward, GWMH are in the daily running of the ward, including the supervision of junior staff, care of the patients and to ensure the proper administration of prescribed drugs.

I have exercised the use of syringe drivers since about 1987. A syringe driver is a motorised device into which the prescribed drugs to be administered to patients are loaded. The syringe is then placed in the patients and the drugs administered over a (constant) twenty four hour period ensuring that pain suppression is given evenly and preventing peaks and troughs of pain and pain relief.

I was trained in the use of syringe drivers at Redclyffe Annexe, GWMH by Code A Code A I remember being informed of which prescribed drugs were suitable for a mix in a

RESTRICTED

driver and which were not.

When a driver is set up it is policy that two trained nurses are present when the driver is loaded with the prescribed drugs.

I am aware of what the analgesic ladder is. This is a scale of pain suppressing drugs starting with paracetamol progressing on to drugs containing Codeine and on through the opiates on to the strongest, Diamorphine.

Syringe drivers are applied when patients are no longer capable of taking their medication orally.

Doctors prescribe drugs; trained nursing staff ensure their proper administration.

I have been referred to Police exhibit BJC/45 medical notes relating to Code A born Code A and who died at GWMH on Code A and JP/CDRB/47 drugs register.

Firstly I should state that the 'named nurse' is the delegated nurse who is the point of contact for the patient's family. They inform the family of a patient's medical condition, progress or otherwise and the continuing care of the patient. In effect the named nurse had overall charge of the patient's daily needs.

None of the above precludes a doctor speaking with a patient's family.

A nursing care plan is a recognised document which sets out for all patients coming on to a ward, their activities of daily personal needs, including dietary and mobility. It is put in place to ensure that all members of staff are aware of those needs. Care plans are updated as and when the patient's needs change. This may be on a daily basis or otherwise depending upon the individual.

In 1999, I was on Dryad Ward, GWMH (elderly care ward). The practice then was that the

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ward was split in two. I had one side of the ward and Code A was the named nurse for the other side of the ward.

It may have been that when a patient was admitted to the ward, I was not present. In that case another trained member of staff would write out the care plan and my name appended as named nurse.

In some aspects of the care plan, for instance mobility, I could not assess this at once and would only be able to do so when I had observed the patient over at least a twenty four hour period.

Put simply a nursing care plan is an aid to nursing staff whether they are permanent, agency or borrowed, and put in place to ensure the proper implementation of nursing care in respect of each patient.

In 1999 every patient admitted to GWMH was automatically swabbed for MRSA testing, normally within the first twenty four hours, depending upon the time they were admitted. Nursing staff obtained the swabs for testing.

In this case I can say referring to page 32 of 175 of the notes that Code A was swabbed axilla, i.e. under the arms and groin, in this case by Code A.

The page reads as follows: 26/3/99 Requires MRSA screening (Problem).

The desired outcome was to prevent infection.

The evaluation date or interval was - result from swabs.

The nursing action was

1. Swabs to be taken from nose, throat, axilla and goings.
2. To prevent infection - nurses to wear plastic apron/gloves.
3. Yellow bags and water soluble bags for clinical waste any clothing/bedding.

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4. Ensure adequate hand hygiene.

26/3/99 MRSA swabs sent.

All of the above was a preventative against MRSA.

Page 33 of the notes reads: 29/3/99 Please re-swab axilla for MRSA and wound site if not already done. It is signed by Code A

31/03/99 Negative in nose, throat and groin. This is my writing but unsigned.

I refer now to page 80 of the notes. This page was written by Code A and is a sheet for a sleep nursing care plan, i.e. the care of the patient during their periods of sleep.

Page 80 reads, 26/3/99 Code A requires assistance to settle for the night. Desired outcome - to try and maintain Code A's normal sleep/rest pattern and to wake on own accord feeling refreshed.

The evaluation was carried out nightly.

The nursing action was:

1. Ensure Code A 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.

26/3/99 Used slipper pan. Difficulty in moving. Slept long periods. Oramorph given as boarded, i.e. as per the chart.

The entries on this page indicate that Code A was having trouble sleeping.

Signed: Code A

Signature Witnessed by:

RESTRICTED

The plan was to ensure she achieved sleep and rest and to be kept as comfortable as possible.

Page 84 is a care plan. It reads:
26/3/99 - Code A is experiencing a lot of pain in movement.
Desired outcome - To eliminate pain if possible and keep Code A comfortable, which should facilitate easier movement and mobilisation.

Nursing Action - Given prescribed analgesia and monitor effect. Position comfortably. Seek advice from physiotherapist regarding moving and mobilisation.

27/3/99 - Is having regular oramorph but still in pain.

28/3/99 - has been vomiting with oramorph. Advised by Code A to stop oramorph. Is now having Metaclopromide TDS (i.e. three times daily) and Codydrymol. (this is an analgesic). Vomited this afternoon.

Page 85 reads - After using commode, refused supper.

29/3/99 Please review pain relief this morning - (this signed by Code A).

31/3/99 - now commenced on 10 mg MST (i.e. morphine tablet) bd (twice daily) walked with physiotherapist this am, but in a lot of pain. Physio demonstrated how to get Code A from chair onto gutter frame, support round waist and hip/bottom level and ask Code A to push herself up to standing position.
1315 Oramorph oral solution 2.5 mls/5mg given for pain with not too much effect. (this entry by me).
1/4/99 S/B (seen by) physiotherapist - to remain on bed during day over Easter Holiday - do walk with gutter frame once/twice a day, see Code A 's report - Code A Code A is a physiotherapist.
Still having pain on movement.

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3/4/99 MST 10mg BD continued. Still continues to complain of pain on movement.

8/4/99 MST increased to 20mgs BD.

9/4/99 To remain on bed rest.

Code A see x-ray of hip.

11/4/99 in pain on movement. Oramorph 5mg/2.5ml given at 0715 hrs.

Page 86 reads, 4/4/91 (problem/need number) - wound on ® (right) hip oozing serous fluid and blood.

Steri-strip in situ at present.

Desire outcome - to promote healing and to aim to prevent infection.
Evaluation Date or Interval - daily.

Nursing Action:
1. Check wound daily.
2. Clean.
3. Apply dry dressing.
4. Secure i.c (i.e. with) hyperfix (a type of tape)

Page 87 reads - 4/4/99 dressings removed, no new leakage seen, steri-strip intact, dry dressing re-applied.

6/4/99 Swabs taken from suture line Rt (right) hip and Rt. Calf. Dressing removed off suture line left uncovered. Wound on calf cleaned with normal saline and Granuflex to cover wound leaking.

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8/4/99 - Wound oozing slightly overnight, re-dress at edge of wound subsiding.

11/4/99 - Commenced antibiotics a few days ago. Wound not healing today but hip feels hot and Code A c/o (complaining of) tenderness all round site. Code A very drowsy and irritable.

