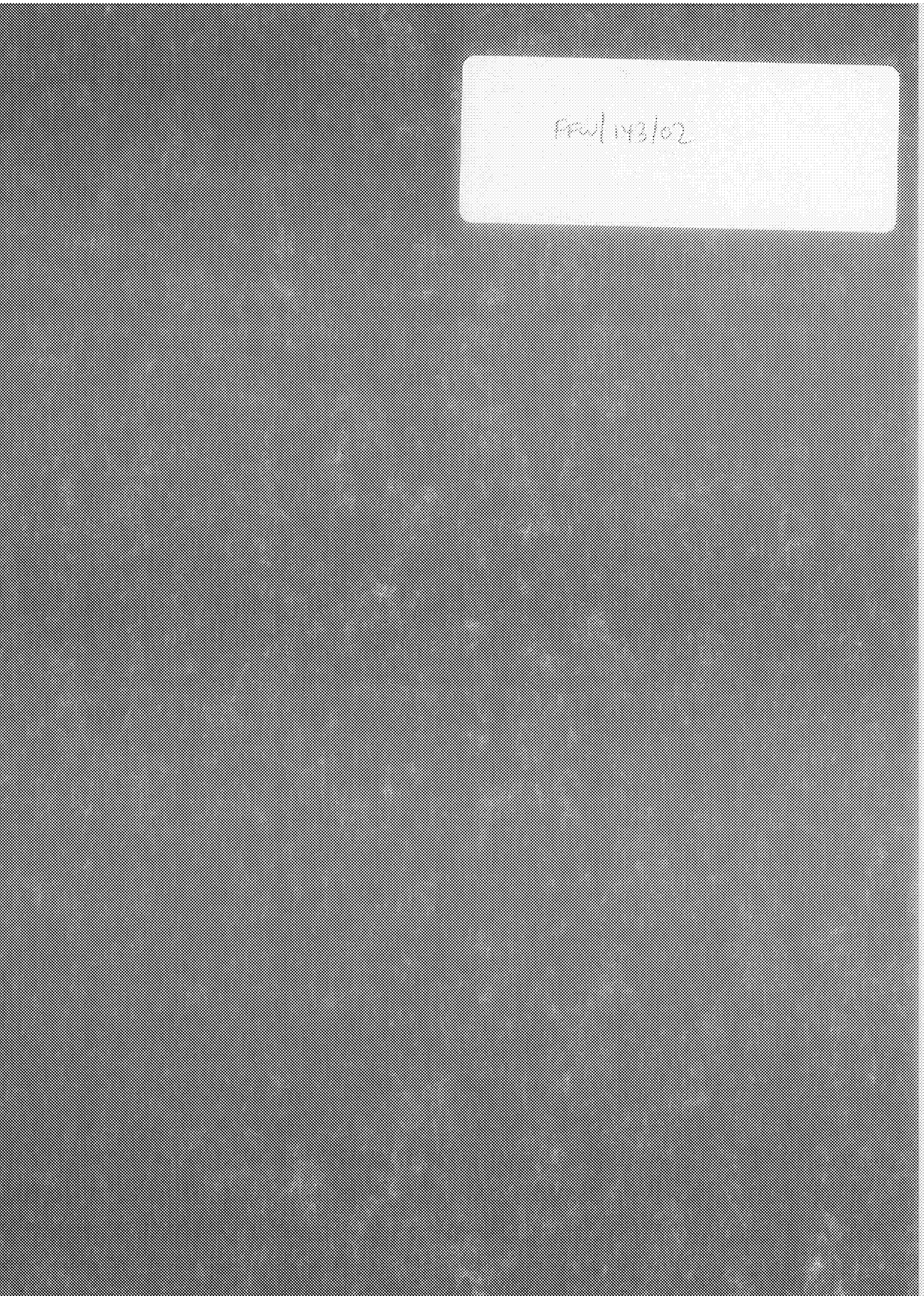

HAMPSHIRE CONSTABULARY

44

GMC AND BARTON INDEX OF FILES RECEIVED FROM HAMPSHIRE POLICE ON 18 JANUARY 2007.

1. Index of all evidence obtained
2. Generic Case File
3. Generic Case File (exhibits)
4. Generic Case File (exhibits)
5. Generic Case File (further exhibits)
6. Generic Case File further evidence re: Devine, Cunningham and Lake
7. Generic Case File further evidence - interviews with Dr Reid
8. Devine Volume 1
9. Devine Volume 2
10. Devine Additional Evidence
11. Devine Hospital Medical Records
12. Spurgin Volume 1
13. Spurgin Volume 2
14. Spurgin - further evidence
15. Spurgin - further evidence
16. Spurgin Hospital Medical Records
17. Spurgin Hospital Medical Records
18. Cunningham Volume 1
19. Cunningham Volume 2
20. Cunningham Hospital Medical Records
21. Cunningham Hospital Medical Records
22. Packman Volume 1
23. Packman Volume 2
24. Packman - further evidence
25. Packman police interviews with Dr Reid
26. Packman Hospital Medical Records
27. Lake Volume 1

28. Lake Volume 2
29. Lake Hospital Medical Records
30. Lake Hospital Medical Records
31. Service Volume 1
32. Service Volume 2
33. Service Hospital Medical Records
34. Service Hospital Medical Records
35. Gregory Volume 1
36. Gregory Volume 2
37. Gregory Hospital Medical Records
38. Gregory Hospital Medical Records
39. Wilson Volume 1
40. Wilson Volume 2
41. Wilson Hospital Medical Records
42. Wilson Hospital Medical Records
43. Lavender Volume 1
44. Lavender Volume 2
45. Lavender Hospital Medical Records
46. Lavender Hospital Medical Records
47. Lavender Hospital Medical Records
48. Pittock Volume 1
49. Pittock Volume 2
50. Pittock Hospital Medical Records
51. Further evidence re: Wilson, Lavender & Pittock
52. GP Records for Spurgin, Pittock, Service, and packman
53. GP Records for Devine, Cunningham and Lavender
54. Copy Extracts from Patient Admission Records
55. Extracts from controlled drugs record book dated 26 June 1995 - 24 May 1996

56. Richards (Eversheds) file: 1 of 2
57. Richards (Eversheds) file: 2 of 2
58. Richards: Medical Records
59. Richards: Further Medical Records
60. Richards: Further Medical Records
61. Richards (Police) - Witness Statements file
62. Richards (Police) - Transcripts of Interviews file
63. Page (Experts' Reports and Medical Records)
64. Wilkie (Eversheds) file: Experts' Reports and Medical Records
65. Clinical Team Assessments for Page, Cunningham, Wilkie, Wilson and Richards.
66. Clinical Team Assessments for Devine, Gregory, Lavender, Packman, Spurgin, Lake and Pittock

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
1	Name: **ALAN WILLIAM LAVENDER** Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
2	Name: Code A Address (HOME): Code A Occupation: HOME HELP Date of Birth: Code A Telephone: HOME Code A E-mail address:			
3	Name: **ALTHEA EVERESTA GERADETTE LORD** Address (HOME): Code A Occupation: CONSULTANT GERIATRICIAN Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
4	Name: **SHEELAGH ANN JOINES** Address (HOME): Code A Occupation: RETIRED RGN Date of Birth: Code A Telephone: HOME Code A E-mail address:			
5	Name: **YVONNE ANN ASTRIDGE** Address (HOME): Code A Occupation: NURSE Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
6	Name: **CHRISTINE JOICE** Address (HOME): **Code A** Occupation: STAFF NURSE E GRADE Date of Birth: **Code A** Telephone: HOME **Code A** E-mail address:			
7	Name: **JUDITH COOKE** Address (HOME): **Code A** Occupation: RETIRED NURSE Date of Birth: **Code A** Telephone: HOME **Code A** E-mail address:			
8	Name: **PATRICIA ELIZABETH WILKINS** Address (HOME): **Code A** Occupation: SENIOR STAFF NURSE Date of Birth: **Code A** Telephone: HOME **Code A** WORK **Code A** E-mail address:			
9	Name: **PAMELA SUSAN RIGG** Address (HOME): **Code A** Occupation: COMMUNITY STAFF NURSE Date of Birth: **Code A** Telephone: HOME **Code A** WORK **Code A** E-mail address:			
10	Name: **CHRISTINE MARY DOLAN** Address (HOME): **Code A** Occupation: STAFF NURSE Date of Birth: **Code A** Telephone: HOME **Code A** WORK **Code A** E-mail address:			

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
11	Name: **MARY ELIZABETH MARTIN** Address (HOME): **Code A** Occupation: RETIRED Date of Birth: **Code A** Telephone: HOME **Code A** E-mail address:			
12	Name: **MARGARET ROSE COUCHMAN** Address (HOME): **Code A** Occupation: STAFF NURSE E GRADE Date of Birth: **Code A** Telephone: HOME **Code A** E-mail address:			
13	Name: **GERALDINE BROUGHTON** Address (HOME): **Code A** Occupation: RETIRED NURSING SISTER Date of Birth: **Code A** Telephone: HOME **Code A** E-mail address:			
14	Name: **FIONA LORRAINE WALKER** Address (HOME): **Code A** Occupation: SENIOR STAFF NURSE Date of Birth: **Code A** Telephone: HOME **Code A** E-mail address:			
15	Name: **IRENE MARGARET DORRINGTON** Address (HOME): **Code A** Occupation: STAFF NURSE E GRADE Date of Birth: **Code A** Telephone: HOME **Code A** E-mail address:			

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
16	Name: **MARGARET WIGFALL** Address (HOME): **Code A** Occupation: STATE ENROLLED NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
17	Name: **CATHERINE JEAN MARJORAM** Address (HOME): **Code A** Occupation: SENIOR STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
18	Name: Code A Address (HOME): Code A Occupation: HEALTHCARE SUPPORT WORKER Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
19	Name: Code A Address (HOME): **Code A** Occupation: HEALTH CARE SUPPORT WORKER Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
20	Name: Code A Address (WORK): Code A Occupation: Date of Birth: Code A Telephone: MOBILE Code A WORK Code A E-mail address:			
21	Name: WENDY ANN EDGAR Address (HOME): Code A Occupation: STUDENT NURSE Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
22	Name: POLICE CHRISTOPHER SCOTT YATES Address (): Occupation: Detective Constable Code A Date of Birth: Telephone: E-mail address:			
23	Name: POLICE GEOFFREY JAMES QUADE Address (): Occupation: Detective Constable Code A Date of Birth: Code A Telephone: E-mail address:			

/ F1 / F2 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: LAVENDER, ALAN WILLIAM

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

This statement (consisting of 3 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: A W LAVENDER Date: 19/05/2004

I am Alan William LAVENDER and I reside at an address known to Hampshire Police. I am making this statement about the care that my mother received at the Gosport War Memorial Hospital and her subsequent death.

My mother was Elsie Hester LAVENDER nee Code A and was born on Code A Code A Elsie had a younger brother Thomas William Henry BRYANT who unfortunately died around 1993 or 1994. My mother married George William Albert LAVENDER on 23rd December 1934 (23/12/1934) and I was there only son. My father died in 1989 and my mother continued to live alone at the family home, which was Code A Gosport. I took early retirement in 1990 and moved to Warsash in order to be closer to her.

My mother was diagnosed as suffering with Diabetes in 1942 and was insulin dependant right from the start. Mum was more than capable of managing her insulin and diabetes. Other than diabetes mum had slight rheumatism and was partially blind in her later years due again to the Diabetes. Other than this she was healthy and a very strong and independent woman and remained so right up to the day she was admitted to hospital in February 1996. She coped with her housework and washing and was a very family orientated person. She did have a home help and a nurse would attend from her surgery twice a day to assist mum with her insulin regime. My mother belonged to the Forton Road Surgery since she was first married and in the later years Dr. Jane BARTON became her GP. Mum had been taken into hospital on a couple of occasions after she had become 'Hypo', they would stabilise her diabetes and send her home

In early February 1996 I received a telephone call from Code A who was my mothers

home help and informed that she had fallen and been taken to the Royal Navy Hospital at Haslar. Mum was in Haslar Hospital for several days before we were told that she had suffered a brain stem stroke, which apparently is a very painful type of stroke. However she was sat up in bed almost from the start. She was obviously in pain, not only from the stroke but the fall as well; she had not fractured any bones but had cut her head open. I was shocked to find that she had had a stroke as up to then I assumed it was an incident due to her diabetes.

Mum remained in Haslar Hospital for two or three weeks and underwent physiotherapy. Her progress was excellent, so much so that the Occupational Therapist spoke to me about preparing her home ready for her to return to it. Mum was now talking to others coherently and understanding what was being said to her. She had also learned to walk with the assistance of a frame. The care that my mother had received at Haslar Hospital was excellent in my opinion. On my last visit to Haslar Hospital the physiotherapist was trying to arrange an adjustable walking stick that mum could take with her when she was discharged. He returned shortly and said that she would not need it as she was going to go to the Gosport War memorial Hospital for rehabilitation.

Mum was very coherent at that time and was always checking that we had fed her cat. The cat was a problem for us as she had had it for many years and it would not let anyone go near it except for mum. We had wanted to sell mums house and move her into a warden controlled flat as we felt it would be better for mum to have constant assistance at hand. Dr. BARTON agreed with this. The nurses would probably still have had to visit twice a day because of her insulin injections. Mum would not move because of the cat and the cat could not be re-homed anyway because of its bad temperament. Mum also referred to the warden assisted flats at Clarence Square as Barracks and was adamant that she would not move into them

My mother was admitted to Daedelus Ward at the Gosport War Memorial and was immediately placed in a room on her own. Just after she arrived a nurse came in and conducted a test, which I believe was for Alzheimer's. It involved answering a lot of questions like what was her mother's maiden name and having to remember a word that she was told at the start of the test and repeat it when asked at the end. Mum passed this test with ease.

Staff at the Royal Navy Hospital at Haslar had told me that mum was just going to the Gosport War Memorial Hospital for rehabilitation and my wife and I visited daily as well as feeding her cat. Within two or three days of being at the Gosport War Memorial Hospital I had an appointment to see Dr. BARTON. I asked when she would be able to go home and said that we needed to know as we would have to get rid of the cat if we were going to get her a warden controlled flat.

Dr. BARTON replied, "you can get rid of the cat." I was stunned with the way she said this.

Dr. BARTON then said, "you do know that your mother has come here to die!"
I did not know that this was the case; I believed that my mother had gone to this hospital for rehabilitation. I could not believe the cold and callous way that Dr. BARTON had broke this news to me, it was as if her death had been predetermined. I was that shocked I did not ask any more questions even though I had a number that required answers. On reflection I should have seen this coming as I had asked the same question of a sister on Daedelus ward and was told that I had better speak to Dr. BARTON. I cannot remember this sister's name but she was a sister at Northcott House previously and my mother knew and trusted her.

Soon after my meeting with Dr. BARTON I noticed that mum had been placed on a syringe driver . Mum had actually said to me on one occasion, " I don't like that thing" and pointed at the driver. I assumed that the syringe driver was for pain relief but did not know what drug was being administered by it.

My mother's health deteriorated quite quickly. On one occasion we visited she appeared unconscious and smelt awful. It really was difficult to be near her because of the smell. I looked at the medical notes and saw that there was an entry stating 'leaking faeces'. Mum was always very proud of her appearance and spotless she would have hated to be in this state.

About two to three days after this visit, on 6th March 1996 (06/03/1996) I received a telephone call from the Gosport War Memorial stating that she had died. The death certificate had been

/ F1 / F2 RESTRICTED

certified by J.A. BARTON BM and gave the cause of death as Cerebralvascular accident and Diabetes Mellitus. We buried my mother at Code A (plot Code A).

I am concerned about the rapid deterioration of my mother when she initially went to the Gosport War Memorial hospital for rehabilitation. I am also concerned about the callous way that we were treated by Dr Jane BARTON and cannot help wondering if mum's death was partly down to her refusal to go into a nursing home, which was placing a financial burden on Dr. BARTON's surgery as she had to supply a nurse twice a day.

I am a realistic person and accept that my mother was an elderly lady and at that time was one of the longest standing insulin dependant people. However she appeared to be making a full recovery from the stroke, was alert, lucid and other than a little pain in her shoulder was not complaining of pain. Mum did not make an issue of the pain in her shoulder but it was obvious that she was at least a little tender as she did not like people touching it and would ask them to be careful if they got near to it. It was not until her final day that I realised that she was being administered Diamorphine through the syringe driver. I was not informed of this by any staff despite visiting nearly every day with my wife.

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

This statement (consisting of 3 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: 07/12/2004

I live at the overleaf address with my husband.

Before I retired in 1997 I was employed by Hampshire County Council Social Services as a Home Carer, formerly known as a Home Help. The local office initially was opposite St Vincent in Forton Road Gosport, but latterly, above Waitrose Store in Stoke Road Gosport.

I was so employed for 20 years or so. I suppose I was responsible for four or five clients per day, male and female.

One of these clients was Elsie LAVENDER , who I called Mrs LAVENDER. I would call and see her at Code A , 3 days per week, one hour a day, on Monday, Wednesday and Friday. I suppose I was with her for four years or so. My responsibilities were cleaning in the main, but I would always check that she had taken her medication, because I knew that she needed insulin for Diabetes. I would also occasionally take her shopping.

I would generally call on Mrs LAVENDER at between 1200 and 1230 hrs.

I recall that she was generally in good health and fiercely independent.

As I have she suffered with Diabetes which did affect her sight. I would say that she was partially sighted, and had a white stick. I believe she had arthritis in her legs and I recall she may have had a back problem. However she was a fairly active old lady who went out shopping on her own often.

RESTRICTED

Continuation of Statement of: Code A

In February 1996, I'm not sure of the day I called on Mrs LAVENDER as usual between 1200 and 1230 hrs. She either usually let me in, or left the door ajar. However on this day the door was ajar but I was unable to gain entry because she had collapsed across the inside of the front door.

I had to gain access to the house via the rear entrance and found Mrs LAVENDER at the foot of the stairs across the front door. She was conscious, and I put her in the recovery position and called for an Ambulance. I then contacted her son Alan and my office to report what I had found. The Ambulance arrived and took her to Haslar Hospital .

Taken by: Code A

Signed: Code A

Signature Witnessed by: Code A

2004(1)

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: LORD, ALTHEA EVERESTA GERADETTE

Age if under 18: Over 18 (if over 18 insert 'over 18') Occupation: COMMUNITY GERIATRICIAN

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: 10/12/2004

I am Doctor Althea Everesta Geradette LORD and I am currently employed by the East Hants Primary Care Trust as a Community Geriatrician for Fareham and Gosport Primary Care Trust. I have held this position since the 21st June 2004 (21/06/2004).

In 1978 I graduated from the Faculty of Medicine at the University of Sri Lanka, Colombo. I obtained an MB (Bachelor of Medicine) and a BS (Bachelor of Surgery).

In 1983 I obtained a post graduate qualification as a Doctor of Medicine at the University of Sri Lanka, Colombo.

I worked at the General Hospital, Colombo as a Senior House Officer and a Registrar in General Medicine until May 1984.

From May 1984 I was employed as a Registrar in Nephrology under the supervision of Professor Code A at the Renal Unit at St Mary's Hospital, Portsmouth. I held this position until October 1985.

Between October 1985 to September 1988 I was employed as a Registrar in Geriatric Medicine at St Mary's and Queen Alexandra Hospitals, Portsmouth .

From October 1988 until March 1992 I was employed as a Senior Registrar on a rotation between Southampton and Portsmouth Hospitals.

RESTRICTED

From the March 1992 until June 2004 I was employed as a Consultant Geriatrician for the Department of Medicine for older people in Portsmouth. During this period I worked at Queen Alexandra, St Mary's and Gosport War Memorial Hospitals .

In 1997 I obtained a F.R.C.P which is the Fellowship of the Royal College of Physicians.

My General Medical Council Registration Number is Code A

Between 1996 and June 2004, as a Consultant Geriatrician, my responsibilities included:-

In-patients at Queen Alexandra Hospital.
In-patients at Daedalus Ward of Gosport War Memorial Hospital.
In-patients at Kingsclere Rehabilitation Ward at St Mary's Hospital.

I also conducted Day Hospital sessions at :-
Amulree Day Hospital at St Mary's Hospital
Dolphin Day Hospital at Gosport War Memorial Hospital

These sessions alternated every week.

In addition I held out-patients sessions weekly at St Mary's Hospital and out-patient sessions on the first, third and fifth weeks at Gosport War Memorial Hospital.

I was consultant for all these patients who required specialist care for their physical health.

All these patients would have been over the age of 65 years.

During 1996 I would have been making weekly ward rounds as consultant responsible for Daedalus Ward of Gosport War Memorial Hospital. A ward round would involve seeing each patient on the ward in turn and making a note on the clinical notes of the patient.

RESTRICTED

This responsibility together with my out-patient sessions and Dolphin Day Hospital sessions meant that I would attend Gosport War Memorial Hospital at least once, but most often twice a week.

When not at Gosport War Memorial Hospital I was available to be called to the hospital or to provide advice should there be any problem that required me to see or provide advice on the care or treatment of a patient.

I have been asked what involvement I had as consultant in charge in the care and treatment of a patient called Elsie LAVENDER date of birth Code A Mrs LAVENDER was an in-patient on Daedalus Ward of Gosport War Memorial Hospital from 22nd February 1996 (22/02/1996) until her death on 6th March 1996 (06/03/1996).

I first wish to state that I have no personal recollection of any involvement with Elsie LAVENDER.

From Friday 23rd February 1996 (23/02/1996) until Monday 18th March 1996 (18/03/1996) I took a period of annual leave.

During this short period of absence it is unlikely that there would have been any locum consultant cover employed. Should any matter arise that required any input at consultant level then this could be sought through contact with the Elderly Medicine Department of the Queen Alexandra Hospital.

I have examined copies of the medical records of Elsie LAVENDER bearing the exhibit reference Code A

From my examination of these notes/medical records I have found no entries or notes to indicate that I had any direct contact with Elsie LAVENDER or that any contact was made with me regarding the care/treatment of this lady.

RESTRICTED

I note that my name does appear on page 9 of 10 which is a copy of a 'Discharge Spell Summary Form. My name appears against the heading 'Consultant' and shows as Dr A LORD. This is technically correct as although on a period of leave I note that Mrs LAVENDER was admitted to Daedalus Ward which was the ward which I had responsibility for at that time.

My name also appears at page 141 and 142, a 'Prescription Chart' against the heading of Consultant.

At page 148 and 150 a General Information Card against the heading of Consultant.

At page 161 and 162 a copy of 'Pressure Sore Documentation Form' against the heading of consultant.

This has been documented correctly as I was the consultant at the time with a responsibility to Daedalus Ward.

This is done as a starting point for staff as a point of contact for matters requiring a consultant input.

I would not be expected to be contacted during a period of leave or absence regarding a patient particularly if I had had no input into the treatment or care of that patient.

As far as I am aware there was and still is not any formal/written instructions for the provision of cover in the event of absences/leave of consultants.

However as a department we would ensure that intended leave and absences due to illness were notified as soon as were known and ensure that a consultant was available to cover any problems that may arise on a 'trouble shooting' basis. In the event of long periods of absence then 'locum' consultant cover may be sought. This would be arranged by the Clinical Director of the department and the hospital Medical Staffing Department. 'Locum' cover would be sought if the Clinical Director felt there were insufficient consultants to provide the necessary

RESTRICTED

cover for the responsibilities of the department.

The consultant arranging a period of absence was not responsible for arranging 'Locum Consultant cover' during their period of absence.

Prior to any arranged period of absence then a verbal handover would be made to the covering consultants informing them of any particular problems.

Taken 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: JOINES, SHEELAGH

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

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: S A JOINES Date: 12/02/2003

I am the above named person and I live at the address overleaf. I began my training as a nurse in 1955 at the Royal and Queen Alexander Hospital in Portsmouth. I qualified in August 1958 as a State Registered Nurse and went on to qualify as a midwife in 1960 at Beckenham in Kent.

In 1961 I married my husband who was in the RAF. In 1963 we were stationed in RAF Changai where I worked as a civilian sister for about 2½ years. I returned to England in 1966 and I began working at the GWMH as a staff nurse on the female ward. I worked there until 1968 when I adopted a son. I gave up work and had a daughter in July 1969.

In March 1970 we moved to South Africa where I again started work as a nurse at the Vordrekkerhoogte Military Hospital. I was a sister on a general ward leaving in 1971. I then worked in Nedpark Hospital Arcadia as a sister for about a year. In early 1973 we returned to Gosport in the UK.

Having returned to England I began working again at the GWMH, I was a staff nurse on the male ward for about two - three months and then began work at Northcote Annex as a sister for about 18 months. This was a geriatric ward, the first one I had worked on.

I then had a period of 18 months on a children's ward before going back to Northcote Annex where I worked for about a year before returning to the children's ward. I think this would have been about 1977.

In 1979 until 1997 (rough dates) I worked on the male ward at GWMH as a sister, dealing with

medical, surgical, geriatric and terminal care patients. During that period the male ward moved to Daedalus Ward in 1993. The male ward at the GWMH came under GP's but Daedalus Ward was under the control of a consultant, Dr LORD . I enjoyed a good working relationship with Dr LORD, who in my opinion was an excellent doctor.

The other doctor who worked on Daedalus Ward was Dr Jane BARTON , who was the clinical assistant. Dr BARTON would make the early morning visits and review the patients. I found Dr BARTON to be one of the best doctors I worked with. She is a very caring lady and someone I would describe as compassionate, she is a fair lady and someone who valued the opinion of her staff. She is still my GP and someone I trust and respect highly. Although we had a first class working relationship we never went out socially.

Although Daedalus Ward was there to cater for rehab patients in my opinion this was not always possible. We would take stroke rehab where it was not always possible to rehabilitate them. We did rehabilitate some patients and got them home or into nursing homes. The rest of the beds in the ward were long stay patients. Many of these patients were at the hospital for respite care. However if it was felt that their relatives were unable to cope with them at home they would then be transferred into a long stay bed. This decision would be made by Dr LORD.

Whilst working I was involved in terminal care of very ill patients. There were people who were so ill they were expected to die. It was always my aim to give these people care, comfort and dignity. I was given instruction in the use of syringe drivers. These provided patients with 24 hour pain relief, normally for patients who were unable to swallow oral analgesics. We could also administer sedation and drugs to dry up secretions.

Only a doctor could authorise the use of a syringe driver, they would be put up by two trained nursing staff and with the consent of the patients family. With regard to the very ill patients for whom there was no further treatment who were in pain or distressed, I would inform the family that the use of the syringe driver would lead to a peaceful, dignified death. The use of the syringe driver did not accelerate the process of dying. In the four years I was at Daedalus only one family declined and asked for treatment by antibiotics. This was done as per their request.

RESTRICTED

Whilst at Daedalus Ward some patients would suffer from pain for a period of time prior to being seen by Dr BARTON. This was because quite rightly the patients were being seen by partners of Dr BARTON who did not know the case history and were therefore unwilling to prescribe analgesic drugs required by the patients.

To that end it was agreed by Dr LORD, Dr BARTON and myself that Dr BARTON would prescribe medication prior to it being required. This was done in case a patient deteriorated and needed the drugs that had been prescribed. The prescriptions were written up as a patients admission in case they were needed, not as a matter of routine. I do not know if this practice was used on other wards.

Once the drug had been prescribed if and only if the patient deteriorated I would inform Dr Code C and tell her I thought the time had come for the drugs to be given. I would see the relatives and discuss the situation with them in detail, involving the outcome and only if they agreed I would speak to Dr BARTON again informing her the family had given their permission and on her authority commence a syringe driver on minimal dosage given the scale as laid down by Dr BARTON. Any increase in dosage could only be authorised by Dr BARTON.

Dr BARTON would only give her permission to start a syringe driver, a few hours after having seen the patient and was fully aware of their medical condition and the need for a syringe driver. At no time did Dr BARTON and I ever disagree about the use of syringe drivers. I have never had any concern about the use of syringe drivers or the drugs given under the direction of Dr BARTON. Had I been worried I would have questioned Dr BARTON had she failed to answer me in a satisfactory manner I would have spoken with my manager or Dr LORD.

I am not aware of any trained or auxiliary staff voicing concern about the use syringe drivers. I am not aware of any of the families I dealt with making complaints about syringe drivers or Dr BARTON.

In my opinion as a result of the current investigation many people will not get the pain free,

RESTRICTED

dignified deaths they would otherwise have had.

In January 1997 I retired from the GWMH. Since then I have worked as a night nurse co-ordinator which is a clerical post based at Waterlooville.

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: JOINES, SHEELAGH ANN

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

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: S A JOINES Date: 13/10/2004

I am Sheelagh Ann JOINES and I live at an address known to the Police.

Further to my previous statement made to the Police on 12th March 2003 (12/03/2003), I would like to add the following; my current role is that of a Night Nurse Coordinator at St Christopher's Hospital in Fareham. I have held this position for some 7 years since my retirement from Nursing.

In 1996 my role at the Gosport War Memorial Hospital was that of Sister in charge of Daedalus Ward. On a day to day basis I was responsible for the running of the ward in general. My responsibilities also included the clerical work, and accompanying the Doctor on the Ward round, usually between 0800 and 0830 hrs.

I am unsure who my line manager was at this time, it could have been Isobel EVANS , Barbara ROBINSON or Sue HUTCHINGS who would have held the position of what we used to call Matron, the person who is charge of the staff is the best way I can describe it.

My weekly hours of work at that time were 371/2. My duties, as far as I can recollect were from 0730 to 1330, 0730 to 1630/1700 and 1215 to 2030.

I was not certified to use IV drugs, and in any event these were not used on the ward at that time.

I have no knowledge of the term Wessex Protocols, but if it means the analgesic ladder, I am of course familiar with that.

RESTRICTED

I am fully trained in the use of syringe drivers but I am unsure what type of driver was being used at the time in question.