Page 88 reads - 26/3/99 Code A has a wound on her right elbow and another laceration type wound on her right calf, posterior aspect. Code A s skin is very fragile right leg swollen and oedematous (i.e. retaining fluid).
Desired Outcome - To heal both as soon as possible.
Evaluation Date or Interval - Daily.
Nursing Action - Dress with paramet and review in a few days. Secure dressing with loose bandage.

26/3/99 - both wounds dressed with paramet. Wound on calf had steristrips in situ. Left in place for present.

Page 89 reads - 29/3/99 both wounds redressed with paramet. Steristrips removed from calf wound as they were hanging off.

30/3/99 both wounds dressed with paramet. Steristrips from wound (post surgery) removed. One small area near top oozing slightly mepore dressing in situ. Check in a couple of days.

31/3/99 both wounds redressed with paramet. Steristrip removed from wound and ankle.

1/4/99 Dressings done as above.

2/4/99 Granuflex applied to wound on calf as oedematous.
Duoderm to small wound on arm.

4/4/99 Granuflex removed to wound right calf.

Signed: Code A

Signature Witnessed by:

RESTRICTED

7/4/99 As difficult to keep Granuflex on right calf wound - duoderm applied this morning, commenced antibiotics as hip wound may be infected.

I believe that the above entries reflect the nursing care which was being given to Code A Code A and illustrates my explanation of the Nursing Care Plan.,

On page 107 I refer to the entry of 7/4/99 which reads: "S/B (seen by) Code A for x-ray tomorrow at 1500 hrs. To commence Flupenthixal. To be reviewed Monday."

Flupenthixal is an anti anxiety drug given by injection. It is not a controlled drug. I can say that paramet is gauze pregnated with yellow paraffin and is a widely used dressing. It keeps the dressing from sticking to a wound.

On page 108 the entry of 12/4/99 reads, "S/B Code A Diamorphine to be reduced to 40 mgs over 24 hrs. If pain re-occurs the dose can be gradually increased as and when necessary. Code A has been spoken to and is aware of the situation. Both of the above entries are mine.

I note that Code A died at 0115 hrs Code A

On page 131 of the notes, the regular prescription sheet shows that on 12/4/99 the first dose of Diamorphine was discarded and the dose of 80mg halved to 40mg.

I assume that Code A must have thought that the patient could get pain relief with that amount. The drug parameters set by Code A were 20-200mg.

I now refer to JP/CDRB/47 the Ward Controlled Drugs Record Book 2/9/98-18/6/99. Controlled drugs are kept securely within a locked cabinet. The Senior Nurse in charge at the relevant time holds the key. When drugs are removed, the amount is entered into the book and countersigned by two trained members of nursing staff.

Signed: Code A

Signature Witnessed by:

RESTRICTED

I can say by referring to page 9 of the book that the following amounts on the following dates, of Morphine Sulphate tablets in 10mgs were given to Code A

31/3/99	0930hrs	10mg
31/3/99	2010hrs	10mg
1/4/99	0730hrs	10mg
1/4/99	2010hrs	10mg
2/4/99	0845hrs	10mg
2/4/99	2015hrs	10mg
3/4/99	0810hrs	10mg
3/4/99	2015hrs	10mg
4/4/99	0800hrs	10mg
4/4/99	2015hrs	10mg
5/4/99	0835hrs	10mg
5/4/99	2015hrs	10mg
6/4/99	0730hrs	10mg
6/4/99	2035hrs	20mg
7/4/99	0830hrs	20mg
7/4/99	2015hrs	20mg
8/4/99	0735hrs	20mg
8/4/99	2010hrs	20mg
9/4/99	0825hrs	20mg
9/4/99	2150hrs	20mg
10/4/99	0725hrs	20mg
10/4/99	2015hrs	20mg
11/4/99	0845hrs	20mg
11/4/99	2115hrs	20mg

On page 69 I see that Code A had 60mg of Diamorphine at 0900hrs 12/4/99 and 40mg at 1640hrs. The last entry was signed by me.

Signed: Code A

Signature Witnessed by:

RESTRICTED

In my view none of the above amounts are excessive.

On page 95 I note that at 0130 hrs 13/4/99 there was wastage from Code A s syringe driver of 6mls.

When parameters are set, they are done so by a doctor. On a scale of 20-200 mgs nursing staff would always start on 20mg unless told otherwise by the doctor.

In this case I have no idea why the doctor (Code A started the dose at 60mg. I have been shown a photocopy of a scale (by the BNF) of conversion from Oral morphine to diamorphine. If Code A was on 20mg twice daily, the scale shows that she should have been given 15mg of diamorphine over 24hrs. I cannot say why Code A prescribed 60mg which means the patient would have been on 90mg oramorph twice daily. Doctors increase the drug dosage.

STATEMENT TAKEN - Code A

RESTRICTED

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: Code A

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

This statement (consisting of 6 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: Code A Date: 06/12/2005

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

I am a registered general nurse and my nursing midwifery council number is Code A

I qualified as a registered nurse for the mentally handicapped in 1975 at Lennox Castle Hospital, Lennox Town Glasgow.

I further qualified as a registered general nurse in 1977 at the Argyle and Bute College of Nursing and Midwifery in Greenock. To obtain this qualification I undertook an 18 month registration course.
I worked for a further year at Broadfield Hospital, Port Glasgow completing in July 1978.

I left the nursing profession in that year and worked in a variety of other positions.

In March 1992 I began work as a Code A staff nurse at the Redclyffe Annexe which formed part of the Gosport War Memorial Hospital .
In 1995 I believe, this unit was closed down and all patients transferred to Dryad Ward at GWMH together with the staff.

I have worked at that Hospital since then and in 1995 I qualified as Code A staff nurse.

My role responsibilities include taking charge of the ward in the absence of senior staff. I supervise healthcare support workers and junior staff. I also have a responsibility for the

RESTRICTED

training of student nurse who are on ward placement.

I have not heard of the term the Wessex Protocols.

Dryad Ward consists of 20 beds and primarily consists of elderly patients over the age of 65 yrs. The majority of these are fully dependant on nursing care and are usually in the ward for a 4-6 week period.

I have received on the job training in the use of syringe drivers . I believe I first used these in or around 1992. I have also attended study days in connection with the manufacturer's requirements relating to their use.

A syringe driver is a small battery operated motorised syringe pump which has been designed to deliver a constant dosage of medicine over a set period of time. It is primarily used for continuous pain relief to patients. It can also be used to prevent nausea in patients who are very sick.

The only person who can authorise the use of drugs administered through a syringe driver is a doctor. In the early years it was policy to allow up to three different drugs to be administered via the syringe driver in one dosage over a set period.

This early policy has since changed.

My understanding of the term the named nurse is that this is the person who is responsible for the nursing care of the patient. They nurses were usually allocated a four bedded bay and split into teams A and B. They were responsible for putting care plans in respect of those patients in place and keeping them up to date. The named nurse would be the person whom the family would speak to if that nurse was actually on duty at the time. If they were not then another member of staff would speak to them. On some occasions the care plans in the nursing notes would be completed by another nurse but show the named nurse on the heading.

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The time and date of all entries in those notes would usually be completed at the time if the patient was seriously ill but in other cases it would be completed when there was time to do so but in any case at the end of the duty tour.

My tour of duty has always been from 0730 to1330 (days) and 1415 to 2030 (lates).

I have been asked to detail my involvement with the patient Code A b. Code A I do not recollect this patient. From referring to the medical notes (exhibit ref BJC/45) I can confirm that I have written a number of entries in the nursing notes commencing on page 106 and 107 as follows;

6/4/99

Seen by Code A, *MST(*= Morphine Sulphate Tablets) *increase to 20mgs.* Code A *has visited if necessary once* Code A *is discharged home. (As she is adamant about not going into a nursing home)He will employ someone to live in.* Code A *has been incontinent of Urine a few times over the weekend. I have spoken to her about a Catheter and she is going to think about it or using pad and pants.*

Code A

On page 107 of the notes I have written the following;

7/4/99

Fracture site red and inflamed seen by Code A *to commence metronidazole 400mgs and Ciprox* (= Ciprofloxacin) *500mgs bd* (= twice daily)

Code A

To clarify the above entries the patient has been seen by Code A I have written the notes so it is highly probable that I was present on the ward round with Code A As this was the morning it would have been just a quick walk round to update Code A with patients who had significant changes.

Signed: Code A

Signature Witnessed by: Code A

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Code A would do a quick ward round every morning around 8am (0800) Monday to Friday. She would speak to a number of the patients, but only examine a patient where there had been a significant or relevant change to that patient's condition. The fact that this patient was seen by Code A may well have come from observations noted by the Night Duty nursing staff. These observations are not recorded within the nursing notes however it is more likely to have been verbally handed over.

The patient's leg has been noted to be red and inflamed which is indicative of an infection. Therefore she was prescribed these two antibiotics "Metronidazole and Ciprofloxacin" to combat the infection which I would have administered.

There is no record in the Clinical notes detailing why these two drugs were prescribed. However there is a record by Code A on page 134 (which is the prescription sheet) of the notes as follows;

7/4/99 Metronidazole 400mgs oral dosage bd(= Twice daily)
7/4/99 Ciprofloxacin 500mgs oral dosage bd
I have administered these drugs at 1800 on 8/4/99

On page 87 of the records an entry has been written in by a health Care support worker Code A which I have countersigned the entry reads as follows;

6/4/99 Swabs taken from suture line right hip and right calf dressing removed off suture line left uncovered.
Wound on calf cleaned with normal saline and granuflex to cover wound leaking.

Swabs were taken to ascertain whether there was an infection.

On page 89 of the records (which is the wound care plan) I have written;

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2/4/99 - Granuflex applied to wound on calf as leg oedematous (=Swollen)

Duoderm to small wound on arm.

Granuflex and Duoderm are all protective dressings. The rest of this entry is self explanatory.

I have been shown the Dryad ward controlled drugs register exhibit JP/CDRB/47 . I can confirm that on page 9 headed "Morphine Sulphate S.R Tabs 10mgs" I have signed my name against the following entries;

31/3/99 0930 Code A *10mgs* administered by me and witnessed by Code A

2/4/99 2015 Code A *10mgs* administered by me and witnessed by Code A

6/4/99 0730 Code A *10mgs* administered by Code A and witnessed by me.

7/4/99 0830 Code A *20mgs* administered by me and witnessed by Code A

8/4/99 2010 Code A *20mgs* administered by me and witnessed by Code A

On page 134 of the notes I have made entries for administering *Metoclopramide 10mgs* (which is an anti emetic) at *1300 & 1800 on 8/4/99*

I can confirm that I have made an entry on page 131 of the records detailed as follows;

Under the heading Diamorphine 20-200mgs S/C 24hrs 12/4/99 as prescribed by Code A

I have administered *Diamorphine 80 mgs at 0900 12/4/99*

Under the heading Midazolam 20-80 mgs S/C 24hrs 12/4/99 as prescribed by Code A

I have administered *Midazolam 20mgs at 0900 12/4/99.*

I cannot remember whether it was Code A s calculations or whether the dosage rate administered to Code A was worked out by senior staff nurse Code A and I. The

RESTRICTED

calculation would have been based on the previous Morphine tablets that the patient had been given on the preceding days.

There is an entry on page 107 of the records by Code A which records that the patient was seen by Code A on the 12/4/99 which is the same day that Code A prescribed Diamorphine as recorded on page 131 of the medical records.

I can confirm that I have been shown the Dryad ward drugs register exhibit JP/CDRB/47. I have written the following entry on page 69

12/4/99 0900 Code A *60mgs Diamorphine administered by me and witnessed by* Code A

I have written the following entry on page 87 of the drugs register JP/CDRB/47;

12/4/99 0900 Code A *20mgs Diamorphine administered by me and witnessed by* Code A

I had no further dealings with this patient.

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

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: Code A

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

This statement (consisting of 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: Code A Date: 22/11/2005

I am Code A and I live at an address known to Hampshire Police. I am a Staff Nurse on Daedalus Ward at Gosport War Memorial Hospital. I qualified in 1983 as an enrolled nurse and my RCN number is Code A

Between 1981 and 1983 I completed my State Enrolled Nurse training at the Argyle Bute and Clyde Health Board General Nursing Council for Scotland.

Between 1985 and 1987 I was an enrolled nurse on the male surgical ward at the Value of Leven Hospital, Dunbartonshire.

Between 1987 and 1988 I was an enrolled nurse for the Crown Nursing Agency, Lee on Solent.

Between 1988 and 1997 I was a Code A enrolled nurse at Gosport War Memorial Hospital.

During 1996 and 1997 I did a conversion course from State Enrolled Nurse to General Nurse at the University of Portsmouth (Queen Alexandra Hospital Portsmouth).

Between 1997 and 1999 I was a Registered General Nurse for Paramed Services Ltd, Medical Information for Life Insurance Companies.

During 1997 and 1999 I was also a Code A Registered General Nurse at Gosport War Memorial Hospital.

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Between 1999 and present I am Code A Registered General Nurse at GWMH. I work permanent night duty. This comprises of 20hrs covering 2 shifts. A shift commences at 2015 and finishes 0745.

In 1998 I was working on Daedalus Ward at the GWMH, my role responsibilities would be: the efficient running of the ward, to care for the patients providing them with a safe and comfortable environment and the issue of prescribed drugs.

My line manager at that time would have been on Daedalus, Code A on days and Code A Code A on nights.

On occasions I would be asked to cover Dryad Ward on nights, usually due to sickness. My line managers there would have been Code A on days and Code A on nights.

I have completed a course on I/V Therapy Cannulation and Venepuncture.