With regards to training for nurses regarding syringe drivers I had been trained in their use, But I can't remember now by whom. It could have been someone from the company that supplied it, a trained nurse, or a Marie Curie or Countess of Mountbatten nurse who would use them far more often that we would. The training would have been for a day at the most but probably less than that. It quite a simple procedure and I have trained it myself. The training consists of how to set up the syringe driver and how to put the required dose into the driver. Trained nurses only would be allowed to use such equipment. Health care and support workers would not.

At this time the there were two teams of nurses, the red and blue teams. The named nurse was the person in overall charge of each of those teams.

The time and date of all entries in the patient notes were usually completed first thing in the morning after handover or done on the day.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I can say that I have no recollection of this patient, but after referring to her medical notes, exhibit reference BJC/30 pages 131,151, 153, 200 to 228 and a letter page 13.

I can confirm that on the 23rd February 1996 (23/02/1996), page 131 I wrote the following on what I believe to be a Diabetes prescription nursing record:

Date	Time	Drug Name and Dose	Reason	Signature
23/2/96 (23/02/1996)	1730	Mixtard Insulin	Blood Sugar 8	S JOINES

With reference to this I can now see that I did not record the actual dose of insulin, which is not like me and I have no explanation as to why. This particular type of insulin is subcutaneously injected just under the skin, usually in the abdomen, upper arm or thigh

RESTRICTED

The blood sugar figure is a sign of whether the diabetes is controlled. The reading 8 is satisfactory.

I must say that I really do not recognise this form, after all this time.

I can confirm that also on the 23rd February 1996 (23/02/1996), page 151 I wrote the following at 1720 hrs on what I believe to be the Kardex admission notes - Pathology phoned- Platelets 36? Too small sample. To be repeated Monday. Dr BARTON informed - will review. This entry is signed by me.

With reference to this entry I believe this to mean that not enough blood was taken, therefore it was not possible to do a full blood count. To repeat and take more blood on Monday, the right amount. Platelets are concerned in the make up of blood. I am not familiar with chemical pathology records so I am unable to comment on any attempt to cross reference the two records.

I can confirm that in a letter from Dr JC TANDY (Consultant Physician in Geriatrics) which reads;

Elsie LAVENDER, DOB Code A

I think the most likely problem here is a brain stem stroke leading to her fall. I note she has iron deficient anaemia. Upper GI investigation might be helpful as, in view of the atrial fibrillation, one might want to consider Aspirin here (I would be reluctant to consider Warfarin as I think she's going to be at great risk of falling). Alas, I don't think her brain stem stroke would show up particularly well on a CT and were now 11 days post-ictus.

I'll get her over to Daedalus Ward, Gosport War Memorial Hospital, for rehab as soon as possible. I'd be grateful if her notes and x rays could go with her.

Thank you for asking me to see her.

Yours sincerely

Signed: S A JOINES

Signature Witnessed by: Code A

RESTRICTED

Dr JC TANDY

Consultant Physician in Geriatrics

CC Dr EJ PETERS , the Surgery, 149 Forton Road, Gosport, P0123HH

Sister S JOYNES, Daedalus Ward, GWMH.

I am shown as being a recipient of this letter, I believe purely because I was the Sister in Charge of the Ward and for no other reason. As I have said I have no recollection of this patient. I don't know Dr TANDY personally, but I know of her.

On Daedalus Ward at that time there were 8 stroke beds and 14 geriatric long stay beds.

I can confirm that on page 153 of Exhibit BLC/30 dated 25th and 26th February 1996 (26/02/2004), I wrote the following 1900 hrs on 25/2/96 (25/02/1996).

Appears to be in more pain, screaming "My back" when moved but uncomplaining when not. Son would like to see Dr BARTON; this entry was signed by me.

On 26/2/96 (26/02/1996), I wrote the following;

Seen by Dr BARTON MST> 20mgms BD. She will see Mr LAVENDER @ 1400 hrs this afternoon. I did phone him. Blood sugars 20> this entry was signed by me

Insulin dose increased

1430 hrs - Son's wife seen by Dr BARTON- prognosis discussed. Son is happy for us to just make Mrs LAVENDER comfortable and pain free. Syringe driver explained.

1440hrs- All mattress needed changing- 10 MST mgms given prior to moving on to Pegasus mattress.

The meaning of this is almost self explanatory in that the use of the syringe driver was explained to Mr LAVENDER junior's wife in order for the patient to be comfortable and to be

RESTRICTED

free from pain.

MST means Morphine Slow release Tablets were used as Mrs LAVENDER was not responding, it was not controlling the pain.

The Pegasus air mattress was required for release of pressure from bed sores.
I can confirm that on page 151 of Exhibit BJC/30, dated 24/2/96, I wrote the following

Pain not controlled properly by DF 118. Seen by Dr BARTON- boarded for MST 10Mgs BD, this entry was signed by me.

I knew that the pain was not being controlled by observing that the patient was in pain when moved. Another reason would be that the patient informed us of pain.

Because of this I informed Dr BARTON who visited and boarded for MST 10 Mgs twice a day. This was usually at 0600 and 1800

Boarded means, written up or prescribed in treatment sheet
BD means twice a day
DF 118 is a strong Analgesic tablet
Dr BARTON increased the MST to 20Mgs on 26/2/96 (26/02/1996)
This is shown on page 145 of BJC/30, the prescription charts.

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: ASTRIDGE, YVONNE ANN

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

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: Y ASTRIDGE Date: 25/10/2004

I am Yvonne Ann ASTRIDGE and I live at an address known to the Police. I am a Clinical Manager (RGN) at Gosport War Memorial Hospital and I have 25 years experience in the Nursing profession.

I began my training in 1979 at the Nightingale School of Nursing at St Thomas's Hospital London and qualified as an RGN in 1981, my pin number is Code A

From 1981 I was employed as a Staff Nurse at St Thomas's Hospital, London where I worked on a night pool for three months and for the next three months on an elderly care ward.

From 1985 to 1986 I worked at the Royal Free Hospital in London as a Staff Nurse on a medical ward

From 1982 to 1984 I worked at Abingdon Hospital as a Staff nurse on a GP ward with a maternity annex

From 1986 to 1987 I worked as an RGN Nursing Officer at a Nursing Home, where when on duty I was in charge of the Nursing Home, its staff and the care given to elderly clients. I was also responsible for recruitment of staff

From 1997 to 1998 I was employed as a Staff and Senior Staff Nurse at the Gosport War Memorial Hospital where I assisted the Clinical Manager (Ward Sister) in the administration of the Department and took an active roll in the development of nursing practice, where I was involved in the rehabilitation of stroke patients and I ran an NVQ group to help other Nurses

study for NVQ qualifications.

From 1998 until 2004 I worked at St Christopher's Hospital in Fareham, on Rosewood Ward and latterly Shannon Ward this is a hospital for the elderly.

I recently returned to Gosport War Memorial Hospital where I am currently employed as the Clinical Manager (Ward Sister) on Dryad Ward.

I am an extremely experienced Nurse having kept up to date with all of my courses including stroke handling and positioning, critical companionship, stroke rehabilitation safe movement and handling of loads, care of the elderly and social services guidelines for the placement of patients.

I am also the holder of a City and Guilds Certificate in further and adult education and a further City and Guilds qualification for assessing a candidate's performance, and assessing candidate using diverse evidence. I also hold an English National Board qualification in the care of the elderly.

In 1996 I was the Senior Staff Nurse on Daedalus Ward at Gosport War Memorial Hospital where I would run the ward in the absence of the ward manager. But my primary role was that of patient care. At that time my line manager was Sheelagh JOINES .

I have had training in the use of IV drugs, but last used them in London in the 1980's. I have not given IV drugs in Hampshire.

The term Wessex Protocols, refers to the Palliative Care Book, used for guidance in what drugs are to be used in that care. I believe that these guidelines were used at the Gosport War Memorial Hospital.

Before 1996 I think it was, I had training in the use in the setting up of syringe drivers . This training would have been purely sessions on the ward. I believe that the brand of syringe drivers

RESTRICTED

used at that time was "Gravesby" and in fact I'm sure these are still used today.

There was formal training in the use of syringe drivers but I am unsure if this was before 1996. There have also been Syringe Driver refresher courses at the Queen Alexandra Hospital .

The Named Nurse is the nurse responsible for overseeing the care of patients, in broad terms. The named nurse does not actually need to do it.

My working hours in 1996 were 37½ hours per week and my tour of duty would have been;

0730 - 1615 for 2 days
0730 - 1330 for 1 day
1215 - 2030 for 2days

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I can say that I have no recollection of this patient, but after reference to her medical notes (exhibit Code A pages 95, 97, 99, 103, 105, 107, 109, 111, 113, 115, 117, 119, 121, 137, 151, 153, 167, 169, 171and 173, I can confirm that on the 27th February 1996 (27/02/1996) page 95, I was shown as the named nurse in the nursing care plan of Elsie LAVENDER which states that ,The problem, "the patient has painful shoulders and upper arms." The desired outcome is "To relieve pain and make Elsie more comfortable" The desired action is "Position patient for comfort. Elsie can lift her arms if given time and dependent on pain. Administer analgesia as prescribed and monitor effectiveness". I have no recollection of this document. On looking at this care plan however I would say that the nursing action in relation to drugs is satisfactory.

I can confirm that on page 97 of the nursing care plan dated 2nd March 1996 (02/03/1996) it is written "slight pain in shoulders when moved" This is signed Y ASTRIDGE and Code A This is neither my writing nor my signature. It was policy at that time that a Healthcare support worker should have any entry countersigned, or a trained member of staff could sign an entry. I rather feel that Code A the health care support worker signed this entry. The account given

should and would be in order.

I can confirm that on page 99 of the notes, dated 22nd February 1996 (22/02/1996) the following is written in the nursing care plan, the problem, "Restricted mobility" The desired outcome "To increase mobility and encourage independence" the Nursing Action, "To assist Elsie to transfer from bed to chair x 2 nurses. Refer to physiotherapists" I didn't start this care plan. My name is at the top means that I am the named nurse, not that I wrote the entry. This is not my writing nor do I recognise whose it is. I would add that if it is painful for the patient to get up then they remain in bed. The patient has the final say if they get up or not.

I can confirm that page 103 and 105 of the notes is a nursing care plan dated the 22nd February 1996 (22/02/1996). and reads, the problem," Unable to care for hygiene needs unaided" The desired outcome," To promote an adequate level of hygiene" the nursing action " Assist to wash and dress daily, offer a bath regularly. Ensure hair teeth and nails are cared for. Encourage independence where possible" This entry of page 103 is written by me but page 105 which is a continuation for page 103 is not. I would add that patients are asked if they can wash and clean their teeth. If not, this should be done with assistance from a nurse. A care plan means a plan of how to address a problem which the patient has. If there is no problem then there is no care plan. In general there is a specific care plan for every problem.

Page 107 dated the same day is another nursing care plan with the named nurse, SSN.Y ASTRIDGE; this is not in my writing and states, Problem, "leg ulcer on R leg and dry skin." Desired outcome" To aid healing." Nursing action," Dress alternate days with kattostat soaked in n/saline, cover with NA dressing and 9x9- bandage. Apply emulsifying ointment to both legs. Even though I am the named nurse I would not necessarily issue such instructions. N/saline means normal saline.

Page 109 dated the same date is a continuation of page 107 regarding leg ulcers. This is not my writing.

Staff would interact with the patient by asking such questions that were necessary and recording

such in the notes. In 1996 it was common practice to ditto entries if those were unchanged, it not however practice now.

I can confirm that on page 111 and 113 of a nursing care plan dated the 22nd February 1996 (22/02/1996) I am shown as the named nurse, but this is not in my writing. The following is written, Problem, Indwelling urinary catheter. This means pertaining to a tube left within an organ for draining. Potential problems of, a) trauma b) infection c) Retention of urine. Desired outcome, to minimise the risk of trauma, infection and retention of urine. Nursing action; catheter care to be carried out daily. Monitor urine output and report. Test urine if infection suspected. Secure tube at catheter to leg to minimise trauma.

This is what I would call a bog standard care plan to assist the patient with the toilet.
The catheter would be inserted if the patient had retention of urine, in the main.
Permission of the patient is required to pass (insert) a catheter, or if that patient is incapable then a medical decision would be necessary. For the catheter to work correctly it should be clean and in working order. If the patient is in retention, with a large amount of urine in the bladder, then in turn it can cause back pressure on the kidneys. Of course once the patient is better then the catheter would be removed.

I can confirm that on pages 115 and 117 dated 21st February 1996 (21/02/1996) of a nursing care plan of Elsie LAVENDER, where I am shown as the named nurse, again this is not in my writing, and the following is written. Problem, red and broken Sacrum.

Desired outcome, to heal. Evaluate daily. Spray minute broken area with Betadene. Nursing action, 24/2/96 (24/02/1996) broken area sprayed with Betadene and signed by a nurse. The other entries are signed by other medical staff, not by me.

Betadene is an iodine spray which kills bacteria. It was a standard pressure sore treatment, but is not used in the same way now. I have reviewed the rest of the entries and it would appear that apart from the spray, iodine dressings were also used.

RESTRICTED

From viewing the notes I can see that on admission her sacrum was red, she was overweight, immobile and not able to get out of bed. On the 27th February 1996 (27/02/1996) the area was blackened, this is bad news for the sacrum.

The Sacrum is the triangular bone just below the lumbar vertebrae.

I can confirm that on page 119 of the notes dated 1st March 1996 (01/03/1996) to the 6th March 1996 (06/03/1996); I am again shown as the named nurse. These entries are not in my writing. The following is written, Problem, "Constipation due to medical problems". Desired outcome; "monitor bowel action daily. Give a high fibre diet and plenty of fluids. Give suppositories or enemas as required". Nursing Action; "Suppositories and enemas given with little result and patient continues to leak faecal fluid". These notes are written by other medical staff and not by me.

From viewing the notes I can see that the patient was not eating and drinking, therefore she was likely to be constipated. She was in pain and this would not encourage the bowels to open. The use of suppositories and enemas was a reasonable course of action.

I can confirm that on page 121 of the notes, dated the 22nd February 1996 (22/02/1996), that a nursing care plan was started. These entries are not in my writing and I do not recognise whose it is. I can say that the following page 123 is linked to page 121. The following is written; problem," Requires assistance to settle for night". Desired outcome, to ensure patient has adequate sleep. Nursing action, "transfers to seat with assistance of 2 nurses" On page 123 the entries range from 22nd February to 3rd March 1996 (03/03/1996) and appear to be a nightly record of her sleep pattern. It also shows analgesic given and records that medication was refused on 1st March 1996 (01/03/1996). I also observe that there are blank spaces on 25/2/.96 (25/02/1996), 27/2/96 (27/02/1996), 28/2/96 (28/02/1996) and 29/2/96 (29/02/1996). It was the practice back then that if there was nothing to report then it would be left blank.

I can confirm that on page 137 of the notes dated 5th and 6th March 1996 (06/03/1996) that this is a doctor's drugs prescription written by Dr BARTON . On 6th March at 0945 hrs I gave the

patient 100 mgs of diamorphine for pain relief and 40 mgs of midazolam as a sedative.