I have not heard of the term the "Wessex Protocols".

I have been shown by a Sister how to us syringe drivers, (on the job training) but I had not received certification. I have this year 2005 received training from a Pharmacist (Code A and now hold a certificate.

Regarding entries in the nursing notes, these would usually be completed at the end of the shift.

The Named Nurse is a day duty term and means the nurse who is allocated and responsible for a particular patient.

There are no ward rounds on night duty, but in case of an emergency I would have a bleep number for an E Grade on call nurse and a telephone number for the on call Doctor who would be a GP. In the case of a cardiac emergency I would call 999 and an ambulance would convey the patient to the Queen Alexandra Hospital.

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I have been asked to detail my involvement in the care and treatment of Code A b Code A

I do not recollect this patient or the subsequent treatment administered.

From referring to the medical notes exhibit ref BJC/45 I can confirm that I have written the following entry on page 81 (nursing care plan).

10/4/99 Spilt drink prior to settling (This is self explanatory).
Very poor night. Appears to be leaning to left.
Does not appear to be as well and experiencing difficulty in swallowing.
Stitch line inflamed and hard area c/o pain on movement and around stitch line. Oramorph 2.5ml/5mg given at 0715 hrs.
Very poor night.

To clarify this entry, the patient has not slept well and at some stage when we have sat Code A up in bed, she appears to have been leaning to the left. It is possible that she was leaning this way as she may have been in pain due to her recent operation on her right hip.

Stitch Line Inflamed - This could be an indication that the stitch line was becoming infected. The hard area could refer to the possible infection underneath the stitch line.

Pain on Movement - We could have moved the patient to check her pressure areas and it would have been noted that she was in pain whilst we were moving her.

I have written the following entry on page 85 of the medical records (which is a Care Plan covering the patient's pain control).

11/4/99 In pain on movement Oramorph 5mg/2.5mls given at 0715.

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

Continuation of Statement of: Code A

To clarify this entry - I have noted that the patient was in pain on movement. I have administered 5mg/2.5mls of Oramorph as per prescription in an attempt to relieve the patient's pain.

The prescription for Oramorph 10mg/5mls was prescribed by a Doctor on 26/3/99.

The dosage range was between 2.5 & 5mls to be administered 4 hourly.

There is no specific entry in the clinical notes by a Doctor relating to the administration of Oramorph on the 11/4/99.

I have been shown the Dryad drugs register for the administration of Oramorph exhibit reference JP/CDRB/24.

I can confirm that on the 11/4/99 @ 0715 I have witnessed Code A measuring and pouring out 5mg/2.5mls of Oramorph that was administered to the patient Code A.

I can confirm that on page 123 of the medical records which is the drugs prescription sheet. I have made an entry:

Oramorph - 11/4/99 0715 5mg 2.5mls Code A

I have administered 5mg of Oramorph at this time and date to the patient Code A for the reasons recorded on page 85 of the medical records.

I had no further dealings with this patient.

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

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: Code A

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

This statement (consisting of 6 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: Code A Date: 30/11/2005

I am Code A and I live at an address known to Hampshire Police. I am a Nurse Practitioner at Lasercare Clinics at Royal Hospital Haslar Gosport . My nursing and midwifery pin number is Code A and my RCN is Code A I qualified as a Registered General Nurse in 1972 and as a State Certified Midwife in 1974.

Between 1968 and 1972 I was a Student Nurse at Royal Alexandra Infirmary, Paisley Scotland.

Between 1972 and 1973 I was a Staff Nurse at Hospital D'Orbe Switzerland, in General Medical and Surgical Departments.

Between 1973 and 1974 I was Student Midwife at Southern General Hospital, Glasgow Scotland.

Between 1975 and 1976 I was an Agency Staff Nurse in mixed specialities.

Between 1976 and 1977 I was Night Sister at Portsmouth Royal Infirmary, responsible for medical and surgical units

Between 1979 and 1981 I was Night Sister at St Christopher's Hospital Fareham responsible for elderly care.

Between 1982 and 2001 I was Code A at Gosport War Memorial Hospital . Responsible for mainly Elderly Care, and GP medical patients, consisting of Dryad,

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Sultan and Daedalus wards, also the 24 hour Minor Injury Dept which closed in 2000.

Between 2001 and 2003 I was a Senior Staff Nurse on a GP Medical Ward, Sultan Ward at Gosport War Memorial Hospital.

Between 2003 and the present I am a Nurse Practitioner specialising in Dermatology treatments at Royal Hospital Haslar Gosport.

I have professional qualifications including;

ENB 931, the continuing care of the dying patient and the family

ENB 998, teaching and assessing in clinical practice,
peripheral I.V.drug therapy training

Life support and automated external defibrillation.

In 1998 I was a Code A previously known as Code A on Sultan Ward at GWMH, but with a responsibility for Dryad and Daedalus Wards also. GWMH was a 130 bed community hospital which as I have previously stated comprised mainly of Elderly Care and GP Medical Patients. I had responsibility for those patients and staff and also for the safety of the building at night. I provided leadership, clinical advice and practical support to my colleagues. I was required to act on my own initiative and exercise independent judgement as there was no on site Doctor.

My Line Manager at that time was Code A I think.

As I have stated I have received training in the use of I.V. drugs but have never put this into practice.

I have not heard of the term, "The Wessex Protocols" I am fully aware however of the

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Analgesic Ladder with regard to pain control.

I have received training from Macmillan Nurses in the setting up of Syringe Drivers . The ones in use at the time were Graysby and they came into use in the late 1980's I believe.

The Syringe Driver is a 24 hour pump that introduces medication to control symptoms experienced by patients. They were mainly used by patients suffering from pain, nausea, vomiting and agitation and where medication could not be delivered orally.

My duties regarding Syringe drivers were to ensure that two trained staff members applied a driver to patients. Sometimes however circumstances would dictate that there was only one qualified staff member available. Therefore I would take the place of the second staff member. The other option could be that a support worker who is trained in the 'checking' role could also take the place of a trained staff member. The reasoning behind the two staff members is to check the prescription and contents.

In 1991 I became aware that some staff at GWMH were expressing concerns over the levels of Diamorphine being prescribed. My belief is that this was resolved internally and that a consultant visited from the Countess of Mountbatten Hospice and explained fully their use to the nursing staff.

One to One training was also available to staff.

The Named Nurse was the person responsible for the care of the patient usually allocated on admission. In my estimation this system did not work, as often the supposed named nurse could be off duty the days following admission.

With regard to the time and date of all entries in the nursing notes I would always complete these at the time of seeing the patient.

My tour of duty at this time was four nights per week, from 2030 to 0745 the following

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morning.

Ward rounds as such were not completed by Doctors during the night, but as Code A I would complete my own ward round of the three wards I was responsible for. I would ask staff about poorly patients, if there were any concerns on the ward.

I have been asked to detail my involvement in the care and treatment of Code A; I do not recall this patient at all but from referral to entries in her nursing notes, (Exhibit Reference BJC/45) I can state that on page 24 of those notes dated Code A I have written on a Speciality History Sheet,
"01.15 AM. Died peacefully. Death confirmed by night Code A in the presence of S/N Code A ? burial/cremation." I have signed that entry Code A

On page 108 of those notes I have written at Code A on a Summary sheet, "01.15h - Died peacefully. Death confirmed by Code A - Code A in the presence of Staff Nurse Code A Code A notified ? burial/cremation. Valuables in safe (ring with body). I have signed that entry Code A

In this case I believe I was called to verify Code A 's death. I would go the ward and see the patient where I would look for signs of confirmation of death. These would be;

1. Absence of Carotid pulse. (In the neck).
2. No heart sounds using stethoscope.
3. Fixed and dilated pupils.
4. Pen torch shone into eyes.

If I was certain of death after these procedures, then I would verify that death. It does not appear that a Doctor was called at this time. If death was expected then a Doctor would not generally be called during the night, but would be called first thing in the morning by the day staff. A doctor may be called however if a patient had an episode during the night when the nursing staff did not feel that they could adequately deal with the situation.

Signed: Code A

Signature Witnessed by: Code A

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Continuation of Statement of: Code A

I see from perusing the notes that the patient was poorly and deteriorating in condition so much so that Code A was contacted on 11/04/1999 and so advised. This was fairly indicative that the patient was dying. The term,? burial/ cremation means that we were unsure whether the deceased was to be cremated or buried at this time.

Statement taken by Code A - Code A Fareham

Signed: Code A

Signature Witnessed by: Code A

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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: Code A

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

This statement (consisting of 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: Code A Date: 30/11/2005

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

In 1987 I qualified as a Registered General Nurse (RGN) in Limerick.

My nursing midwifery council pin no is Code A

From 1987 to 1994 I worked as a RGN at the Limerick Regional Hospital.

Between July 1994 and October 1995 I did agency work with the Crown Nursing Agency. I worked as a D grade Nurse at the Queen Alexandra Hospital, Portsmouth. I normally worked on B3 ward, which was a general medical ward.

From October 1995 I was employed by the Fareham and Gosport Primary Care Trust as Code A Code A Registered General Nurse working at St Christopher's Hospital, Fareham Whilst at St Christopher's in 1996 I applied for and was accepted as Code A RGN.

In November 1997 I commenced working as Code A RGN on Dryad Ward, Gosport War Memorial Hospital ; Dryad Ward was at that time a continuing care ward comprising of 20 beds for elderly patients.

Four of the beds were for Respite Care.

In July 2003 I left Dryad Ward and commenced working on Sultan Ward as a grade F RGN.

Signed: Code A Signature Witnessed by: Code A

As far as I can recollect I commenced using Syringe Drivers in January/February 1996. There was a set procedure in the use application of syringe drivers. Two trained members of staff were required to check the "five rights" which are:

1. Confirm that is the right patient's name, d.o.b match the details as per the prescription.
2. Confirm the right dose to be administered.
3. Confirm that it is the right drug.
4. Confirm that it is the right date.
5. Confirm that it is the right hour to administer.

Syringe drivers were used for the administration of controlled drugs to patients who were no longer able take them orally. The syringe driver delivered a controlled amount of the drug over a 24 hour period.

Initially the syringe driver was set up by inserting a butterfly needle subcutaneously into the patient.

It was a requirement for the controlled drug to be administered by two trained nurses.

The drugs are stored in a locked cupboard within a locked cupboard. A register was kept recording all controlled drugs administered to patients. The entry in the drug register was normally signed by the nurse administering the drug, this was witnessed, by another trained nurse.

Whilst on Dryad Ward I was contracted to work for 25 hours a week. I worked mainly night shift, which commenced at 2015 hours and finished at 0745 hours. I would normally work 3 nights one week followed by 2 nights the following week.

My responsibilities on the Ward at that time included supervising the health care support workers.

Administering controlled drugs to the patients. To oversee the smooth running of the ward this included maintaining a safe environment for patients and staff.

I also dealt with the relatives of the patients on the ward.

I have bee asked to comment on the use of the following;

ANC - I have not heard of this term. I have been told that it means, "All Nursing Care" This would not usually be written by Nursing Staff. If I had seen this term I would assume that the person was quite poorly and not able to do much for themselves regarding nursing interaction. It is a broad term for the fact that everything would need to be done for them, in relation to hygiene, feeding and dressing etc.

TLC - Tender Loving Care. This I feel would mean that the patient was gravely ill and it would probably mean that the patient would not be resuscitated. The task would be to keep the patient comfortable but nothing more would be done to improve the patient's condition.

"I am happy for staff to verify death" This is a term I have heard at GWMH and elsewhere, usually in Nursing Homes. This would indicate to me that the patient is expected to die soon. If death was expected the Doctor was never called out to verify death.

This would be the case if the patient was not responding to treatment; there was a decline in general mobility, the patient was unconscious; they could not or would not eat and drink; their blood pressure dropped; their pulse was irregular/fast; their breathing would be laboured; urine output would be reduced due to renal failure; her colour would be pale and perhaps blue on some occasions.

There were no ward rounds on night duty but on the occasions I have worked a day duty on Dryad Ward. Code A does a ward round each day during the week where she would walk to each bed and speak to each patient. A nurse would accompany her with a report on each

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Continuation of Statement of: Code A

patient from night duty.

I worked a 20 hour week in 1998 which consisted of 2 nights per week.

I have been asked to detail my involvement in the care and treatment of a patient named Code A Code A. I do not recall this patient but from referral to entries in her medical notes, identification reference BJC/45 I can state that on Page 83 of the notes dated 11/4/99 I have written;

"Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way. Did settle for long periods.

On 12/4/99 I have written, "Condition remains ill. Urine very concentrated. Signed Code A

Oral hygiene attended to. Syringe driver satisfactory. Appears to be in some discomfort when attended to. Breathing very shallow". Signed Code A

I have stated that the syringe driver was satisfactory, this means that it was both running and working correctly. It having been set up before I came onto night duty. These were generally not set up on night duty.

On Code A I have written, "@ 01.35. Patient RIP @ 01.15 A/M". Signed Code A

On page 24 of the notes Code A has written on Code A "01.15 A/M Died peacefully. Death confirmed by Code A in the presence of S/N Code A Code A

? burial/cremation. This entry was signed by Code A

The procedure to be followed to verify death is as follows;

Signed: Code A

Signature Witnessed by: Code A

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Check for pulse

Listen for heartbeat

Check for breathing signs

Shine a light in the eyes, if deceased then pupils would be fixed and dilated.

Once death was verified the body would be washed, any drips and catheter would be removed.

The patient would be dressed in their own nightclothes.

The body would be taken to the hospital mortuary.