I can confirm that on page 151 of the notes Code A at 1700 on 22nd February 1996 (22/02/1996), this is an admission summary and written by me. I am unsure though if I actually admitted the patient. The entry states," 83 yr old lady, insulin dependant, registered blind, atrial fibrillation; (an irregular often rapid heartbeat) had a probable brain stem CVA 5th Feb 96 (05/02/1996). CVA means a Cerebrovsacular accident (Stroke). She now has problems with her grip in both hands and also experiences pain in arms and shoulders. She can transfer with 2 nurses. Seen by Dr BARTON, medication prescribed. Catheterised size silastic (a trademark for a substance similar to rubber) which drained 750 in the first hour? Retention. General bath given and leg ulcer on right leg redressed. Area on left leg appears healed". This entry is signed by me.

On 23rd February 1996 (23/02/1996) I have written, "Referred to physio, FBC ESR U's & E's taken". This entry is signed by me. FBC means Full blood count. ESR means check for sedimentation speed of erythrocytes when spun.

"S/B Dr BARTON. Antbiotics prescribed for probable UTI ". This entry is signed by me. UTI means urinary tract infection.

Transfer with 2 nurses' means that the patient can be got out of bed and into a chair, with a 90 degree turn with 2 nurses

S/B means seen by Dr and medication written up. U's and E's mean urea/creatine and electrolyte in bloods taken

I can confirm that on page 153 of the notes of Elsie Lavender dated 27th February 1996 (27/02/1996) that I have written "Bloods taken" This means that blood samples were obtained from the patient. I have no idea why these were taken. It could have been because of a spoiled previous sample, or some other results were required or that the patient's condition had deteriorated. This would probably have been authorised by a doctor, and a blood nurse would

RESTRICTED

have taken the sample.

I can confirm that on page 167 of the notes which is an abbreviated mental study dated 22/2, that I wrote the name Elsie Lavender on the top of the page. This is a mental test score of which the patient scored 10/10, which means that this lady had all her marbles.

On page 169 of the notes which is a Waterlow Pressure Sore Prevention/Treatment Policy dated 22/2/96 (22/02/1996), I can confirm that I wrote the patients name at the top of the page. This is what we call a Waterlow score and details the patient's susceptibility to bed sores. This patient has a score of 21 which is very high and places that patient as a very high risk. A score of below 10 is ok, a score of above 10 is a risk, a score of above 15 is a high risk and over 20 is, as I have said is a very high risk. If the patients appetite is poor this just adds to the problem.

On page 171 of the notes also dated 22/2/96 (22/02/1996) which is Lifting/Handling Risk Calculator. This patient scored 15, which means she was difficult to move. Any score of above 10 means that a specific care plan is needed.

On page 173 of the notes which is a Daybar Basic Nutritional Assessment Plan, the patient has scored a 3 which is ok. A score of above 5 means that the patient would usually need additional nutritional supplements. A score of below 5 means that the patient would require reassessing regularly. This plan is no longer used.

I have been asked to comment if I have any issues regarding patient care at the Gosport War Memorial Hospital. I would like to say that if I did have any concerns then I would not work at the Hospital. It is a good hospital and the standard of care is excellent. The use of diamorphine was in my estimation an ideal way of making patients more comfortable and I had no problem with its use in syringe drivers in 1996.

Taken 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: ASTRIDGE, YVONNE ANN

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

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: Yvonne ASTRIDGE Date: 23/02/2005

I am Yvonne Ann ASTRIDGE and I live at an address known to the Police.

Further to my previous statement made to the Police in relation to Operation Rochester, an investigation into alleged suspicious deaths at the Gosport War Memorial Hospital , I would like to add that on page 155 of the medical notes, (exhibit BJC/30) relating to Elsie Hester LAVENDER dated 6th March 1996 (06/03/1996), I have written in a Patient's summary" Seen by Dr BARTON , medication other than through syringe driver discontinued as patient unrousable" I have signed this entry.

Unrousable means that she was deeply asleep, or comatose. Y ASTRIDGE

Because this patient was unable to swallow, the only route to administer medication considered was through a syringe driver. Y ASTRIDGE

Taken 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: JOICE, CHRISTINE

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

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: C JOICE Date: 10/11/2004

I am Christine JOICE; formerly Christine Carraher and I live at an address known to the Police.

I am a Community Registered Nurse presently employed at the Queen Alexandra Hospital Cosham as an Intermediate Care In-Reach Nurse.

I qualified as an RGN at the Portsmouth School of Nursing in 1988, my Pin Number is **Code A**

Between 1988 and 1999 I worked at Gosport War Memorial Hospital as a Staff Nurse on General Medical and Surgical Wards and also on the Continuing Care and Stroke Rehabilitation unit on Daedalus Ward. I was the Team Leader of the Stroke Rehabilitation Team. I was responsible for multi-disciplinary team planning, implementing and evaluating care with the aim of discharge, either to home or other care. I supervised junior staff and managed the ward and on occasions I was "Duty" Nurse in charge of the hospital.

In 1995 I was Acting Senior Staff Nurse for 6 months on Daedalus Ward where I assisted and managed a 24 bed ward. I was also responsible for security and advising members of staff on any problems (nursing, medical and social).

In 1996 during a spell of illness from the Gosport War Memorial Hospital I commenced voluntary work at the Rowans Hospice at Purbrook.

Between October 1999 and November 2003 I worked as a Community Registered Nurse for

RESTRICTED

Gosport and Fareham Primary Care Trust. In that role I provided nursing care for a wide range of clients with varying needs. Including terminal care, general nursing care, specific nursing care (e.g. dressings) and post operative care. I was responsible for the caseload planning in the absence of senior staff. I assessed the needs of clients and implemented care plans together with evaluation. I was also the Continence Team link nurse and the Community Health representative for Age Concern.

From 2003 to the present I am employed as an In-Reach nurse at the Queen Alexandra Hospital Cosham. My role there includes identifying patients who are suitable for transfer to appropriate care services in the community. I liaise with social services, multi-disciplinary teams within the hospital wards, medical assessment unit and accident and emergency in order to secure the best care service for residents via supported discharges and promotion of independent living. I attend discharge planning meetings and liaise with district nurses. I respond to requests from discharge planners to assess patients who may be suitable for intermediate care and I monitor delayed discharges for NHS and social services to identify patients who can be discharged into the community with support.

I am an extremely experienced nurse and have recent qualifications in rehabilitation and intermediate care, continence care, pressure sore, leg ulcer and wound management. I have also attained the module in facilitating learning in clinical practice. I have attended a recruitment and selection workshop, and also qualified in the care of the elderly ENB.

In 1996 I was a staff Nurse on Daedalus Ward at the Gosport War Memorial Hospital. My primary role was that of patient care, and where on occasions I was the duty manger for the hospital.

I have received training in the use of IV drugs but I have never administered them at Gosport War Memorial.

I do not know the term, the Wessex Protocols.

RESTRICTED

I have received mandatory training in the setting up of syringe drivers . The models of such drivers are "Graysby" and there have been two such models.

I am not sure about what training was offered to nurses regarding syringe drivers.

My understanding of the term, Named Nurse is that it is the person in charge of the patient who is the patients and relatives contact. The named nurse may not be the person however who has day to day care of the patient.

Entries in the medical notes are usually made at the time, but in certain circumstances these may be made up later or indeed at the end of duty.

My hours of duty in 1996 were between 30-37 per week. From memory my shifts were days, 0730 - 1230, lates, 1315 - 2030. The long day was 0730 - 2045. The weekly shifts were 2 x early, a long day and 2 x lates.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I have no recollection of this patient, but after reference to her medical notes (Exhibit BJC/30) pages 97,133,139,153and 155, I can confirm that on the 4th March 1996 (04/03/1996), The following is written in the Nursing Care plan, "S/B physio-exercises: - 3 turns of head to right & 5 neck retractions every 2 hours. Elsie needs Analgesia increased" This entry is both written and signed by me as C. CARRAHER .

S/B Physio means, seen by Physiotherapist.

The entry "Analgesia increased" may have been included because the exercises were painful.

It appears from the previous days entries that she was in slight pain then.

The MST (Morphine Sulphate Tablets) which is slow release Morphine was increased from 20Mgs on 3rd March 1996 (03/03/1996), to 30Mgs the following day 4th March 1996

RESTRICTED

(04/03/1996). This was because of the increased pain the patient was suffering.

I can confirm that also on page 97 of the notes dated 27th February 1996 (27/02/1996) the following is written in the nursing care plan," Analgesia administered. Fairly effective. Able to help when dressing this a.m" This entry is written and signed by me as C.CARRAHER.

The patient had been given 10Mgs of MST up until 26th February 1996 (26/02/1996) but it had only been fairly effective, and the analgesic was increased to 20Mgs of MST on 27th March 1996 (27/03/1996). I gave her the increased analgesia and then helped her to get washed and dressed. My involvement with Mrs LAVENDER appears to have been on a day to day basis.

I can confirm that again on page 97 of the notes dated the 28th February 1996 (28/02/1996) the following is written, "R Arm less painful able to lift it above head height. L arm less improved" this entry is both written and signed by me as C. CARRAHER.

As I have previously stated the patient had been on 10Mgs of MST taken both AM and at night, from admission to 26th February 1996 (26/02/1996) and increased to 20Mgs on 27th February 1996 (27/02/1996) to be taken both AM and at night. She was also prescribed de-hydrocodeine as required.

All of these drugs had been prescribed by Dr BARTON .

I can confirm that on page 133 of the notes dated the 5th March 1996 (05/03/1996) the following is written in an Exceptions to Prescribed Orders form,

First entry
Date 5/3/96, (05/03/1996)
Time - Alltimes,
Drug Name and Dose - Oramorph S.R. 30mg,
Reason - Pt.on s/c analgesia
This is written and signed by me as C. CARRAHER.

Signed: C JOICE
2004(1)

Signature Witnessed by: Code A

RESTRICTED

Second Entry

Date 5/3/96 (05/03/1996)

Time - 1730

Drug Name and Dose - Human Mixtard

Reason - Dose not required

This is written and signed by me as C. CARRAHER

Third Entry

Date dittoed as 5.3.96 (05/03/1996)

Time - 1800

Drug Name and Dose - Ferrous Sulphate 20mgs (Iron Tablets)

Reason - Pt unable to swallow

This is written and signed by me as C. CARRAHER.

Pt means patient

s/c means Sub Cutaneous, (under the skin)

These entries are written on a new chart for the date to which they refer and therefore are not included on page 131 which is dated 23.2.96 (23/02/1996).

Oramorph was not administered to the patient. This is an exception to a prescribed order and shows what the patient was NOT given, not what they were.

The patient was on Sub Cutaneous analgesia, and she either didn't require the drug, or she was unable to swallow. I wouldn't necessarily give Morphine on top of what the patient was previously prescribed as it may have had a detrimental effect. This is also shown on page 139 on the regular prescription sheet with crosses in the Oramorph column on 5th March 1996 (05/03/1996).

Oramorph is the trade name for MST.

RESTRICTED

I cannot recall why on the first entry on page 133 I have written, Alltimes in the time column next to Oramorph. This may be because she had not been given it all that day.
The other entries are as follows

Human Mixtard is Insulin; Dose not required is self explanatory.
Ferrous Sulphate is Iron Tablets; Pt is unable to swallow is also self explanatory.
These drugs were also NOT given.

I can confirm that on page 153 of the notes dated 4th March 1996, (04/03/1996) the following is written, "Patient complaining of pain, and having extra analgesia PRN. Oramorph Sustained Release Tablets dose increased to 30mg BD by Dr BARTON" This entry is written and signed by me as C.CARRAHER.

PRN means, "As and when required"
BD means, "Twice a day"
This means that the patient was complaining of pain and was given MST analgesia which had been increased from 20 to 30Mgs as and when required, and prescribed by Dr BARTON. This is shown on prescription chart on pages 139 and 145 dated 4/3/96 (04/03/1996) the entries of which are signed by Dr BARTON.

Page 133 refers to drugs NOT given rather than those that were.

Taken by: Code A

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: RETIRED NURSE

This statement (consisting of 3 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: Judith COOKE Date: 10/02/2005

I am the above named person and I live at the address shown overleaf. I was trained as a state enrolled nurse in Haverford West Hospital in 1959 or thereabouts. This was a two year course. When I finished I registered with the Nursing Council, I don't recall my registration number.

I worked at a local hospital in Haverford West, St Brides, then at Summerlands Hospital in Yeovil. After a short break of 2½ years I worked at a hospital in Plymouth I do not recall the name of this hospital. I moved around quite a bit because my husband was in the Royal Navy. I followed him and his postings.

In 1974 I started work at the Northcote Annexe which is part of the Gosport War Memorial Hospital . This ward dealt with elder care. Prior to working at the Gosport War Memorial Hospital I had not worked with geriatrics. I was still working as enrolled nurse.

When the annexe closed, I don't recall when this was, I worked at the main hospital on the relief team. This meant I worked on various wards apart from maternity. After working on the relief team for about three years I worked on Daedalus Ward for about three years prior to my retirement in 1997.

Looking back I would say the hospital was a happy place to work, the level of care for the patients was excellent and I enjoyed my 25 years. I had no concerns about patient care as individuals, staff or patients.

I have never heard the term 'Wessex Protocols'.

RESTRICTED

I had what I would call on the job training with syringe drivers these had to be set up by a State Registered Nurse although I would assist them in doing this. Normally the drivers were for Morphine or Diamorphine , although other drugs could be given this way.

Syringe drivers were used on patients who were in the later stages of life to assist with palliative care. The families were informed by a GP or the sister of the ward. Medical staff would seek the agreement of the family and not proceed without. I am unable to recall a family saying no when it was properly explained.

I have been asked about a lady called Elsie LAVENDER , I have no recall of this patient. I can confirm that I have made and signed on the medical notes of Elsie LAVENDER.

On page 113 I have written catheter drained satisfactorily". This would indicate that the patient was able to urinate and was properly hydrated.

On page 115 I have made an entry dated 25/02/96 (25/02/1996) "Sacral area blade and blistered, betemadine spray applied".

This meant some skin areas had broken down, I don't know why she could have been like that on arrival or as a result of her lying still, it is impossible to say which as I have no recall of the patient. I can not see any other notes I have made regarding this patient.

Taken by:DC 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: WILKINS, PATRICIA ELIZABETH

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: P E WILKINS Date: 03/02/2005

I am the above named person and I live at an address known to the Police.

In 1969 I joined the Royal Navy and I commenced nursing training at Stonehouse Royal Naval Hospital in Plymouth Devon.

In 1970 I was posted to Malta in BIGH Naval Hospital and then MTARFA Naval Hospital where I worked nursing service personnel and their families.

I qualified in 1971 as a State Enrolled Nurse.

In 1971 I returned to the UK where I was posted to the sick bay at HMS Victory, now known as HMS Nelson in Portsmouth.

Between 1973 and 1975 I was posted to The Royal Naval Hospital Haslar in Gosport where I worked in the Nurses Quarters there in an administration role.

I then left nursing to go on [redacted] leave.

In 1979 I was employed at Beechcroft Manor Nursing Home where I nursed the elderly patients.

In 1984 I was employed by the Portsmouth NHS Trust as a State Enrolled Nurse at Redcliffe Annexe at the Gosport War Memorial Hospital . I continued to work on the male ward and then

RESTRICTED

onto Daedalus Ward at that hospital.

In 1991 I converted from an SEN to an RGN, a Registered General Nurse. My Nursing and Midwifery Number is Code A

In 2003 I transferred to the Dolphin Day Hospital at the Gosport War Memorial Hospital, where I currently work as a Senior Staff Nurse.

At the time of this investigation in 1996 I was an E Grade Staff Nurse on Daedalus Ward at the GWMH. My responsibilities at that time were as part of a nursing team with Health Care Support Workers with a primary concern for the welfare of the patients.

I had in 1998 (approximately) received on the job training in relation to the administration of subcutaneous drug therapy via syringe driver . In 1996 I had received no training in IV drugs.

My understanding of the term the Wessex Protocols is that it is the Analgesic Ladder.

Graseby syringe drivers were used in 1996.

In respect of the term the named nurse, this related to the person who was supposedly responsible for a particular patient and their family. In my opinion this did not work. For example I had been shown as named nurse in the past when in fact I had been on leave, it was a system that needed improving. A better way would be to have a team responsible for 6 or 7 patients.

In respect of the time and date of all entries in the nursing notes, these would usually be done when we had time to complete them. However all drug entries would be completed at the time.

In 1996 I worked 37½ hours per week. My duties would have been 0730 to 1615, 1215 to 2030 and 0730 to 1330.

RESTRICTED

I have been asked to detail my involvement in the care and treatment of Elsie LAVENDER . I do not recall this patient but from referral to copy entries in the medical notes Code A I can confirm that on Page 99 of the notes which is a Nursing Care Plan dated 23/2/96 (23/02/1996) is written," Transferred x2" This entry is signed Code A and P WILKINS. This is not however my signature. I believe it to be that of Code A who is a Healthcare Support Worker. This was standard practice for one of the two to sign for each other, and a Healthcare Support Worker had to have an entry countersigned by a trained nurse.

Transferred x 2 means that the movement of the patient is conducted by two persons.

I can also confirm that on page 105 of the notes which is a Nursing Care Plan dated 23/2/96 (23/02/1996) is written," Bed Bathed" This entry is also signed P WILKINS and Code A as above. The writing and signatures are that of Code A as explained above.

I can also confirm that also on page 105 of the notes dated 6/3/96 (06/03/1996) is written, "Bed Bathed" This entry is written and signed by myself. I have also included the name of Wendy EDGAR who was with me and who at that time was a Health Care Support Worker.

I can also confirm that on page 109 of the notes which is a Nursing Care Plan dated 6/3/96 (06/03/1996) which is dittoed from an entry above dated 29/2/96 (29/02/1996), "Dressing remains in place". This dittoed entry is signed by me and again I have included the name of Wendy EDGAR who was with me at the time.

I can also confirm that on page 113 of the notes which is a further Nursing Care Plan dated 6/3/96 (06/03/1996) which is dittoed from an entry above dated 28/2/96 (28/02/1996), "Catheter draining satisfactorily". This dittoed entry is signed by me and again I have included the name of Wendy EDGAR who was with me at the time.

In 1996 it was common practice for entries in the nursing notes to be dittoed if they were identical to the entry before. This is not the practice now however.

RESTRICTED

I can also confirm that on page 117 of the notes which is a further Nursing Care Plan, dated 6/3/96 (06/03/1996) is written, Betanide spray to sacrum" This entry is written and signed by me and I have again included the name of Wendy EDGAR who was with me at the time.

Betanide is an iodine antiseptic spray which was used for healing sores.

I can also confirm that on page 119 of the notes which is another Nursing Care Plan, dated 6/3/96 (06/03/1996) is written," Continues to leak faecal fluid". This entry is written and signed by me and again I have included the name of Code A who was with me at the time.

Taken by: Code A

Signed: P E WILKINS

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: RIGG, PAMELA SUSAN

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

This statement (consisting of 3 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: P S RIGG Date: 10/02/2005

I am the above named person and I live at the address shown overleaf. I am a Community Staff Nurse and I work at the Gosport Health Centre. I have worked here for nearly two years, prior to that I worked at the Gosport War Memorial Hospital for a period of ten years.

I was a student nurse between 1976 and 1979 at West Suffolk General in Bury St Edmonds. I qualified as a State Registered Nurse and in order to practice I am registered with the Nursing and Midwifery Council. My registration number is **Code A**

Having qualified I went to Scotland and worked at the Royal Infirmary (Unit), Edinburgh. I was a medical ward staff nurse, I was there for a year prior to joining Decoress Hospital where I worked for another year. I then worked at the Queen Elizabeth Hospital in Kings Lynn where I worked on the intensive therapy unit and also on the coronary unit. I was there for about one year prior to working at St Columbus in Edinburgh. I was there for about four years. I was a staff nurse in the unit which dealt with palliative care issues.

In 1986 I moved to Gosport and worked as an agency nurse till 1993 when I began work at the Gosport War Memorial Hospital.

The first ward I worked on was the Redcliffe annexe. I was working as a Grade D Staff Nurse. In 1995 Redcliffe Annexe patients and staff were moved to a purpose built ward within the main hospital named Dryad Ward. I worked there till about 1997 when I started work on Sultan Ward.

Signature Witnessed by:

RESTRICTED

I remained at Sultan until I left the GWMH in April 2003. Looking back at my time with the GWMH I can only describe what I saw and that is general patient care was excellent. I think everyone did the best they could and I have no particular concerns about any member of staff or patient cases that I wish to raise.

I am not familiar with the term the Wessex Protocols. I was only aware of the term analgesic ladder in my last few years but the basic knowledge was there. I had previous instructions with regard the use of syringe drivers whilst I worked at St Columbus Hospice. I do feel that the general level of training at the GWMH was not as patient specific as it might have been.

I would say that in my opinion there was a good understanding of palliative care and syringe drivers and diamorphine was used in the right and proper circumstances.

I have been asked if I can recall a lady called Elsie LAVENDER . I have no recall of this patient. I have been asked to look at her medical records, exhibit Code A

I have reviewed the notes for Elsie LAVENDER, I have not made any entries upon it. The patient was in fact on Daedalus Ward where I worked for one day only to cover.

Taken by:DC Code A

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: DOLAN, CHRISTINE MARY

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

This statement (consisting of 2 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: 10/06/2003

I am the above named person and I reside at an address known to Hampshire Police.

I am employed as a Staff Nurse (Grade D) at the Gosport War Memorial Hospital . I have worked at this hospital since 1986.

Up until March 2002 I worked on Sultan Ward, now I work on the Dolphin Day Ward.

In my opinion the general patient care was very good at the hospital.

I have used syringe drivers and have been on study days in order to learn about their use. I feel that I have received sufficient training in their use, they are an excellent means of administering a constant level of pain relief and I have had no concerns about their use. I have also no concerns about the prescription and administering of diamorphine at the hospital.

I am aware of previous police investigations at the hospital having seen it in the media.

I am also aware of the CHI report although I was not spoken to.

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: DOLAN, CHRISTINE MARY

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: 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: C M DOLAN Date: 26/10/2004

I am Christine Mary DOLAN and I live at an address known to the Police. I am a Registered General Staff Nurse at Gosport War Memorial Hospital and I have 21 years experience in the Nursing profession.

Further to my previous statement made on 10th June 2003, (10/06/2003) I would now like to add that in 1973 I joined the Queen Alexandra Royal Naval Nursing Service as a State Enrolled Nurse.

I did my training at the Royal Naval Hospital Haslar, Gosport until 1977.

Between 1978 and 1980 I was employed at Greenbank Hospital Plymouth, where I worked as a State Enrolled Nurse on the Outpatient Ward. Where I worked on day duties.

Between 1980 and 1986 I worked for Plymouth Health Authority as an SEN Bank nurse where I provided General nursing care.

Between 1986 and 1995 I worked at the Gosport War Memorial Hospital on Night duty as a grade D Registered Nurse. I rotated through various wards, medical, surgical, elderly care and GP admissions. I was responsible for many aspects of patient care.

Between 1990 and 1991 I worked at weekends for the Crown Nursing Agency at Haslar Hospital Gosport on the General Ward.

Signature Witnessed by: Code A

RESTRICTED

Between 1995 and 2001 I worked on Sultan Ward as a Grade E staff nurse. This is a GP unit for medical conditions, respite care and rehabilitation following surgery. My responsibilities included the routine running of the ward and the continuing care of patients during the night period, where I would assess, implement, evaluate and reassess the patient's individual care need. I was also responsible for the safe administration of medicines. I ensured that procedures for admission and discharge of patients were followed carefully. I supervised all junior staff and covered for the Night Sister when she was unavailable. I was in contact with patients relatives regarding their care and treatment. I was the Manual Handling Link Nurse for the night duty staff. I continued to liaise with GP's and Health Care Services (GP deputising service) regarding care and required treatment of their own patients.

From January 2002 to date I have been working as a Grade D Staff Nurse in the Dolphin Day Hospital at the Gosport War Memorial which is nurse led. My responsibilities include monitoring the care of elderly patients living in the community and preventing readmission of those recently discharged. I am the Infection Control Link Nurse and also the Continence Link Nurse. I am also team leader for the consultant in Elderly Care. It is my responsibility to ensure that all medical records and results are available for each patient when they attend for review.

I am fully up to date with courses including basic life support, manual handling, and acute life threatening events recognition and treatment (ALERT).

I have not received training in the use of IV drugs, I am therefore not certified.

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

Regarding Syringe drivers , I have been on various study days in order to learn about their use. I feel that I have received sufficient training in their use. I am unsure what brand of syringe drivers were being used in 1996 but I felt they were an excellent means of administering a constant level of pain relief.

A Named Nurse would be the person who admitted the patient and completed the admission

RESTRICTED

procedure. This would usually be the team leader on the day shift, but on the night shift where I worked I would look after all patients.

The time and date of all entries in medical notes would in fact only be completed by nurses if someone had died on the ward, when two nurses would make such an entry. However with regards to the nursing notes, these would be written generally at the time, but at all other times by the end of the shift.

My tour of duty between 1986 and 2001 was permanent nights, 2015 hrs to 0800 hrs.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I have no recollection of this patient, but from referral to entries in her medical notes, (Exhibit reference Code A) page 123 dated 25th February 1996, (25/02/1996) I can confirm that this is a blank entry I have signed in the Nursing care Plan. As I have signed the entry I am confident I was based at Daedalus Ward for that night and not just visiting in the course of my work. At the time and date I signed the entry, nothing untoward had happened so as was my practice I have left the line blank. However if anything untoward had occurred, then that would have been included. Policies have changed since that time, and a similar circumstance would prompt an entry such as "slept well" or similar. This is through my experience.

Taken by: Code A

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: MARTIN, MARY ELIZABETH

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

This statement (consisting of 3 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: ME MARTIN Date: 22/09/2004

I am a retired Registered General Nurse, I qualified after 3 years training at the Queen Alexandra Hospital , Cosham this was in 1978.

I was employed as a nurse from 1978 until my retirement in 2000. I worked at Gosport War Memorial Hospital until 1985 when I went to St Christophers Hospital in Fareham where I worked as a Staff Nurse on permanent nights. I stayed at St Christophers for about 3 years. I then returned to Gosport War Memorial Hospital where I worked as a Staff Nurse at the Redcliffe Annex. I worked on various wards, permanently on nights until my retirement in 2000.

I have been shown exhibit Code A patient notes for Elsie LAVENDER b. Code A I have been asked to comment on two signatures dated 28th February and 29th February 1996 (29/02/1996). These are on page 123. Above my signatures are entries by Sister Geraldine BROUGHTON dated 26th and 27th February 1996 (27/02/1996). I can confirm that the two signatures of 28th and 29th February 1996 (29/02/1996) are mine. Although I have signed on those dates there are no written entries, this would usually mean that it was a ditto entry, in other words the entry was the same as the one above it. The entry on 26th February 1996 (26/02/1996) written by Sister BROUGHTON reads 'Nursed on both sides'. Her entry for 27th February is blank so I take it that this was a ditto entry as were my following two for 28th and 29th February 1996 (29/02/1996).

'Nursed on both sides' means that the patient was turned over during the night. This is a standard procedure, it helps to prevent bed sores etc.

RESTRICTED

I cannot think of another reason for signing patient notes without an entry (as in this case).

Taken by:DC1162 QUADE

Signed: M E MARTIN
2004(1)

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: COUCHMAN, MARGARET ROSE

Age if under 18: OVER 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: M R COUCHMAN Date: 15/12/2004

I have been in the nursing profession for over 25 years, I am a fully trained RGN. I trained at The Portsmouth School of Nursing in 1976. My RGN. NMC number is Code A and my RCN number is Code A I worked at The Royal Hospital, Portsmouth throughout the 1970's until it closed. I had general experience in surgical, medical, children's nursing, private nursing and orthopaedic nursing. I then moved to The Queen Alexandra Hospital, Cosham, where I worked on the orthopaedic wards. I left the Queen Alexandra Hospital in 1980 when I went to work with autistic adolescents at Anglesey Lodge, Alverstoke.

In 1982 I started working at Gosport War Memorial Hospital . Initially I worked on the children's ward, at this time the hospital was carrying out minor ENT and orthopaedic operations. The NHS later closed down the children's ward and I moved onto the male ward dealing with the terminally ill, dermatology, GP Unit etc. The theatre was also closed down and changes were made to the wards, the male ward was turned into Daedalus Ward when we took on Elderly Services, I have been on this ward ever since. I was at that time and still am an 'E' grade nurse. I currently work two nights a week. As an 'E' grade Staff Nurse I would mostly take charge of the ward, I will also often have the keys to the hospital which means that I am the person responsible at that time.

I have been asked about my knowledge of a patient named Elsie LAVENDER , I cannot remember this patient. I have been shown original documents relating to Elsie LAVENDER and concerning her stay at Gosport War Memorial Hospital (Code A.

I have been shown several pages of these notes and make the following comments.

RESTRICTED

On page 153 there is an entry dated 29/02/96 (29/02/1996) which reads "Blood sugar at midday 20 mmls, BARTON contacted ordered 10 units Actrapid stat". I can confirm that this is in my handwriting and that I have signed the entry. I have been asked to explain this entry. The patient was a diabetic and at midday her blood sugar levels were high. 20 mmls stands for 20 millimoles which is a measure used for blood sugars. Because of this high level I contacted Dr BARTON , I cannot remember exactly how I did this but it was probably by bleep. If Dr BARTON was in the hospital and available she would have visited the patient as a result of my request, or as it seems happened in this case she may have ordered/authorised 10 units of Actrapid. Dr BARTON would then have signed up the Actrapid on the Once Only Medication Chart, either at the time or post administration of the drug. Going by the available record Code A I am not sure if Dr BARTON did attend or not, but clearly her authority was given, I would normally have chased her up to complete the entry, though I am unable to find one in this case.