? burial/cremation means that we were unsure whether the family preference was for the body was to be cremated or buried at this time.

It appears that a Doctor was not called at this time, and I can only assume in this case that the death was expected. If this was the case then a Doctor would not be called out of hours.

On page 81 of the notes dated 30/3/99, I have signed a blank entry, Code A which reiterates what is written on above entries. This indicated that nothing significant had occurred.

On page 81 of the notes dated 31/3/99, I have written, "Did sleep well". I have signed that entry Code A

On page 81 of the notes dated 1/4/99, I have written, "Wound in rt hip oozing large amounts of serous fluid and some blood. Hole noted in wound 1-1½ cm. Steri strip applied. Still oozing this A/M". I have signed this entry Code A

On page 81 of the notes, dated 6/4/99, I have written,"Incont of urine x1" I have signed that entry Code A

This means that she had wet herself on one occasion.

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On page 81 of the notes dated 7/4/99, I have signed a blank entry, Code A This again indicates that nothing significant had occurred.

I have also referred to the Dryad Ward Controlled Drugs Record Book (identification reference JP/CDRB/47) , page 95 which indicate Syringe Driver Wastage, I have written on 13/4/99 at 0130 that 6mls administered to Code A which consisted of 40 mgs of Diamorphine and 20mgs of Midazolam was wasted. I have signed this entry which was witnessed by Code A Code A This would have been the remains in the syringe driver after the patient's death.

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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: Code A

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

This statement (consisting of 4 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: Code A Date: 15/02/2006

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

I retired from the NHS in 1999, after 38 years nursing experience.

I retired as a Staff Nurse at Gosport War Memorial Hospital ; I cannot recall my RCN number.

In 1997 I was a Staff Nurse working night duty only on Dryad Ward at the Gosport War Memorial Hospital.

My responsibilities were in the main "patient care" and I was in charge of a team of two or three Auxiliary nurses. Our task on nights were to care for the patients, give medication, make up care plans and hand over to the day shift. My supervisor at that time was I believe to be Code A Code A

I don't believe I received any training in the use of I/V drugs. I may have received hand outs.

I have never heard the term the Wessex protocols.

I attended a day course at GWMH in the use and setting up of syringe drivers . I recall I was nervous regarding their use and along with others I requested more training.

Usually, by the time we came on to nights the syringe drivers for patients had already been set up for us by the day team.

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The title named nurse is something used on days, but not on nights. This was the nurse who was responsible for a particular patient and whose name was usually on a board in the nurse's station.

In relation to the time and date of all entries, I would complete these in the notes when I had finished all of my jobs, however if the patient was really poorly I would write in the notes at the time.

As I have said I only worked a night duty. I worked 20 hours per week which consisted of two nights. My hours were from 1930 until 0730 the following day.

I have been asked to detail my involvement in the care and treatment of a patient named Code A Code A I do not recall this patient but form reference to her medical records (Exhibit Reference BJC/45) I can state that on page 81 of those notes which is a nursing care plan in relation to sleep, I have written;

On 2/4/99 I have signed a blank single line Code A

On 8/4/99 I have also signed a blank single line Code A

On 9/4/99 "Needed some assuring at times with regards to Catheter. Fluids encouraged, though spilt 2 drinks in bed. Had a nightmare early morning" I have signed that entry Code A

I would think that the catheter had only just been put in place. I see from a previous entry that she had been incontinent of urine. Older people do tend to not understand what a Catheter is or what it does.

In relation to the blank entries, these would indicate that although the patient had been observed, nothing untoward had occurred to affect an entry being written.

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Continuation of Statement of: Code A

On page 9 of the Dryad Ward Controlled Drugs Register (Exhibit Reference JP/CDRB/47) dated 2/4/99 at 2015 hrs I have signed that I witnessed the administration of 10 mgs of Morphine Sulphate SR Tabs (MST) by Staff Nurse Code A

Also on page 9 of the Dryad Ward Controlled Drugs Register (Exhibit Reference JP/CDRB/47) dated 8/4/99 at 2010 hrs I have signed that I witnessed the administration of 20mgs of Morphine Sulphate SR Tabs (MST) by Staff Nurse Code A

Also on page 9 of the Dryad Ward Controlled Drugs Register (Exhibit Reference JP/CDRB/47) dated 9/4/99 at 2150hrs I have signed that I administered 20 mgs of Morphine Sulphate SR Tabs (MST) witnessed by Staff Nurse Code A

Also on page 9 of the Dryad Ward Controlled Drugs Register (Exhibit Reference JP/CDRB/47) dated 10/4/99 at 0725 hrs I have signed that I administered 20mgs of Morphine Sulphate SR Tabs (MST) witnessed by Staff Nurse Code A

These last two entries are cross referenced on page 134 of the notes where I have initialled that I administered the MST on 9/4/99 and 10/4/99.

Also on page 134 of the notes I have initialled that I have administered 10mgs Metoclopramide to Code A at 0600 on 9/4/99 and 10/4/99.

Also on page 134 of the notes I have initialled that I have administered Senna Tablets to the patient on 2/4/99, 8/4/99 and 9/4/99.

Morphine Sulphate Tablets are an Opiate pain killer.
Metoclopramide is an anti-emetic drug for nausea and vomiting.
Senna is used for constipation.

All of the drugs administered were written up and signed by Code A and on night duty I used that as my authority to administer them.

Signed: Code A

Signature Witnessed by: Code A

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Continuation of Statement of: Code A

Signed: Code A

Signature Witnessed by: Code A

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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: Code A

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: Code A 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 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 [redacted]

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.

Signed: Code A Signature Witnessed by: Code A

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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 [redacted]

In 1981 I resumed nursing again and returned to the Radclyffe 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 Code A 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, Code A , 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 Code A 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.

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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 Code A 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 Code A and Code A 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 Code A

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.
Code A 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 Code A contacted the

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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 Code A 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 Code A The Code A I believe was Code A.

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 Code A 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 Code A. 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 Code A

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 Code A administer 10mg Oramorph in 5mls and at 0655 on 27/3/99 I have again witnessed Code A administer 5mgs of Oramorph in 2.5mls both to Code A

This is further cross referenced on page 125 of the notes where Code A 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. Code A 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 - Code A requires help with washing and dressing
Desired Outcome - To try and maintain a standard of hygiene acceptable to Code A
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 - Code A 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 - Code A 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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Continuation of Statement of: Code A

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

Signed: Code A

Signature Witnessed by: Code A

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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: Code A

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

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: Code A Date: 09/12/2005

I am a Senior Staff Nurse at Gosport War Memorial Hospital , where I work nights on Sultan Ward. I trained at The Royal Hants County Hospital, Winchester from 1982 to 1986, my Nursing and Midwifery Council number is Code A and my RCN no is Code A After my training I worked at Beechcroft Manor Nursing Home Gosport for 9 months until May 1987 when I started work at Gosport War Memorial Hospital, first employed at the Redclyffe Annexe at the Avenue, Gosport which was a geriatric ward for patients who couldn't cope on their own, they were not necessarily ill but needed nursing care. In 1998 I was employed as a Senior Staff Nurse on Dryad Ward at Gosport War Memorial Hospital I have been employed there since that time as Senior Staff Nurse on Night Duty only, now covering Sultan Ward as well as Dryad Ward.