I have been asked about another entry dated 1/3/96 (01/03/1996) on page 97 which reads "Complaining of pain in shoulders, on movement". I can confirm that this is my writing and my signature. This would have been recorded as the patient had probably told me that she was in pain when she moved, she was not necessarily in pain at the time, only when she moved. She was not given anything for pain at this time.

I have also been asked about an entry dated 5/3/96 (05/03/1996) on page 97 which reads "Pain uncontrolled, patient distressed, syringe driver commenced 0930 hrs. Son informed". I confirm that this is my writing and that I have signed the entry. On page 153 (the Summary page) there is a further entry dated 5/3/96 (05/03/1996) which reads "Patient's pain uncontrolled very poor night. Syringe driver commenced 5.3.96 (05/03/1996) at 0930 hrs. Diamorphine 100mg. Midazolam 40mg. Son contacted by telephone. Situation explained". Again I can confirm that this is my writing and that I have signed the entry.

Regarding these last two entries I can explain them as follows; I would have been told by the night staff that the patient had a very poor night. She was in uncontrolled pain and she was

RESTRICTED

distressed. She had been seen by Dr BARTON who had authorised the commencement of a syringe driver, this was commenced at 0930 hrs and contained 100mg of Diamorphine and 40mg of Midazolam. The patient's son was contacted by me on the telephone so that I could explain the situation.

I have been asked why Mrs LAVENDER was put on the syringe driver and if this was the start of that process. I can say that this was the start of the process and that it was started on the instructions of Dr BARTON and on page 153 Sisters JOINES has written that the son had requested we keep his mother comfortable and pain free.

I have been shown an entry of the same set of notes (BJC/30) on page 85 dated 5/3/96 (05/03/1996), this is Dr BARTON's writing and is the instruction to commence the syringe driver application.

I have also been asked whether another nurse was involved, in answer I will explain how we withdraw drugs. The drugs are kept in a locked C.S.S.D room and within that room they are held in a locked cupboard, within the locked cupboard is a further secure cabinet and it was from that which the Diamorphine and Midazolam were withdrawn. The correct procedure to follow (and this would have been the case in this instance) was for two trained nurses to be present when the drugs were withdrawn and administered. Entries were then made in the Ward Controlled Drugs Record Book. These entries include the amount, date, time, patient's name, amount given, person administering and witness. Unfortunately I have not been shown the relevant book for the drugs previously mentioned, I have been told that it is no longer available. However I have been shown page 137 of Code A this is a prescription page and shows that Dr BARTON has signed up the prescription of 100 - 200 mg of Diamorphine and 40 - ? of Midazolam on 5/3/96 (05/03/1996). It also shows that on 5/3/96 (05/03/1996) I administered those drugs to Mrs LAVENDER as has been previously stated. I administered 100 mg of Diamorphine and 40 mg of Midazolam, the lowest amounts were given as it was considered that they would be appropriate to the pain level being suffered, in other words it would keep her comfortable. These drugs were over 24 hours.

RESTRICTED

I have been asked if I have had any training in the use of syringe drivers, I cannot be specific at this time but this would have been covered during our regular training sessions, on site training from Countess Mountbatten staff, during my time at Queen Alexandra Hospital, Gosport War Memorial, training days at Countess Mountbatten Hospital and there was also a large poster in the office which acted as an aide memoir.

Taken by: G QUADE

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: BROUGHTON, GERALDINE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED 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: G BROUGHTON Date: 05/02/2003

I am the person named above and live at the address shown on the attached form.

I qualified as a State Registered Nurse in 1957.

In 1958 I commenced working as a nurse at the Gosport War Memorial Hospital in Gosport. Here I worked until 1996, apart from 3 years from 1962-65 when I left to have my daughter.

In 1968 I became a night sister at the hospital on a part time basis, which was either two or three nights a week. My responsibilities as a night sister was for the staff and patients at the main hospital complex, as well as the two annexes which was Northcote and Redclyffe House.

The use of painkillers at the hospital was always on the basis of a prescription from a doctor, apart from Paracetamol. In regard to opioid analgesics these carefully controlled. These had to be prescribed by a doctor then administered by two trained staff, who checked the dosage and entered it into the controlled drug register.

I cannot recall when syringe drivers were introduced at the hospital. These were normally set up by the day staff after the doctor prescribed them for the patient. The dosage for the syringe driver was for a 24 hour period, which was slowly fed into the patient over that time. The only problems I experienced with the drivers was blockages or if they stopped working.

Once again when ever these were 'set up' or maintained it was always done by two trained staff.

RESTRICTED

I retired in 1996.

Whilst working at the hospital I was not aware of any problems with the use of controlled drugs or syringe drivers. Neither was I aware of any problems with the doctors.

Signed: G BROUGHTON
2004(1)

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: BROUGHTON, GERALDINE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED RGN 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: Date: 30/11/2004

Further to my previous statement made to Police on 5th February 2003 (05/02/2003), I would like to add that in 1953 I went as a Student Nurse to St Mary's Hospital Portsmouth. I attended the Primary Training School there. I qualified in 1957, but in those days you were never guaranteed a nursing position and it wasn't until February 1958 that I obtained my first post at the Gosport War Memorial Hospital as a staff nurse. I remained at that hospital for the rest of my nursing career, in the children's ward then the casualty ward, the female ward and the male ward. I was made ward sister in 1968. In 1990 the new wing of the hospital was opened and I then worked permanent nights on Daedalus ward. There were three part time sisters on the ward at that time. The position of ward sister was also known then as the Clinical Ward Manager. My responsibilities included being in charge of the whole hospital, including initially casualty and responsibility for the ward in general.

I had received training in the use of I/V drugs. I believe I attended a one day course at Queen Alexandra Hospital at Cosham . I received a certificate as a result.

I have never heard of the term "Wessex protocols"

There was in house training available at the Gosport War Memorial Hospital regarding the setting up of syringe drivers, however I am unsure what other training was offered to nurses regarding them. When syringe drivers were used they had usually already been set up by the day staff when we came on night duty.

A named nurse was the carer of a patient, providing medical care for someone who was sick.

RESTRICTED

The time of all entries in the nursing care notes were usually done at the time or after the patients had settled down at night, however in the morning these entries would always be done immediately.

My hours worked in 1996 and indeed throughout my career on night duty were 25 per week. My tour of duty was always from 2015 hrs to 0745 hrs.

I have been asked to detail my involvement in the care and treatment of Code A I have no recollection of this patient, but from referral to entries in her medical notes Code A page 123. I can confirm that on 26th February 1996 (26/02/1996) I have written and signed an entry as follows "Nursed on alternate sides". This entry simply means that if a patient was immobile their sleeping position should be changed frequently to prevent bed sores.

The entry following this on the 27th February 1996 (27/02/1996) has been left blank and has also been signed by me. The reason it has been left blank is because it is an identical entry to the one I have previously described. At the time, the procedure we used was that if the day's entries were the same as the previous day then the line would remain blank but signed. This policy has since changed and would be completed in full. I note from the records that subsequent entries on both the 28th and 29th February 1996 (29/02/1996) are also blank and signed by Staff Nurse MARTIN who like me has retired from nursing.

I can confirm that on page 119 of the notes dated the 5th March 1996 (05/03/1996), I have written and signed an entry as follows "Continues to leak faeces" This entry means that the patient was unable to retain excrement from the intestines. But from examining the notes further I see that the patient had been constipated and as a result was given suppositories and enemas to assist with the constipation and the leakage was as a result of those.

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: WALKER, FIONA LORRAINE

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

This statement (consisting of 3 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: 23/01/2003

I am the person named above and live at the address shown on the attached form.

I have been a nurse for 35 years.

I began training as a nurse in 1968 and in 1982 I commenced working at the Gosport War Memorial Hospital as a night sister.

I was one of three night sisters and my responsibilities were for the patients and staff whilst on nights, this also included minor injuries and the hospital premises.

In the late 1980's 'syringe drivers' were introduced at the hospital. The driver is a 24 hour 'pump' that introduces medication to control symptoms experienced by the patients. They were mainly used on patients suffering from pain, nausea, vomiting, agitation and where medication could not be delivered orally.

My duties regarding syringe drivers was to ensure that two trained staff applied a syringe driver to the patient. Sometimes circumstances would dictate that there was only one qualified member of staff available to apply a driver. Therefore I would take the place of the second member of staff that was required. The reason that two staff was required was in order to check the prescription and contents. This process/procedure is the same for anytime that a controlled drug is given to a patient.

In 1991 I was aware that some staff at the hospital expressed concerns over the levels of

RESTRICTED

Diamorphine being prescribed. My belief is that this was resolved internally and that a consultant came over from the Countess Mountbatten Hospice and explained the situation to the nursing staff.

After this I was unaware of any problems concerning syringe drivers or Diamorphine. This was until 1998 when the relatives of a patient named Gladys RICHARDS made a complaint regarding her treatment and her subsequent death.

I was interviewed by the police over this. I explained to them that I had no direct involvement in the treatment of RICHARDS that I could remember. I was asked by the police to explain the use of syringe drivers, which I did as I have described previously. Also I explained that I was unaware of any mistreatment of RICHARDS.

I heard nothing further about this until I read about an enquiry in the papers recently. In respect of syringe drivers I have attended a palliative care course which incorporated their use and have been involved in their use for over ten years. I am happy that when used correctly they are beneficial for the patient. I am unaware of any misuse of the drivers or controlled drugs at the hospital.

In regard to the doctors at the hospital I am satisfied with their treatment of patients.

I am still working at the Gosport War Memorial Hospital as a senior staff nurse.

I would like to add here that in regard to controlled drugs when they are administered to a patient and that two staff are required for this, one must be a registered nurse but the second one could be a support worker who has been trained for the 'checking' role of administering them. More often not it is two registered nurses who administer these drugs.

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: WALKER, FIONA LORRAINE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: 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: P WALKER Date: 01/12/2004

I am Fiona Lorraine WALKER and I live at the address shown on the attached form.

I am currently employed as a Nurse Practitioner with Laser Care Clinics based at Haslar Hospital, Gosport . I am also employed by 'Prime Care' as a custody nurse for the Hampshire Constabulary.

I have been a nurse for 36 years and qualified as a Registered General Nurse for 32 years.

In 1982 I began working at Gosport War Memorial Hospital . I was employed as a 'Night Sister'.

I was employed at Gosport War Memorial Hospital until 2003, at that stage I was employed as a Senior Staff Nurse (nights) based on Sultan Ward of the Hospital.

I was one of three 'Night Sisters' employed at the Hospital. Only one night sister usually being on duty at one time.

During the 'Night shift' which was from 2015 hours to 0745 hours my responsibilities were for the whole hospital and members of staff and patients. This included a Minor Injuries Department of the hospital which was open 24 hours a day.

During the Night Shift I would be in charge of the whole hospital and available to be called to any part or ward of the hospital that required the presence of a senior member of the nursing

RESTRICTED

staff to provide advice and assistance.

This responsibility was for the whole of the Night Duty period.
There was no on-site Doctor available 24 hours a day at Gosport War Memorial Hospital. Therefore if there was a need to call a Doctor for advice and to discuss a patients condition then this responsibility would often fall to me.

The doctor called would then decide whether it was a matter that could be dealt with by the Nursing Staff or if it was necessary for the doctor to attend the hospital.

If it became necessary for me to have this kind of involvement in the care of a particular patient then I would usually make a note on the patients medical record in the nursing section if it had not already been noted by a trained member of staff.

During the course of a Night Duty I would try if possible to visit each ward of the hospital to ensure that there were no problems with either patients or staff.

I have previously made statements to the police regarding Gosport War Memorial Hospital on 23rd January 2004 (23/01/2004) and also on 19th October 2004 (19/10/2004).

Signed F WALKER

Further to my earlier statements I have been asked what involvement I had in the care and treatment of a patient called Elsie LAVANDER who was a patient at Gosport War Memorial Hospital on 'Daedalus Ward' from 22nd February 1996 (22/02/1996) until her death on 6th March 1996 (06/03/1996).

I have been allowed to examine a copy of the Medical Records of Elsie LAVANDER, exhibit Code A From my examination of these records I can see no note or signature that I recognise as mine.

RESTRICTED

I have no personal recollection of Elsie LAVANDER. It is possible that I may have had some contact with this patient during her stay at Gosport War Memorial Hospital as it is during the time that I was employed at the hospital as 'Night Sister' but I do not have any recollection of this lady.

Part of my responsibilities as 'Night Sister' was to support and give advice or information to relatives of patients at Gosport War Memorial Hospital.

I have been asked if I recall having a conversation with a man called Alan LAVANDER who was the son of Elsie LAVANDER regarding his mother.

I have no recollection of having a conversation with Mr LAVANDER and it is also unlikely as my tour of duty commenced at 2015 hours and ended at 0745 hours. General visiting hours ended at about 2030 hours. Therefore it is more likely that he had a conversation with the 'Day Sister'.

It is a possibility that the conversation was with me; but I do not recall it.

Taken by:DC Code A

Signed: P WALKER

Signature Witnessed by: Code A

2004(1)

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: DORRINGTON, IRENE MARGARET

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

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: I M DORRINGTON Date: 02/12/2004

Further to my previous statement made to the Police on 16th October 1996, (16/10/1996) I would like to add that I kept up to date with all my Nursing courses with yearly reviews, up until I retired in 1999, having 38 years nursing experience. I am unable to remember my RGN number

I was a Staff Nurse in 1996 working night shift 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 either Fiona WALKER on Sultan Ward or Anita TUBBRITT on Dryad Ward.

I don't believe I received any training in the use of I/V drugs except for hand outs

I have never heard the term the Wessex protocols.

I did a day course at the Gosport War Memorial Hospital in the use and setting up of syringe drivers . I must say that I was nervous regarding their use and with others I asked for more training. Usually when we came on to nights the syringe drivers for patients had already been set up by the day team.

The named nurse is something that was used on days mainly, but not 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 care plan at the time.

My tour of duty was always night duty, I had never done days. I worked 20 hours per week which was 2 nights. My hours of duty were from 1930 to 0730 the following day.

I have been asked to detail my involvement in the care and treatment of a patient on Daedalus Ward, Elsie Hester LAVENDER . I have no recollection of this patient at all and from working on Dryad Ward, I would only cover another ward in the case of absence through sickness or otherwise. From referral to entries in her medical notes, exhibit reference Code A I can confirm that on page 123 of those notes which is a nursing care plan, dated the 23rd February 1996 (23/02/1996) I have written and signed the entry "Analgesic given before settling, comfortable night. DF118x 2 given at 0630 at her request" DF118 is an analgesic and is also known as dihydrocodeine. I should imagine that the patient was in some discomfort and she may have had a stroke. It is clear that the analgesic worked because I have written that she had a comfortable night. After referral to the drug charts of page 141 of the notes I see that I gave her the tablets at 2300 and 0630.

I can also confirm that also on page 123 of the notes dated the 24th February 1996 (24/02/1996) I have written and signed the entry" Comfortable, appeared to have picked a spot on forehead. It bled copiously forming clots. Managed to stop it by pressure. No further episodes"

I can also confirm that also on page 123 of the notes dated the 1st March 1996 (01/03/1996) I have written and signed the entry"Refused medication at 2200 hours, took a while but I persuaded her to take them. Eventually took them at at 2300 hours. Leaking faeces. Nursed on alt sides." The medication refused was DF118 dihydrocodeine. I have no recollection of this patient as I have said but it was a fairly usual occurrence for deteriorating patients to refuse

RESTRICTED

medication. It was however always worth persevering and they usually took the medication later, as in this case. The term nursed on alt sides meant the patient was moved from side to side in an attempt to prevent pressure sores. Alt means alternate.

I can also confirm that again on page 123 of the notes dated the 2nd March 1996 (02/03/1996) I have written and signed the entry "Took medication well, nursed on alt sides. Still leaking faeces PR."

The term took medication well simply means that the medication was taken without incident, such as refusal.

PR means Per Rectum.

I can finally confirm that on page 151 of the notes, which is a nursing summary regarding the patient Elsie LAVENDER dated, Night 24th February 1996 (24/02/1996) I have written and signed the entry" Comfortable night. At 0300 appeared to have picked a spot on forehead which bled copiously. Managed to stop it by pressure. MST 10Mg given 0615. BS high at 24.2. Insulin given earlier." The part of the entry regarding the picking of the spot on the forehead I had mentioned previously on the nursing care plan.

The part of the entry regarding the picking of the spot on the forehead I had mentioned previously on the nursing care plan of the same date. MST is Morphine Sulphate Tablets 10Mgs given. BS means Blood sugar which was high and her Mixtard insulin was given at 0700 hrs.

Taken 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: WIGFALL, MARGARET

Age if under 18: Over 18 (if over 18 insert 'over 18') Occupation: ENROLLED 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: M Wigfall Date: 11/10/2002

I am the person named above and live at the address shown overleaf.

I am a D Grade Enrolled Nurse and I am employed by the Gosport and Fareham Primary Care Trust.

I started training as a Nurse in 1965 and qualified in 1967.

I began as a General Nurse, but in 1968 I became a Naval Nurse at the Haslar Hospital in Gosport.

In 1971 I had my first child, and then in 1977 I returned to work as an Agency Nurse.

Then in 1981 I was employed at the War Memorial Hospital in Gosport.

I worked at the Redcliffe Annexe part of the hospital which deals in caring for the elderly.

Most of the patients although elderly were there for long term care.

Several years ago, I cannot remember exactly when we started using 'syringe drivers' on the patients.

All of a sudden they were there. Their use caused me some concern and I was uncomfortable with their use.

RESTRICTED

This was because I felt that they were used too often.

Rather than being used to control pain they were used on patients who were approaching death and suffering from anxiety and distress.

The main medication used in the 'drivers' was Diamorphine. However, sometimes there would be an addictive or Midazolam.

The use of the 'driver' and the medication to be used within it would be prescribed by the doctor who covered the ward, who at that time was Doctor BARTON.

Then the decision when to use it would then be made by a Nurse who would choose the appropriate time.

However, I never made these decisions because they had to be made by a Senior Nurse.

My concerns were increased because it appeared that an awful lot of the patients that died were on syringe drivers.

Around this time the capacity at Redcliffe changed from 11 patients to 20, this was because the top floor was opened.

The type of patients we were receiving changed whereby we started having some with acute problems.

I discussed my concerns over the use of the drivers with Anita TUBBRITT, a Senior Nurse, and other nursing staff.

I recall that there was meetings with management at the hospital over the concerns that I and the other nursing staff had over the use of syringe drivers but I cannot recall anything about them.

RESTRICTED

I cannot remember what the management's response was to our concerns.

However, I have checked my training records and discovered that I received training on pain control and the use of syringe drivers on the 10/12/1990.

But I cannot recall if this was prior to or after the above incidents.

In regard to the use of syringe drivers by Nurses.

Because I am only an Enrolled Nurse I am not allowed to set them up. This can only be done by a Senior Nurse, and Enrolled Nurses can only assist.

Furthermore, it takes two Nurses to set a syringe driver up for use.

In the intervening years Anita has mentioned that she has papers relating to this period and the problems we had.

Approximately eight years ago we moved from the Redcliffe Annexe into the Dryad Ward at the new War Memorial Hospital.

Doctor BARTON has still remained the doctor who covered the ward until fairly recently.

Also throughout this time myself and some of the nursing staff have shared concerns over the use of syringe drivers.

I have worked at the Gosport War Memorial Hospital since 1981 to date. I work 10 hours one night every week.

I am aware that the 'papers' that Anita referred to over the years were handed over to the hospital management at a recent meeting.

RESTRICTED

I can confirm that I have never seen these papers.

I have always felt that Doctor BARTON and the Nursing Staff always acted in the best interest of the patients.

Just because I was concerned about the syringe drivers does not necessarily mean that their use was wrong.

Finally I never directly discussed my concerns with Doctor BARTON.

Signed: M Wigfall
2004(1)

Signature Witnessed by: DC 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: WIGFALL, MARGARET

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

This statement (consisting of 3 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: Margaret WIGFALL Date: 30/11/2004

Further to my previous statements made to the Police, on 11th October 2002 (11/10/2002) and 9th July 2004, (09/07/2004) I would like to add that since 1981 I have worked one night a week at the Gosport War Memorial Hospital . At first at Redcliffe Annexe and then on Dryad Ward where I am still working. Very occasionally I would cover other wards in the event of absence or sickness on those wards.

My role would be that of general patient care.

I am unsure who my line manager was in 1996.

I have not received training at all in the use of I/V drugs

I have heard recently of the term 'Wessex Protocols' but I do not know what they are.

The term Named Nurse means that this person is the patient's main nurse who is responsible for their care.

The entries in the medical notes, including Nurse's Care Plans would usually be written up towards the end of night duty heading towards handover, unless a patient was really poorly when the notes would be made at the time.

My weekly hours are 10 hours per week and my tour of duty is from 2015 until 0745 the next day.

RESTRICTED

I have previously mentioned about my training in the use of syringe drivers.

I have been asked to detail my involvement in the care and treatment of Elsie Hestor LAVENDER . I have no recollection at all of this patient, but from referral to her medical notes Code A I can confirm that on page 123 of the Nursing Care Plan dated 22nd February 1996 (22/02/1996) where I have written and signed the following entry, "Settled and slept well C/O sore shoulders, analgesia given"
C/O means complaining of.

The entry is self explanatory really, it is clear the patient was in some pain with a sore shoulder and I have given her analgesia.

I have referred to the prescription charts on page 141 and I have given the patient two tablets of Dihydracodeine (DF118) at 2300hrs and 0500 hrs. I am unsure what the exact dosage was because the copy Code A is not clear enough.

That is the only entry I have made in this patient's notes. I do not recall the night in question and for that reason I do not know why I was covering Daedalus ward that night from Dryad Ward.

Taken by: Code A

Signed: Margaret WIGFALL
2004(1)

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: MARJORAM, CATHERINE JEAN

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

This statement (consisting of 2 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: C MARJORAM Date: 12/06/2003

I am the above named person and I live at the address shown overleaf.

I first qualified as a nurse in December 1970 and currently work on Daedelus Ward at the Gosport War Memorial Hospital as a Senior Staff Nurse. I have worked on all the wards at the GWMH and in my opinion the general patient care is excellent.

With regard to the use of syringe drivers I feel at all times they were properly used on patients. I do now fear that they are not used enough when a patient is in pain. This is a view I extend to the use of diamorphine.

I have previously been interviewed by police into the death of Gladys RICHARDS . I was never spoken with by CHI formally but I did speak with them on the wards.

As a result of this ongoing investigation I feel morale is poor at the GWMH and we struggle to recruit and maintain staff.

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: MARJORAM, CATHERINE JEAN

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

This statement (consisting of 8 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: C MARJORAM Date: 28/10/2004

I am Catherine Jean MARJORAM and I reside at the address detailed overleaf. I am employed at the Gosport War Memorial Hospital as a Senior Staff Nurse (nights) based on Daedalus Ward of the hospital but with a responsibility to the whole hospital during the course of the night.

A night duty is from 2015 hours to 0745 hours. At this time I work 3 nights a week. The days of working in my case is flexible usually working around other members of staff.

I was interviewed by the police in June 2000 regarding the death of Gladys RICHARDS at Gosport War Memorial Hospital I have also provided a witness statement to the police regarding other matters concerning the use of certain drugs, syringe drivers and care of patients at the hospital. This statement I made to the police in July 2003.

During March of 1996 I was employed at Gosport War Memorial Hospital as an E Grade Staff Nurse on night duty. I was at that time based on Sultan Ward I believe.
The responsibility of a E Grade Staff Nurse on nights would be; to be in charge of my ward during the night. However if the need arises then to provide cover for the Senior Staff Nurse or Night Sister.

I began my training as a nurse in 1967 and qualified as a State Registered Nurse (Staff Nurse) in 1970. Including my training I have been a nurse for 37 years. I have been employed at Gosport War Memorial Hospital since 1976. So have worked at this hospital for about 28 years.

RESTRICTED

I have been asked what involvement I had in the care and treatment of a patient called Elsie LAVENDER during her time at Gosport War Memorial Hospital from 22nd February 1996 (22/02/1996) to 6th March 1996 (06/03/1996). I first wish to state that I have no personal recollection of a patient called Elsie LAVENDER whatsoever.

I have been allowed to examine a copy of a set of medical notes bearing the exhibit reference of Code A

From my examination of these notes I am able to state the following:-

I was involved in the admission of Elsie LAVENDER to Gosport War Memorial Hospital on 6th May 1989 (06/05/1989). I have completed paperwork at pages 177 and 178 and also at 179 and 180 of Code A regarding her admission on that date.

I have also completed paperwork at page 175 and 176 regarding the same admission and stay at the hospital. At page 129 and 130 my signature appears on a prescription sheet for Elsie LAVENDER on 6th May 1989 (06/05/1989).

I have therefore been involved in the nursing of Elsie LAVENDER during an earlier stay at the Gosport War Memorial Hospital.

On page 87 and 88 of Code A the medical records of Elsie LAVENEDER I have made the following note on the 'clinical notes'.

'Death verified by C J MARJORAM RGN' I have then signed this entry. I have not been able to find any other entries on the medical records of Elsie LAVENDER BJC/30 relating to her stay at the hospital in February or March of 1996 that has been made by me.

The only reason that I believe that I have made this note is as follows:-

Where the death of a patient is expected in Gosport War Memorial Hospital as there is no on site 24 hour doctor cover then a trained member of the nursing staff is able to 'verify death'. It is quite common that this is done by two members of staff.

I note from page 85 and 86 that an entry appears on the 'clinical notes' which reads as follows:-

RESTRICTED

'6th March 1996 (06/03/1996) 2128 hours asked to see'

'No cardiac sounds'

'No respiratory movement/sounds'

'Pupils fixed and dilated'

This entry appears to immediately proceed mine on the clinical notes and to have been signed by a Registered General Nurse. I do not recognise the writing or signature of this entry.

It is likely that the trained member of staff has been asked to examine Elsie LAVENDER by a member of the nursing staff.

The trained member of staff has examined Mrs LAVENDER and has found her to be dead.

It would have been possible for this nurse to verify death herself. However it would appear that on this occasion I have been called to 'Daedalus Ward' by the trained nurse to confirm the result of her examination.
In order to do this I would have checked Mrs LAVENDER's chest for heart sounds, breathing sounds and movement of her chest.

I would have also checked Mrs LAVENDER's eyes and established that her pupils were fixed and dilated. These are standard checks that are made before verifying death of a patient.

I would have made all these checks myself prior to making my entry on the 'clinical notes'.

This is one of the few occasions that nursing staff make an entry on a patients 'clinical notes' as the clinical notes are normally reserved for the use of the doctors.

I note that a corresponding note has been made on the nursing notes by the same nurse at page 155 and 156 under the time of 2128 hours on 6th March 1996 (06/03/1996).
Only a doctor is able to certify death. The verification of death by nursing staff is only

RESTRICTED

permitted in the circumstances that I've previously described.

The verification of death by trained staff at Gosport War Memorial Hospital allows the staff to properly inform members of the family.

Layout the body of the patient and arrange for the removal of the body from the ward.
The removal of the body from the ward minimalizes distress that may be caused to other patients on the ward.

It also allows the body to be refrigerated.

Taken by: Code A

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: HEALTHCARE SUPPORT WORKER

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: 26/10/2004

I am Code A and I live at an address known to the Police. I am a Healthcare Support Worker; previously known as a Nursing Auxiliary at Gosport War Memorial Hospital I have 13 years experience in that role.

In September 1991 I began work in that capacity after completing a two week induction course at St Mary's Hospital Nursing School in Portsmouth.

I initially worked on the male ward at the Gosport war Memorial Hospital, providing care for the patients in back up to the fully trained staff. I passed my NVQ in health care in 1992.

In 1993 when the hospital was modernised and extended I began work in Daedalus Ward. This was initially a stroke rehabilitation ward with mixed sexes aged over 60 years.

My responsibilities were and still are to assist trained staff to care for the needs of the patients and to help with, amongst other duties, Physiotherapy, Hygiene requirements and Nutrition.

I am trained in Moving and Handling of Patients, Basic Life Support, Fire Drill, Data Protection and Food Hygiene.

I have been in my current role for 2-3 years and my current line manager is Code A. My line manager in 1996 was the Ward Sister, Sheelagh JOINES .

My current responsibilities have lessened in the fact that I cannot now weigh patients, nor do

RESTRICTED

blood pressures.

I have never had dealings with IV drugs nor know anything about drug sheets.

I have never heard of the term Wessex Protocol.

I was never offered training in the setting up or the use of Syringe Drivers due to my role. I obviously know how they work, from observations over the years, and of course I would know if anything was wrong with their use. The Syringe Drivers have changed in make and design in my time at the hospital and I have no idea which one were being used in 1996.

My understanding of the term Named Nurse is that this the Nurse assigned to the patient to oversee their care, and that any relatives could see that named nurse to ask any questions.

Any entry in the patient notes would usually be made as the patient was seen, but of course in a busy period this would be done later.

My duties in February and March 1996 would vary between an early shift 0730 to 1330, and a late shift 1300 to 2030.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I have no recollection of this patient but from referral to entries in her medical notes, (Exhibit reference Code A) page 97 dated 29th February 1996 (29/02/1996) and in the notes dated 3rd March 1996 (03/03/1996), I can confirm that on the 29th February 1996 (29/02/1996) page 97 I wrote the following in the Nursing Care Plan: 29.2.96 (29/02/1996) - "able to move arms for washing and dressing".
This entry was signed by me C. TYLER. I have noted that she had analgesia on day one for painful shoulders and upper arms, and it is my belief that this pain had been relieved on 29th February 1996 (29/02/1996), hence my entry. I have however further noted that on the following day the patient was complaining of pain again.

RESTRICTED

Continuation of Statement of: Code A

I can confirm that on 3rd March 1996 (03/03/1996) on Exhibit Code A I wrote the following on the Nursing Care plan: 3.3.96 (03/03/1996) dittoed the entry from above. This entry is signed by me C. TYLER, and is for the same date of 3.3.96 (03/03/1996) and states - "slight pain in shoulders when moved". This entry is signed by Y.ASTRIDGE and Code A

I have noted from the Nursing Care Plan that bed rest was maintained throughout.

This would mean that the patient would be kept in bed and washed in bed whilst she was in pain.

The entry in question was dittoed by me because it was an identical observation to the one previous. In 1996 we were allowed to ditto a previous entry if it was the same. This procedure was changed about 2 years ago and we now are obliged to write every entry in full.

Taken by: Code A

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: HEALTHCARE SUPPORT WORKER

This statement (consisting of 3 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: 26/10/2004

I am Code A and I live at an address known to the police. I am a Health Care Support Worker, formerly known as a Nursing Auxiliary, at Daedalus Ward, Gosport War Memorial Hospital.

I have worked in the Health Service for 21 years.

Between 1976 and 1985 I worked as an Auxiliary Nurse at Blackbrook Maternity Home in Fareham.

Between 1992 to the present day I work at Gosport War Memorial Hospital as stated above.

I have no nursing qualifications, but I am up to date with courses required in my role such as, manual handling, nutritional requirements and basic life support.

My role at the time of this investigation is the same as it is now.

My responsibilities then are as now, to care for the patients, to wash and feed them and to assist trained staff in that role.

I do not use IV drugs and therefore have received no training.

I have never heard of the term, Wessex Protocols.

RESTRICTED

I am not trained in the use of syringe drivers and have never used them. I have no idea what syringe drivers were being used in 1996.

My understanding of the term named nurse is that they would be responsible for that particular patient and any problems with them if on duty. If not on duty then another would be the named nurse.

Entries in the nurse's notes are usually made at the time of any contact with the patient, but they may be done later if it's in the middle of a busy period, or indeed at the end of the shift.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I have no recollection of this patient, but from referral to entries in the medical notes (exhibit reference Code A) page 97, dated 2nd March 1996 (02/03/1996), I can confirm that I have written, "Slight pain in shoulders when moved" I have signed that entry and I have also signed the name Yvonne ASTRIDGE , the staff nurse who was with me when I was with the patient. This was standard practice when I was with another member of staff.

Although I have no recollection of this patient, one who was in pain might inform us of the fact, we might ask the patient if they were, or the patient might wince when moved.

I have perused the notes and find that my signature is also on the following entries in the notes;

Page 99 dated 23.2.96 (23/02/1996) "Transferred X 2" together with the signature of Pat WILKINS

Page 101 dated 25.2.96 (25/02/1996) "Bed rest maintained" together with the signature of Yvonne ASTRIDGE

Page 105 dated 23.2.96 (23/02/1996) "Bed bathed" together with the signature of Pat WILKINS

Page 105 dated 25.2.96 (25/02/1996) "Blanket bathed"

Page 109 dated 2.3.96 (02/03/1996) dittoed from entry above which says "Dressing remains in place"

Page 113 date Code A 25/02/1996) "Catheter draining" together with the signature of Judith

RESTRICTED

Continuation of Statement of: Code A

COOK

Page 113 dated 2.3.96 (02/03/1996) "Catheter draining satisfactorily"

Page 115 dated 25/2/96 (25/02/1996) "Sacral area weak and blistered Beterdene spray applied"

together with the signature of Code A

Taken by Code A

Signed: Code A

2004(1)

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: THOMAS, ELIZABETH BASSETT

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

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: E THOMAS Date: 24/01/2005

I am Elizabeth Bassett THOMAS and I live at an address known to the Police. I am a Physiotherapist at the Queen Alexandra Hospital Cosham Portsmouth. I qualified in 1991. I am a member of the Chartered Society of Physiotherapy, my membership number is Code A My Health Professions Council membership no is Code A My membership number of the British Thoracic Society is Code A

Between September 1991 and February 1994 I worked at the Ipswich Hospital NHS Trust in a rotational post. The rotations included the outpatient respiratory dept, pulmonary and cardiac rehabilitation, care of the elderly, ICU and outpatient dept.

Between February and May 1994 I worked at the Colchester General Hospital in a Senior 11 locum post in cold orthopaedics, surgery and ICU.

Between May and September 1994 I was employed at the Llwynypia Hospital, Rhondda Mid Glamorgan also in Senior 11 locum post in acute medicine and rehabilitation for the elderly.

Between September and October 1994 I worked at the Royal Bournemouth Hospital in a Senior 11 locum post on In and out patient neuro rehabilitation.

Between September and December 1994 I worked at St Mary's Hospital Portsmouth in a Senior 1 locum post in acute medicine and ICU

Between December 1994 and October 1996 I was employed at the Royal Hospital Haslar

Gosport in a Senior 1 post. I worked in acute medicine and ICU. I also did in service training and staff appraisal.

Between October 1996 and October 1997 I worked at the Wigan and Leigh NHS Trust also in Senior 1 locum post. I was involved in the management of acute and sub acute medical respiratory physiotherapy service. I had hands on involvement in consultant led research to study the effects of threshold loading and incremental training of the inspiratory muscles. This post included regular commitment to ICU.

Between October 1997 and May 1998 I was employed at the City General Hospital in Stoke on Trent in a Senior 1 locum post in acute medicine.

Between June and July 1998 I worked at the North Manchester General Hospital in a Senior 11 locum post in the surgical wards and ICU.

Between July and September 1998 I was employed at the Macclesfield District General Hospital in a senior 1 locum post in acute medical chests and ICU.

Between September 1998 and March 1999 I was employed at the Airedale General Hospital Skipton West Yorkshire in a Senior 1 locum post. I was responsible for Co-ordination and management of acute medical and surgical chests and ICU. The post included setting up and running a comprehensive in-service training programme and journal club, regular commitment to the Breathe easy Club and improving the profile of respiratory physiotherapy within the trust.

Between March and September 1999 I worked at the Tameside general Hospital Ashton under Lyne Manchester again in senior Locum 1 post. I worked in the surgical wards and ICU. I also trained on call staff in acute respiratory staff.

Between September 1999 and August 2000 I worked at the Royal Liverpool University Hospital Trust in Senior 1 locum post. I was co-ordinating respiratory physiotherapy on a large ICU and general surgical wards. This included the utilisation of non invasive ventilation, on call work, in

service training and supervision and appraisal of rotational physiotherapists and students.

Between October 2000 and December 2002 I worked at Gloucestershire Hospitals NHS Trust Gloucester in Senior 1 locum post. I was involved in the management of acute medical respiratory problems for the first 22 months, followed by 6 months of surgery and ICU. Respiratory outpatients were seen throughout the 2 years, referrals were predominately for the management of hyperventilation syndrome.

Between January 2003 and August 2004 I was employed at Northampton General Hospital also in a Senior I locum post. There I coordinated the inpatient respiratory service to surgical, medical and maxillo-facial wards and ICU. As the lead respiratory clinician for acute services there was a close liaison with the nurse led ICU outreach team. There was regular commitment to the physiotherapy departments Service Development Group. I set up a critical care Allied Health Professional/ Health Care Scientist group within the trust, for which I was the representative at Central England Network meetings. As part of this role, I also attended Critical Care Delivery Group and Consultant meetings.

Between May and August 2004 I worked at the St James University Hospital Leeds in a Senior 1 locum post. I was clinically responsible for medical HDU including acute non invasive ventilation, and medical respiratory wards and also respiratory outpatient work.
I have also completed Further Clinical Education including "Care of the Chronically Breathless Patient", "Aspects of Acute Respiratory Care".

I was awarded the MSc in Respiratory Physiotherapy, involving the completion of the following modules, Chronic Lung Disease, Critical Care, Clinical Decision Making, Applied Research, Clinical Education and Medical Ethics. I completed my research dissertation in December 2002.

I have also lectured on the Sheffield Hallam University MSc Respiratory Physiotherapy course for the past three years.

At the time of this investigation in February 1996, I was working as a Senior 1 locum medical

RESTRICTED

respiratory physiotherapist. I also worked on the intensive care unit. Patients with respiratory disorders would be referred to me. I would attempt to get patients with restricted mobility back to their previous level of independence. This included patients with multiple pathologies causing general functional deterioration, stroke patients, and patients with other neurological disorders.

At this time I had no terms and conditions as I was a Locum and not employed by the NHS trust as far as I can remember.

I have never heard of the term the Wessex Protocols.

On the occasions I documented in the medical notes, to inform the doctors of a patient's progress, I would do this immediately following patient contact. I would also often have physiotherapy notes which I would complete within 24 hours. As far as I can remember these were kept separately from the medical notes.

My hours of duty at that time were between 36-371/2 hours per week. I worked day duty between Monday to Friday. I also did on-call via a bleep.

I have been asked to detail my involvement in the care and treatment of Elsie LAVENDER . I do not recall this patient but from referral to entries in a copy of her medical notes exhibit reference Code A, I can confirm that on page 157 dated the 8th February 1996 (08/02/1996) I have written, "S/B Physio.

S. Previously mobile lady adl independent
O. Currently c/o shoulder U/L tenderness and abdo pain on assessment - oedematous hands
No voluntary active mvmt (on request)
Due to pain + bilat shoulders
Full passive/assisted ROM both shoulders
Muscle power difficult to assess but seems intact.

RESTRICTED

Mobility - sit ↔ stand C 2 Full support req'd for a few steps

A Pain in shoulders seems to be major problem. N/S having to feed/wash/dress this previously independent lady at present."

I have signed this entry Elizabeth THOMAS

S/B means seen by
S means Subjective
O means Objective
Pain + means a lot of pain both shoulders
ADL means Activities of daily living
C/O means complaining of
UL means Upper limbs
Oedematous means Swollen
ROM means Range of movement
Sit ↔ stand means Sit to stand
C2 means With the assistance of 2 persons
A means Analysis
N/S means Nursing staff

I can also confirm that on Page 165 of the medical notes JR/11A I have written, "Continuing c Physio

S: Requires encouragement to mobilise
UL: UL Function improving, starting to feed herself c encouragement. For OT assessment (wash/dress) today. Still c/o shoulder pain.

Mobility remains poor - sit ↔ stand c2
Standing balance poor. Mob c2 short distance
Unable to issue walking aid due to UL function

Signed: E THOMAS
2004(1)

Signature Witnessed by: Code A

RESTRICTED

Discharge to own home seems unlikely in the near future."

I have signed this entry as Elizabeth THOMAS.

Signed: E THOMAS
2004(1)

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: STUDENT NURSE

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: 22/08/2003

I am the above named person and I live at the address overleaf. From November 1994 - September 2000 I worked as a Nursing auxiliary on days on Daedelus Ward at the GWMH .

At the time I had no formal nursing qualifications, although I about to qualify as a Staff Nurse. I would describe general patient care at the hospital as good and I never had any concerns about the use of syringe drivers or drugs that were being used. I was not trained in the use of syringe drivers.

I am aware of investigations of the GWMH via the local press. I have no other issues or concerns that I wish to express.

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: 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: 26/10/2004

I am Code A and I live at an address known to the police. Further to my previous statement made on the 22nd August 2003 (22/08/2003), I would like to add that I am currently employed as a Staff Nurse at Haslar Royal Naval Hospital Gosport ; I have been qualified since October 2003.

Between 1982 and 1983 I was a Domestic Auxiliary nurse at Haslar Hospital on weekends only.

Between 1983 and 1985 I worked at Westbury Manor Nursing Home at West Meon .

Between 1986 and 1992 I worked as a Health Care Support Worker at St Christopher's Hospital Fareham .

Between November 1992 and August 2000 I was employed by Portsmouth Hospitals NHS Trust as a Health Care Support Worker (Nursing Auxiliary) at Gosport War Memorial Hospital .

Between September 2000 and October 2003 I was a Student Nurse.

Between October 2003 and January 2004 I was a Staff Nurse at the Queen Alexandra Hospital at Cosham .

I started at Haslar Hospital as a Staff Nurse in February 2004.

When I was at Gosport War Memorial I worked on Daedalus Ward which provided continuing

RESTRICTED

care and slow stream stroke rehabilitation for frail elderly patients. In 1996 my duties were to assist in the general care of patients, washing, dressing and feeding, as well as assisting the qualified nursing staff who supervised me. I did not make any decisions as to how a patient was nursed, nor was I involved in decisions concerning medication. I did not administer IV drugs and consequently I have never had any form of training.

I have never heard of the term Wessex Protocols.

I had not received training nor ever used syringe drivers in 1996.

My understanding of the term Named Nurse is the person who deals with an individual patients care, and also who can advise the relatives of the patient's prognosis.

All entries in the medical notes are usually made at the time, or as soon as convenient, but on some occasions at the end of the tour of duty.

In 1996 I worked 32 hours a week. My duty tours were similar to; early shift, 0730 - 1330, late shift, 1315- 2030.

I have a diploma in Adult Health Care.

I have been asked to detail my involvement in the care and treatment of Code A Code A. I have no recollection of this patient, but from referral to this patient's medical notes (exhibit reference Code A page 97, dated 6th March 1996 (06/03/1996), I can confirm that it is written in a Nurses Care Plan "Pain well controlled, syringe driver renewed at 9.45 AM" (0945). This is not in my writing but the entry bears my name, but not my signature, along with that of Nurse Code A. I assume that the entry is in Code A writing and would have been written at the time or shortly after. It was usual to have two signatures if I was with a qualified nurse and we both had contact with the patient.

Although I cannot recall this patient, I can assume that the pain was controlled by the use of the

RESTRICTED

Continuation of Statement of: Code A

syringe driver, and if it was not used then the patient would incur further pain.

What I have said in this statement is what I would do now as a qualified nurse, this is not necessarily how I may have thought as a Health Care Support Worker.

Taken by: Code A

Signed: W EDGAR
2004(1)

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: YATES, CHRISTOPHER SCOTT

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: DETECTIVE CONSTABLE 2479

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: C Yates Date: 04/04/2005

I am Christopher Scott YATES, Detective Constable Code A of the Hampshire Constabulary presently attached to the Major Crime Department.

At 0917 hours on Thursday 24th March 2005 (24/03/2005) in company with Detective Constable QUADE I conducted a tape recorded interview of Doctor Jane BARTON. The interview took place within an office of the Fraud Squad at Netley Support Headquarters and in the presence of her solicitor Mr. Ian BARKER. 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 Code A During this interview Doctor BARTON produced a prepared statement which she read and then signed as being her statement. This prepared statement is now available with an identification reference of Code A The interview concluded at 0939 hours.

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: QUADE, GEOFFREY JAMES

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: DETECTIVE CONSTABLE 1162

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: G Quade Date: 06/04/2005

At 0917 hours on Thursday 24th March 2005 (24/03/2005) in company with Detective Constable YATES we conducted a tape recorded interview of Dr Jane BARTON in an office within the Fraud Squad at Support HQ, Netley . Also present was Doctor BARTON's solicitor Mr Ian BARKER .

The interview was concluded at 0939 hours that morning. During the interview Doctor BARTON made a prepared statement which she read out and then signed and dated. This prepared statement is available with an identification reference of Code A

The interview was conducted in accordance with the Codes of Practice for tape recorded interviews and the sealed master tape is available with an identification reference of Code A