In 1999 I was a Senior Staff Nurse on Dryad Ward at GWMH and I was working on night duty, my role responsibility was that I was in charge of the ward and indeed of the whole hospital on nights in the absence of the night sister. My line manager at that time was Code A

At the time of the investigation I had received no training/certification in the administration of I.V. drugs. I have since 2003 received such training.

I understand the Wessex Protocols to be drug prescribing and administration guidelines.

I understand the analgesic ladder to be the administration of drugs beginning with low strength analgesia working up to strong opiates, depending on a particular patients need. The Doctor would decide regarding the drugs administered and also the patient would have input if they

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were able to, regarding if still in pain. How the drugs are prescribed by the Dr would indicate if a nurse can make any decision as to increasing the dosage.

I had training before 1999 in the setting up of syringe drivers in a group session at GWMH and also at Queen Alexandra Hospital. The syringe drivers used were Graysby and were administered sub cutaneously (under the skin). Training was generally available then although widely so although as more were used more training became available. Nurses could also apply to attend training.

The Named Nurse was the nurse allocated to a particular patient. That nurse would be in charge of care and would also manage care, providing the link between the patient and the family if there were any questions to be answered.

The time and date of entries in the nursing notes would depend on the patient and how busy the shift was. But generally these would be completed when we had time or at the end of a round on nights when we were getting the patients ready to go to sleep.

Since qualification I have worked night duty. I worked 25 hours week from 2015 to 0745. Two nights on week, 1 then three nights on week 2.

There were no ward rounds on night duty.

Code A would usually be in the hospital by 0730 and would sometimes ask regarding specific patients.

I have heard the term All Nursing Care, but not the abbreviation ANC. This means that we were providing all the care that patient required, in that they were unable to do anything for themselves. Their Bartel score would be low. We would provide care in relation to washing, dressing, feeding, repositioning, bathing and toileting.

The term TLC means Tender Loving Care and would indicate to me that the patient was poorly

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and not expected to live very long.

The term, "I am happy for staff to verify death", I have heard of, and indicates that a patient is terminally ill and is expected to die fairly soon and the doctor is happy for nurses to verify death.

I have been asked to detail my involvement in the care and treatment of a patient named Code A Code A. I do not recall that patient, but from referral to entries in her medical notes, BJC/45 I can state that on page 125 I have initialled that I have administered Oramorph on or around 2200 on 26/3/99. On the same page I have initialled that I have administered Oramorph on or around 0600 on 27/3/99.

On page 47 of the Dryad Ward Controlled Drug Record Book (Oramorph Oral Solutions only) JP/CDRB/24 I have written;

At 2315 on 26/3/99, that I have administered 10mg/5ml of Oramorph to Code A which was witnessed by Staff Nurse Code A

At 0655 on 27/3/99, that I have administered 5mgs/2.5mls of Oramorph to Code A which was again witnessed by Staff Nurse Code A

At 0700 on 28/3/99 that I have witnessed Staff nurse Code A administer 10mg/5ml of Oramorph to Code A

At 0715 on 11/4/99, that I have administered 5mg/2.5mls of Oramorph to Code A which was witnessed by Staff Nurse Code A.

I have had no further dealings with this patient.

The reason that I administered Oramorph to this patient was that it was prescribed by and written up by Code A on 26/3/99. The dose being 10mg / 5ml once a day, (a 2.5mg dose, 4 hourly). On admission it is written up on page 106 that the patient has complained of a lot of

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pain, for which she was receiving Oramorph regularly, with effect. I felt that the further administration of this drug was therefore appropriate in those circumstances.

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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: Code A

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

This statement (consisting of 6 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: Code A Date: 22/02/2006

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

I am a Community Bank Nurse working for NHS Professionals, my Nursing and Midwifery Pin no is Code A I qualified in 1992.

Between 1989 and 1992 I did my Nurse training at St Mary's Hospital Paddington and at Southbank Polytechnic London where I completed my Registered Nurse and HND Nursing training.

Between 1992 and 1993 I was employed by the Crown Nursing Agency, agency nursing in the local area

Between 1993 and 1996 I was employed by Home of Comforts for Invalids at Southsea, where I was the Nurse in charge of some 35 patients in the absence of the Matron.

Between 1993 and 1994 I was employed by Intercounty Nursing Services where I was an Agency nurse working in local nursing homes and hospitals.

Between 1994 and 1995 I was employed by Portsmouth Healthcare NHS Trust I was a D Grade nurse working in the Community on nights. I gave palliative care to chronic and terminally ill patients.

Between 1995 and 1996 I was employed by Portsmouth Healthcare NHS Trust as an E Grade

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nurse on call on night duty.

Between 1996 and 2005 I was employed by Portsmouth Healthcare NHS Trust as a Code A nurse working in the Community on nights and during the day and twilight bank.

Between 1996 and 1999 I was a night Staff Nurse Code A on Dryad ward at Gosport War Memorial Hospital where I was in charge of the ward in the absence of a senior member of staff.

Since 2004 I have been an NHS Professionals bank nurse, working in the community for the District Nursing Team.

In 1998 I was a night Duty Staff Nurse working on Dryad Ward at GWMH where my responsibilities included the administration of drugs, patient care and supervising patient care.

My line manager at the time was Code A.
I did not receive training/certification in the administration of I.V. drugs.

I received mandatory training in the community regarding the setting up of Syringe Drivers; I believe this was at the Countess of Mountbatten Hospital. I received no certificate.

I have not heard of the term, the Wessex Protocols. I do however have a good knowledge of the analgesic ladder regarding pain relief.

The named nurse is a term that is not used on night duty, but it is the nurse who is responsible for the planning, administering and implementing patient's care plans.

The time and date of entries in the nursing notes would depend on the circumstances.
If the patient had an acute problem then the notes would be completed at the time, but otherwise, if it was an uneventful night then they would be completed at the end of the shift.

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In 1998 I worked 20 hours per week which consisted of two night duties.

The term ANC, I have not heard of. I have been told that it means "All nursing care."
If it had been GNC "General nursing care" that would be a better term. I would say that this term would indicate that the patient was pretty helpless, regarding hygiene matters and the ability to move for example.

The term TLC "Tender loving care," I am more familiar with. This would indicate to me that this patient was getting towards the end of their life, and there was likely to be no rescue efforts to resuscitate them.

The term "I am happy for staff to verify death" I am familiar with, and understand it to mean that death was expected, and that there would be no need for a Dr to be called out during the night if the patient passed away. In a larger hospital this would not occur because there would always be a Dr on duty. GWMH is basically a half way house between a larger hospital and a patients home.

Ward rounds were not conducted during a night duty.

I have been asked to detail my involvement in the care and treatment of a patient on Dryad Ward named Code A. I do not recall this patient at all, but from referral to her medical notes (Exhibit Reference BJC/45) and the Dryad Ward Controlled Drug Record Book (Exhibit Reference JP/CDRB/24) I can say that on page 81 of those notes I have written the following on a nursing care plan for sleep;

27/3/99 I have signed a blank one line entry
28/3/99 I have signed a blank one line entry
29/3/99 I have also signed a blank one line entry

This indicated that nothing untoward had happened during the night regarding the patient

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On page 125 of the notes which is a prescription sheet I have initialled that I gave the patient Oramorph at 2200 hrs 27/3/99 and at 0600 hrs 28/3/99.

I have also initialled the fact that I have given the patient Co- Dydramol at 2200hrs 28/3/99 and at 0600 hrs and 2200 hrs 29/3/99 and also at 0600 hrs 30/3/99.

On page 134 of the nursing notes, which is also a prescription sheet I have initialled that I gave the patient 10mgs of Metoclopramide at 0600 on 29/3/99 and at 0600 on 30/3/99.

On the same page I have initialled that I administered one Senna Tablet to the patient at 2200 hrs on 29/3/99

On page 47 of the Dryad Ward Controlled Drugs Record Book (Exhibit Reference CDRB/24) I have completed the following entries;

At 2220 hrs on 27/3/99 I administered 20 mgs of Oramorph in 10 mls to Code A witnessed by Code A who was a Health Care Support Worker.

At 0700 hrs on 28/3/99 I administered 10 mgs of Oramorph in 5 mls to Code A witnessed by Nurse Code A

Both Oramorph and Co-Dydramol are used in for pain reduction
Metoclopramide is used as an anti sickness drug.
Senna is used as a Laxative

The drugs I have administered were prescribed and written up by Code A and it was on that authority only, that I did my job as a nurse in caring for the patient.

The Oramorph and Co-Dydramol were administered to the patient to ensure that she had good, pain free nights sleep. The Metoclopramide and Senna as described are self explanatory in administration.

Signed: Code A

Signature Witnessed by: Code A

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The Oramorph were recorded as a regular prescription every 4 hours.

The Co Dydramol were recorded as ∏ which means two tablets.

I left the GWMH in April 1999. Code A

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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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: SENIOR PHYSIOTHERAPIST

This statement (consisting of 4 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: Code A Date: 15/02/2006

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

In 1980 at Coventry University I qualified as a member of the Chartered Society of Physiotherapy.

I trained for three years, between 1997 and 1980.

Between 1980 and 1991 I was a Junior Physiotherapist at Southampton General Hospital.

Between 1981 and 1982 I was a Junior Physiotherapist at St Mary's Hospital, Newport Isle of Wight

Between 1982 and 1984 I was Senior Physiotherapist at Lynbank Hospital, Dunfermline Scotland

Between 1984 and 1986 I was Senior Physiotherapist at Sandy Point Hospital Hayling Island

Between 1986 and 1987 I was Senior Physiotherapist at Exmouth Devon (Community Team)

Between 1987 and 1991 I was Senior Physiotherapist in the Ministry of Defence Paediatric and Obstetric Physiotherapy Dept in Gibraltar.

Between 1991 and 1993 I was Senior Physiotherapist at St James's Hospital Portsmouth

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(Community Team)

Since April 1993 I have been the Senior Physiotherapist at Gosport War Memorial Hospital I am now also the team leader

In 1990 however I worked with one assistant at GWMH, there was no team then.

My responsibilities are to rehabilitate patients to reach their maximum abilities.

I would visit all wards where I was required to see patients and write entries in the notes after seeing the patient and before I left the ward. I would also work in the community.

In 1999 I worked 35 hrs per week starting at around 0845 and finishing around 1700

I have been asked to detail my involvement in the care and treatment of a patient named Code A Code A. I do not recall this patient at all, but from referral to her medical notes, (Exhibit Reference BJC/45) I can say that on page 85 of the notes an entry is written but not by me as follows;

1/4/99 "s/b physiotherapist- to remain on bed during day over Easter Holiday- to walk with gutter frame once/twice a day, see Code A s report".

On page 96 of the notes which is a Speciality History Sheet, relating to Code A, I have written,

PHYSIOTHERAPY CARE PLAN

1.4.99. "Please can you leave Code A on her bed over the w/end rather than in her chair, but she will need to walk x 2 daily using gutter frame."

I have signed this entry Code A.

Signed: Code A

Signature Witnessed by: Code A

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This entry was written as information for the nurses to follow.

A gutter frame is a high framed walking aid higher that a Zimmer frame, supporting the forearms. This would be used when the patient was in pain and not weight bearing.

x 2 means twice a day
s/b means seen by.

These entries indicate to me that the patient was in pain, because I asked her to be on her bed rather than a chair, a gutter frame suggests also that the patient had difficulty in walking pain free.

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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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: Code A

This statement (consisting of 1 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: Code A Date: 19/09/2005

I am Code A of the Hampshire Constabulary presently attached to the Major Crime Department.

At 0916 hours on Thursday, 15th September 2005 in company with Code A Code A I conducted a tape recorded interview of Code A The interview took place within an office of the Fraud Squad at Netley Support Headquarters and in the presence of her solicitor Code A. The interview was conducted in accordance with the codes of practice on tape recorded interviews and the sealed master tape is available with an identification reference of CSY/JAB/10 .

During this interview Code A produced a prepared statement which she then read and signed as being her statement. This prepared statement is available with an identification reference of JB/PS/9 .

The interview was concluded at 0944 hours that day.

Signed: Code A Signature Witnessed by:

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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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: Code A

This statement (consisting of 1 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: Code A Date: 14/11/2005

I am Code A of the Hampshire Constabulary presently attached to the Major Crime Department.

In addition to my previous statement regarding the interview of Code A on 15th September 2005 (15/09/2005), I wish to add the following. I have caused the tape of the interview, bearing the identification reference CSY/JAB/10 , to be fully transcribed. The transcript of the interview is now available with an identification reference of CSY/JAB/10A.

Signed: Code A Signature Witnessed by:

RESTRICTED

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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: Code A

This statement (consisting of 1 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: Code A Date: 07/11/2005

At 0916 hours on Thursday 15th September 2005 myself and Code A conducted a tape recorded interview with Code A The interview took place within an office of the Fraud Squad at Netley Support Headquarters and in the presence of her solicitor Code A Code A The interview was conducted in accordance with the Codes of Practice on tape recorded interviews and the sealed master tape is available (CSY/JAB/10).

During this interview Code A produced a prepared statement which she then read and signed as being her statement (JB/PS/9).

The interview concluded at 0944 hours.

Signed: Code A Signature Witnessed by: