FFW/133/02.

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER

GOSPORT WAR MEMORIAL HOSPITAL

Code A

Volume 2

Witness list
Witness statements

49

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

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4. Generic Case File (exhibits)
5. Generic Case File (further exhibits)
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66. Clinical Team Assessments for Code A and Code A

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: Code A Address (HOME): Code A Occupation: RETIRED RMN Date of Birth: Code A Telephone: HOME Code A E-mail address:			
2	Name: Code A Address (WORK): Code A Occupation: GENERAL PRACTITIONER Date of Birth: Telephone: WORK Code A E-mail address:			
3	Name: Code A Address (HOME): Code A Occupation: DOCTOR Date of Birth: Code A Telephone: HOME Code A E-mail address:			
4	Name: Code A Address (HOME): Code A Occupation: REGISTERED MENTAL NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
5	Name: Code A Address (HOME): Code A Occupation: CONSULTANT GERIATRICIAN 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: Code A Address (HOME): Code A Occupation: CONSULTANT PHYSICIAN IN GERIATRICS Date of Birth: Code A Telephone: WORK Code A E-mail address:			
7	Name: Code A Address (HOME): Code A Occupation: DOCTOR Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
8	Name: Code A Address (HOME): Code A Occupation: NURSING SISTER G GRADE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
9	Name: Code A Address (HOME): Code A Occupation: COMMUNITY STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
10	Name: Code A 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

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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: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
12	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
13	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE GRADE E Date of Birth: Code A Telephone: HOME Code A E-mail address:			
14	Name: Code A Address (HOME): Code A Occupation: TEAM LEADER SOCIAL SERVICES Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
15	Name: Code A Address (HOME): Code A Occupation: SENIOR STAFF NURSE 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: 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:			
17	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
18	Name: POLICE Code A Address (): Occupation: Detective Constable Code A Date of Birth: Telephone: E-mail address:			
19	Name: POLICE Code A Address (): Occupation: Detective Constable Code A Date of Birth: Code A Telephone: E-mail address:			

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 RMN

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: 08/11/2004

I live at the address known to the Police.

I am the daughter of Code A b. Code A who died in the Gosport War Memorial Hospital on 24th January 1996 (24/01/1996).

My father was born in Hemel Hempstead. He had two sisters, one who died as the result of an ectopic pregnancy whilst in her 20- 30's and the other who died of cancer in her late 50's.

My father was a submariner in the Royal Navy. Whilst in Canada he met and married my mother Code A They had my bother Code A and the family came to England in 1947.

My parents had three children, Code A is the eldest and I have a younger sister Code A Code A

My father suffered from severe depression for a great deal of his life. He made several attempts to end his life and had to be admitted to hospital for treatment.

He was admitted to Knowle Hospital, Wickham on a number of occasions throughout the 60's, 70's and 80's and received ECT treatment.

My father was physically, a very strong man and it was mainly due to his strong constitution that his attempts to end his life failed.

Signed: Code A Signature Witnessed by:

RESTRICTED

My father retired from the navy after twenty two years service and then worked as an instructor at the Nautical Training School, T.S. Mercury, on the river Hamble.

My father loved sailing and he enjoyed his job but when the training school closed he seemed to lose his purpose in life and withdrew into himself.

Sometime around 1993/1994 my father was admitted to Alverstoke ward at Knowle Hospital . He was very depressed and had no motivation. My mother had been caring for him at home and the strain this placed on her was giving concern to my father's psychiatric nurse, Code A and his social worker Code A whose surname escapes me.

Because of this, a decision was made that my father would be discharged to a rest home.

My father left Knowle and went directly to Hazledene Rest Home where he lived until he was admitted to Mulberry Ward at the Gosport War Memorial Hospital.

My father became progressively worse whilst at the nursing home. He would not socialise with any of the other residents who were predominantly women. He remained in his room and rarely spoke to anyone. He wasn't rude, he just wouldn't initiate any conversation. He would be the same when the family visited He stopped eating and drinking properly and was eventually admitted to Mulberry Ward which is a psychiatric ward at the Gosport War Memorial Hospital.

My father continued to deteriorate mentally and physically. He didn't respond to treatment, he seemed to have given up.

The nursing staff in the ward were excellent and took great care of my father.

The family visited regularly, Code A and I would take it in turns to take my mother into visit my father.

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After a period of time, Dr Code A told us that my father had a chest infection. She informed us that the clinical team had considered and rejected treating my father with ECT (Electro Convulsive Therapy) because of his physical condition. She told us that there was nothing more that could be done for him on Mulberry Ward and that he was going to be moved onto Dryad Ward.

I knew that my father was not eating or drinking. He would lie in bed all of the time and ignore everyone. He believed that he had parkinsons disease.

I understood that my father was going to Dryad ward for terminal care. This was never actually said to me but my knowledge of the type of patient that Dryad took led me to believe this.

I visited my father regularly with my mother and as a family we watched as my father died through what I would describe as 'self neglect'.

He had become extremely frail and just seemed to have lost the will to live.

I remember asking the nurses if he was in any pain and if he had any pressure sores because he was immobile.

The nurse told me that my father's skin was breaking down and that he cried out when the nurses turned him. I remember that 'morphine ' was mentioned to me for pain relief but I cannot recall if I was told that my father was already receiving it or was going to receive it.

I knew that his body systems were breaking down and that he would have been uncomfortable. I was not alarmed by the thought that my father was being given morphine. I considered it to be appropriate care.

The nurse turned him regularly and I recall that he had a blister on his ear.

My mother was spoken to about the use of a 'drip' and was kept informed about my father's

RESTRICTED

condition and how grave it was. I have no recollection of ever seeing a drip being used in relation to my father, so I assume that my mother was referring to a syringe driver.

The family acknowledged that invasive or aggressive treatments would be inappropriate in my father's case. By this I mean to force feed him or to use ECT to try and lift his mood.

I remember that it seemed to take my father a long time to die. I expected him to die as he was in a dehabilitated state, wasn't eating or drinking and had a chest infection.

My father died on 24th January 1996 (24/01/1996). His dead was certified by Dr Code A Code A and his cause of death was given as bronchopneumonia. He was cremated at Portchester Crematorium on 30th January 1996 (30/01/1996).

I have been asked if I ever spoke to a doctor during the time that my father was in Dryad Ward. I didn't speak to a doctor as I was kept fully informed of my father's condition by the nursing staff. Had I felt that I needed to speak to the doctor I would have taken the necessary steps in order to do so.

My father's GP was Code A, who had a very good understanding of my father's condition and was very supportive of my mother.

I think it is pertinent to mention that I am a retired qualified Registered Mental Nurse, having nursed the elderly mentally ill for most of my career. At the time of my father's admission to Mulberry ward and subsequently, Dryad ward, I was the 'G' Grade clinical manager at the Phoenix Day Hospital within the Gosport War Memorial Hospital.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

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

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 03/11/2004

I am a practising General Practitioner at the Bridgemary Medical Centre, Gosport . I have been so employed as a GP at this practice since May 1989.

As a GP I had qualified as BMBCh Bachelor of Medicine, Bachelor of Surgery. I obtained these qualifications in August 1984.

From August 1984 to February 1985 I was pre registration house officer in surgery at John Radcliffe House situated in Oxford. From February 1985 to July 1985 I was pre registration house officer in General Medicine at Poole General Hospital.

I obtained full registration with the General Medical Council in July 1985.

My registration number is Code A

From October 1985 until February 1986 I was the Senior House Officer in Casualty Department also at Poole General Hospital.

From March 1986 until February 1989 I was a Senior House Officer on the Bournemouth and Poole Vocational Training Scheme for General Practice.

A General Practitioner deals with the day to day care of ill health.

The catchment area for this surgery is the PO12 and PO13 post code areas.

RESTRICTED

I am employed by the Gosport and Fareham Primary Care Trust.

I have been asked to detail my involvement with the care of the late Code A

Although Code A was not registered with me but with my partner I was his general medical practitioner from May 1989.

I remember Code A as I saw him frequently in the surgery.

Code A suffered from a chronic depressive illness which necessitated him being on anti depressant medication on a long term and continual basis.

A review of his General Practical Medical notes show that he had suffered from depression at least since 1962. Despite him being on medication for depression his mental condition deteriorated from time to time necessitating hospital admissions.

The GP medical notes show that Code A was admitted to Knowle Hospital for in patient treatment on (8) eight occasions during the period 1967 to 1992.

Following hospital admission in April 1992 Code A was discharged to Hazledene Rest Home as his wife felt that she could no longer cope with him at home.

She thought that he had always been a selfish and obsessional person and she had had enough of him.

He was admitted to Hazledene Rest Home in January 1993.

During the 9 months that Code A was an in patient at Knowle Hospital he had 30 (ECT) Electro Convulsive Therapy treatments without any change of his mental state. There were numerous changes in his medication and he was finally discharged on six (6) different types of

RESTRICTED

psycho copic medication.

Despite this medication Code A agitation remained to a certain extent.

In March 1993 Code A was reviewed by Doctor Code A, her medical team together with Mr and Code A

Because he remained anxious and depressed it was agreed that he should remain at the rest home with regular review by the community psychiatric nurse (CPN).

He was assessed by Dr Code A Consultant Psychiatrist on the 26th May 1993 (26/05/21993) when she wanted to try a change in the medication he was receiving. To this end he was again admitted to Knowle Hospital between the 21st June 1993 (21/06/1993) and the 9th July that year.

During this admission the notes states that he seemed to settle well with the new drug regime and appeared less agitated and restless.

On the 3/9/93 (03/09/1993) I visited Code A after he had fallen in the rest home. He had received a soft tissue back injury which required no treatment.

On the 25/9/93 (25/09/1993) Code A was seen by Code A who at that time recommended no change in his medication.

On the 18/11/93 (18/11/1993) I visited Code A at Hazledene Rest Home when he received treatment for a rash on his groin.

He was next seen by Code A and her medical team on the 25/4/1994 (25/04/1994) again she found him anxious and depressed but recommended no change in his medication.

In August 1994 he was again reviewed by Dr Code A who found him chronically depressed

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and again made no changes.

On the 11/10/94 (11/10/1994) Code A was given a flu jab by a colleague from this practice.

Code A was assessed in January 1995 when it was felt that his mental state was deteriorating and new medication was introduced by a locum consultant in old age psychiatry.

He was seen again in Feb and March 1995 but with little change in his mental state.

On the 18th August 1995 (18/03/1995) I was asked to assess Code A by the Hazledene Rest Home staff because of concern about a slow deterioration in his general condition. A physical examination of him showed no abnormalities.

Blood tests were taken at this time which subsequently proved to be normal.

A review of the correspondence in his medical notes shows that he was admitted informally by Dr Code A to the Mulberry A Ward on the 14/9/1995 (14/09/1995).

According to the notes Code A was discharged on the 24/10/1995 back to Hazledene Rest Home.

During this admission he appeared to improve.

I had no further dealings with Code A after my visit on the 18/8/1995 (18/08/1995).

To summarise Code A condition he had a chronic intractable depression for which he received continual treatment.

It was apparent in the 5 months before Code A died that his physical condition had also begun to deteriorate.

Signed: Code A

Signature Witnessed by:

RESTRICTED

Continuation of Statement of: Code A

Taken by:DC Code A

Signed: Code A

Signature Witnessed by:

2004(1)

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

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

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: 04/02/2005

I am employed by the Hampshire Partnership Trust as a Consultant in old age psychiatry at the Moorgreen Hospital, Botley Road, West End, Southampton. I have held this position since November 2002.

In 1981 I graduated from St Georges Hospital, University of London. I obtained an MBBS which is a Batchelor of Medicine and Surgery.

From August 1981 to February 1982 I was employed as a house officer at St James Hospital, Balham, London.

Between February 1982 and August 1982 I was a house officer in Urology and Orthopaedics at the Mayday Hospital in Croydon.

From September 1982 to January 1983 I worked primarily as a locum in geriatrics. I have GP training experience including posts in Orthopaedics, Psychiatry, Radiotherapy, Obstetrics and Gynaecology.

I also completed a year in General Practice at the Park Lane Practice, Stubbington and Manor Way, Lee-on-Solent.

Between March 1986 and December 1986 I was employed as a Senior House Officer in Psychiatry at the District General Hospital in New Zealand.

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From March 1987 I was employed as a Senior House Officer and Registrar Rotation in Psychiatry.

Between August 1989 and May 1992 I was employed at Bristol as a Senior Registrar Rotation which included a period as a lecturer in old age psychiatry.
From May 1992 until October 2002 I worked as the consultant in old age psychiatry for the Gosport catchment area.

Between May 1992 and March 1995 I was based at Knowle Hospital. During this time there was a reprovisioning of the old age psychiatry services to the newly built Mulberry Ward at the Gosport War Memorial Hospital .

The majority of the in-patient services were transferred to the Mulberry Ward.

From January 2000 I was associate head consultant for the Fareham and Gosport locality.

My General Medical Council Registration Number is Code A I am registered with the Medical Defence Union register number Code A

In 1986 I became a member of the Royal College General Practitioners.

In 1989 I became a member of the Royal College of Psychiatrists.

In 2004 I was accepted into the Fellowship of the Royal of Psychiatrists.

Whilst I was the consultant at the Mulberry A Ward at the Gosport War Memorial Hospital I also ran the Phoenix Day Unit at the hospital. This was for assessment and treatment of mental illness for patients living in the community of Gosport and Lee-on-Solent.

Mulberry A Ward was a short term functional assessment treatment ward for elderly patients over 65 suffering primarily with depression.

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Mulberry A Ward consisted on average of 12 beds.

I was one of 3 consultant psychiatrists who had responsibility for patients on this ward.

I was responsible for patients from the catchment area of Gosport and Lee-on-Solent.

At that time working on the ward would be one or possibly two psychiatrists Senior House Officers (SHO) working on rotation as part of the Solent SHO training scheme in psychiatry. Mulberry Ward was also covered by a part time clinical assistant, Dr Code A

There would normally be two trained Royal Mental Nurses (RMN) who were not necessarily RGN qualified. The nursing staff would be supported by auxiliary nurses. There would be a Senior RMN on duty on most occasions.

I would only physically attend Mulberry A Ward approximately twice a week.

Also attached to the ward would be an occupational therapist. Their role was primarily assisting in the assessment and management plan of the patients.

I normally worked between 9am (0900) and 5pm (1700) during this period I was on call to manage psychiatric patients.

In 1996 I would conduct a ward round at Mulberry A Ward accompanied by the clinical team which comprised of a junior doctor, trained nursing staff, community psychiatric nurse, social worker, occupational therapist and physiotherapist. The clinical team would discuss each patients case in the staff room on the ward.

At this time there was a local GP practice who covered out of house calls for patients with physical problems on Mulberry A Ward.

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Psychiatric problems for the patients were managed by the on call psychiatry service between 5pm (1700) and 9am (0900) and weekends. I have been shown the photocopy of a microfiche exhibit JBC71 which are the medical/nursing notes relating to Code A

I do remember Mr Code A he was a very chronically depressed man. Mentally frail, ie, in terms of his ability to cope with life.

I do recollect visiting Code A at his home address. However I do not have the records relating to these home visits to refer to.

I have been shown page 10 of exhibit Code A which is a copy of the letter written by Dr Code A which is a referral initiated by myself relating to Code A

I have been shown a photocopy of the microfiche dated 13/12/95 (13/12/1995) which are the medical notes for Mulberry Ward A detailing the admission of the patient Code A they are as follows.

Admission 13/12/95 (13/12/1995) - admitted by Dr Code A, my registrar at this time. I was not present at the time of admission.

'Informal admission' - Code A was willing to come into hospital.
'PC' - Presenting complaint.
"Everything is horrible" this is the patient's actual statement to Code A
'From R/H - Rest Home
'Verbally aggressive to wife and staff' - My interpretation of this entry is that the patient was shouting, swearing, raising his voice.
'Staying in bed' - this is a symptom of his low mood.
'Not mobilising' - he is not initiating activities of daily living.
'Constipated' - self explanatory.
'Not eating well' again self explanatory.
Sleep - Code A states "Alright".

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No DVM - translated this means Diurnal Variation in Mood - this is a symptom of depression.

"Feels bad all the time" as stated by Code A

"Hopeless and suicidal".

The above entry by Code A are a précis of Code A presentation re his feelings.

PPH = past psychiatric history

Chronic Depression

Previous ECT course (Electro Convulsive Therapy)

Chronic Depression means patient has a substantial history of persistent depression with acute exacerbation. This patient has suffered with depression since his 50's, ie, for 30 years.

PMH = Past Medical History

Hypothyroid = Under active Thyroid Gland

Constipation

DH = Drug History

Mag Hydrox Codenthrusate - both are laxatives which have been administered to treat his constipation.

Sertraline 100mg ON - an anti depressant drug given orally (in this instance at night).

Lithium CO3 400mg ON ON = at night Lithium Carbonate. This is a mood stabiliser which is also a treatment for depression.

Diazepam 10mg bd = twice daily - this drug is used for treating symptoms of anxiety.

Thioridazine 50mgs QDS = 4 times a day - this drug is an anti-psychotic used in the treatment of depression, agitation and anxiety.

Temazepam 10mg ON. This drug is given to assist in sleeping at night.

Thyroxine 50 micro grams marne = in the morning.

Background - see previous notes. This indicates that the patient has been admitted on previous occasions which will include family background, upbringing and work history.

The drug history as detailed would have been the same as on his previous admission to

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Mulberry A Ward from the 14/9/95 (14/09/1995) to 24/10/95 (24/10/1995), ie, he would have been maintained on this regime between admissions.

MSE = Mental State Examination

A+b = Appearance & Behaviour - withdrawn, monosyllabic (ie speaks only odd words), unwilling to move or mobilise. Seems a little agitated and irritable.

Speech - indistinct, quiet, nil spontaneous except one statement.

Mood "I might as well tell you I just want to be dead". This reinforces that Code A was depressed and has thought about overdosing.

Thoughts (Code A form and structure).

"No hallu" = hallucinations, delu = delusions - these are severe psychotic symptoms of depression.

Insight, ie, someone's understanding of their illness.

"I'm a wreck, I might as well be dead".

Physical - full rectum, ie an examination of the patient's rectum has revealed his passage was full of stools which could be a reflection of his constipation.

P80 reg - Pulse 80 reflection of heart rate - in this case showing it is regular.

HS1-11 - heart sound 1st and 2nd nothing abnormal noted.

Shuffling gait - this normally indicates that a person walks with very small steps, does not lift feet off the ground.

2 mobilise - ie, that it takes 2 nurses/members of staff to get Code A out of a chair or bed.

Slight tremor on moving - I believe this refers to Code A hands slightly shaking.

Ä = Diagnosis. Depressed.

The following is the care plan and investigation initiated by Code A

ECT discussed - no decision, ie, Code A was not sure that he wanted this course of therapy.

Bisocodyl suppositories - a laxative inserted into the back passage.

Check [LI] - check Lithium - this means to check that he is on an effective dose of Lithium.

U&E = Urea & Electrolytes - this means check with blood tests to establish levels are normal or otherwise.

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Recent = means tests completed TFT, LFT & FBC normal.

TFT - thyroid function test ie, that he is receiving adequate thyroid replacement.

LFT = Liver function test

FBC = Full blood count - checks were made to ascertain if he was anaemic.

D/W = discussed with Code A , this indicates that Code A would have either phoned me or spoken to me in my office at Gosport War Memorial Hospital regarding Code A admission, treatment and care plan.

+further info from R/H = further information available from the rest home.

15/12/95 (15/12/1995) - asked to see - fell yesterday evening no injury noted, not any pain except back pain this am - physio will assess long standing mobility problems - ?2° to OA this means secondary to Osteoarthritis which is a degenerative joint disorder.

Try PRN = Paracetamol, ie, as required.

With reference to the above entry I am unable to identify which doctor made this entry.

20/12/95 (20/12/1995)

Bowels → loose stools 5 days

? diahorrea

? overflow

This would indicate that the bowels of Code A were very full of hard stools with liquid stools bypassing the hard stools.

Abdo = abdominal examination of the middle torso

Soft = non tender. BS - Bowel sounds normal

PR = Rectal examination empty

→ = plan for Code A AXR = abdominal x-ray which in this case have been seen showing the bowel is empty.

→ = for reporting.

Stop aperients - stop laxatives.

This entry has been signed by Dr Code A

Signed: Code A

Signature Witnessed by:

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20/12/95 (20/12/1995) WR = Ward Round by Dr Code A (a specialist registrar). This indicates that I was not present at the hospital at this time.

Mobility ↓↓- this indicates that it has reduced, is poor.

V. Parkinson features - this indicates that the patient is stiff has a shuffling gait and tremors.

Low +++ = very depressed

↓ = decrease Thioridazine to 25mg QDS - 4 x a day

+PRN = as required.

Procycladine 5mg BD = 2 x a day - review Friday.

?↑ = increase Sertraline next week.

This entry has been signed by Dr Code A

22/12/95 (22/12/1995)

Diahorrea x 1 this morning

Generally weak today.

Left basal crepidations = abnormal noises in the bottom left had side of the chest.

Chest Infection

Plan - Encourage oral fluids - no solid food yet.

Enythromycin suspense = antibiotic in fluid which is the treatment for his chest infection.

250mgs TDS = 3 x a day.

This entry signed by Code A (a part time clinical assistant at the time of this entry).

27/12/95 (27/12/1995) Code A

Chesty - sounds noisy coughing sputum

Poorly = unwell, abusive (to staff and family).

Not himself at all.

→ plant, chest physio, sputum sample. Enythromycin finished → for cefactor = a different variety of antibiotic to treat the chest infection.

STOP procycladene until well.

Reassess mood once medically better.

Also ? further INX - investigation of bowel. This means there may be an underlying problem

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with Code A bowels which may need further investigation and treatment.

Catheterised end of last week by on call GP as in urinary retention = on call GP attended and inserted a tube into Code A penis in order that he can relieve himself.

Geriatrician review may be helpful.

CXRV = chest x-ray form has been organised.

This entry has been signed by Code A

27/12/95 (27/12/1995)

Physio = Physiotherapist has attended.

Thank you for this referral - obs = observations, BS = throughout = has listened to Mr Code A chest.

↓ (L) = left, LZ = indicates reduced breath sound to the left lower zone of chest - few scattered coarse inspiratory crackles = added noises indicating a possible infection.

RXACBTS = Active cycle breathing treatment.

- ↓° expectorated = no sputum produced.

Post drainage shown to N/S, ie, nursing staff shown how to move/shift the patient in order to move the sputum.

RV Marne =review morning.

This entry was written by an unknown physiotherapist.

2/1/96 (02/01/1996) - remaining poorly and lethargic.

Reports of him saying "Why don't you let me die".

Skin breaking down - Pegasus bed = a specially designed very expensive bed designed to alleviate pressure on the skin.

V. Poorly - I interpret that Code A was very frail, very unwell. The chances of recovery are becoming increasingly unlikely.

FBC √ = rechecking blood tests.

U&E √ = (LI) + TFT = all tests to be arranged again.

Geriatrician review to make sure not medical problem - which translated means an examination

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by a geriatrician has been requested.

This entry has been signed by Dr Code A

The following entry is written also by Dr Code A

2/1/96 (02/01/1996) - Dear Dr Code A

Thank you for seeing Code A who has been treated for many years for resistant depression. On this admission his mobility initially deteriorated drastically and then he developed a chest infection. His chest infection is now clearing but he remains bed bound, expressing the wish to just die. This may well be secondary to his depression but we would be grateful for any suggestion as to how to improve his physical health.

Thanks Code A

(PS He also complains of some abdo pain intermittently which I thought may have been constipation but an AXR showed his bowels to be very empty so his aperients were stopped. Unfortunately he still has pain intermittently).

3/1/96 (03/01/1996) W R Dr Code A

Poor food intake, fluid ok

Deteriorating, some breaks in skin now.

? fit for ETC - may not agree to it? Would it work.

→ (means go to) fortisips (a high calorie drink) plus high protein diet.

Await EC - elderly care review.

Needs more time to convalesce. ↓ = decrease Diazepam. Stop Thioridizine + Temazepam.

Watch for benzodiazepine withdrawal - this means that Mr Code A has been on both these drugs for some considerable time and stopping them can cause an unpleasant, distressing withdrawal symptom.

Probably will need NH - nursing home.

This entry has been written and signed by Dr Code A

The following entry relates to blood test results.

GLU 4.3 = a normal reading.

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U = Urea -7.2 PO4 1.05 AST 127

Na = (Sodium) 137 Ca (Calcium) 2.21 (2.45) adjusted calcium Alk 110 K = (Potassium) 4.8

Bili (bili Rubin) 9 Cr (Creatine) 91 Alb = (Albumin) 27 T.Pro 57.

I am unable to state who wrote this entry.

These readings obtained from the blood test results are indicators of bodily function.

Noticeably the albumin scored at 27 is low which is a reflection of his poor dietary intake.

The next entry dated the 4/1/96 (04/01/1996) is the examination and assessment of Code A Code A by the consultant geriatrician Dr Code A which reflects the entries as previously shown in the patients medical notes.

4/1/96 (04/01/1996) Elderly Medicine

Thank you. Frail 82 year old with

1.Chronic Resistant Depression - very withdrawn

2.Completely dependent - bartel 0

3.Catheter by passing

4.Ulcertaion (superficial) of (L) buttock and hip

5.Hyproproteinaemic

Suggest

1.High protein drinks

2.Bladder wash outs x 2/wk, ie twice a week

3.Catheter by passing, ie, the urine is going down the inside and outside of the tube from the bladder.

4.I'd be happy to take him over to a L/sty bed at GWMH.

I feel his RH place can be given up as he's unlikely to return there.

(This entry signed by Dr Code A - geriatrician).

In this letter by Dr Code A I believe she has summarised Mr Code A severe mental illness and has recognised that he has been physically unwell with a chest infection.

Signed Code A

Signature Witnessed by:

RESTRICTED

Dr Code A has identified that Code A is entirely dependent on nursing staff for his activities of daily living (ADL).

She has summarised his poor physical condition which outweighs his mental condition. Therefore she has suggested that Mr Code A should be transferred to Dryad Ward which could manage his physical state more appropriately.

She has given guidelines as to his management.

The letter also notes that Code A has been made aware of her husband's frailty and poor outlook, ie, that he may not survive to leave the hospital.

Code A was transferred to Dryad Ward on the 5/1/96 (05/01/1996).
I had no further dealings with Code A

At this time in 1996 the policy and procedure in respect of entries in the clinical notes written by doctors were completed/recorded when the patient was reviewed on or shortly after a ward round. There would be timely entries detailing the review of the relevant problems which had been noted and discussed by the clinical team in relation to each patient.

These entries would summarise current medical, physical and psychiatric problems.

Other entries would be initiated as part of a planned review by medical staff including physiotherapists or at the request of other members of the clinical team, ie, nursing staff or at the request of the patient or relatives.

Entries into the clinical notes are only made where necessary and relevant.

There is no set format for entries written into the clinical notes.

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There are no entries in the clinical notes over the weekends as there were no resident doctors at that time.

I have previously been consultant for the treatment of Mr Code A mental health illness since I started as a consultant in 1992. I was aware that Mr Code A had suffered from a chronic resistive depression since the early 1960's.

In my role as a consultant psychiatrist I monitored Code A illness with other members of my community mental health team primarily his CPN (Community Psychiatric Nurse) a Mr Code A and his social worker Code A
This was undertaken whilst Code A was resident at Hazledene Rest Home, Bury Road, Gosport . He was monitored on a regular basis by the mental health team whilst he was at the rest home this was between 1993 and 1995. From researching the medial notes I am able to state that Code A was admitted to Alverstoke Ward on the 27/4/92 (27/04/1992) and discharged on 3/2/93 (03/02/1993) at Knowle Hospital and again on the 21/6/93 (21/06/1993) until the 9/7/93 (09/07/1993) when he was discharged back to Hazledene Rest Home.

He was again admitted on the 14/9/95 (14/09/1995) to the Mulberry Ward at Gosport War Memorial Hospital for assessment and treatment for his chronic depression. He was discharged on the 24/10/95 (24/10/1995).

Code A was again admitted on the 13/12/95 (13/12/1995) on an informal basis to the Mulberry Ward at the Gosport War Memorial for further treatment and assessment for his chronic resistant depression.

On the 5/1/96 (05/01/1996) Code A was transferred to the Dryad Ward as previously mentioned.

Where it is written on Code A notes that geriatricians advice would be helpful, it had been agreed by the team review that his physical state was very poor. It was therefore decided to request examination of Code A by a geriatrician in order that his physical state could

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be reviewed. This was done promptly by Code A

In the event that a patient on Mulberry Ward was expected to die then the process that was undertaken at that time as far as I can recall is as follows.

If there were concerns about someone's physical health and there was a possibility of the patient dying then a member of the medical team would meet with the family or discuss over the phone with the family the patient's poor prognosis.

Once it had been established with the family that the patient was expected to die.
The next step would be a formal 'sick noting' of the patient. This was a form written by a nurse or a ward doctor giving a brief outline of a patient's very poor physical state or poor prognosis. A copy was given to the relatives and a copy was pinned to the front of the patient's notes.

If the patient subsequently died then it was the procedure for qualified nursing staff to verify the death.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: REGISTERED MENTAL 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: 09/09/2004

I live at an address known to the Police.

I am a Registered Mental Nurse (RMN); my General Medical Council number is Code A I qualified in 1991 at Southampton University. I did my training at Knowle Hospital, Wickham, Southampton .

My qualification is the same as a Registered General Nurse, but is specialised in mental health. I am not qualified to work on a general ward.

Upon qualifying in 1991, I worked at Knowle hospital on GALBRAITH ward. This was an acute ward.

In 1995 I moved to ALVERSTOKE ward within the same hospital and when ALVERSTOKE ward moved location to the GOSPORT WAR MEMORIAL HOSPITAL (GWMH) and became MULBERRY ward, I moved with it. This ward is an elderly mental health ward, its patients are aged 65 and over. The ward was divided into three sections, these were 'A' which contained patients who were 'functionally ill'. By this I mean were suffering from something like depression or grief, they were expected to be treated and then discharged. Section 'B' which contained patients who were suffering from the early stages of dementia but would have periods of lucidness and Section 'C'. These patients were suffering from dementia; they would be incontinent, not eating and regressed. They were highly dependant. At this time I would have been involved with the everyday care of the patients, I would have been a 'named nurse' for some of them. By this I mean that I would have been responsible for identifying that individual

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patient's problems in relation to their care needs, as apposed to their medical needs. Determining the over all goal in relation to the problem and devising the action plan, the method by which that goal would be attained. I would also be more available for the patient by that I mean I would spend time chatting with them and being the person who they recognised as being 'their' nurse.

As a trained member of staff I would have been responsible for the dispensing of medication to the patients. If the medication was a controlled drug then two members of trained staff would check a patient's prescription and then take the drug out of the controlled drug cupboard, enter the amount taken in the controlled drug book and make an entry on the patient's drug card. Both members of staff would then witness the patient taking their medication.

If the drugs required were not controlled drugs then I would dispense them by myself.
Whilst working on MULBERRY ward I worked an 'in house' shift system. I worked a 0700 - 2100 shift three days a week and then had four days off. I always worked days.

In June 1996, due to disability, I was unable to continue working on the ward and upon my return to work in December 1996, I took up my current post.

I am currently working as a RMN E grade, at Lee Grove House, Gosport. This is an eight bed adult mental health rehabilitation ward. My responsibilities are to teach everyday living skills to people who have become institutionalised, in order to determine the most appropriate environment for them to live in.

I have been asked if I can recall a patient by the name of Code A.
I do recall this gentleman, I first met him when I was working on ALVERSTOKE ward as a student. It would have been between July and September 1990, I was 21 in the September and this is why I can place the time. I also recall him because he was the father of a lady who worked within the mental health field, a Code A. I had worked with her at HEWITT HOUSE, where she ran the day hospital.

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I remember Code A as being a stocky, strong man with grey hair and a beard. I remember him as being chatty but I can not recall anything about his illness. I do remember that he was well known to the team I worked with and was admitted on a regular basis.

I next met Les some 5 to 6 years later when he was admitted to MULBERRY ward from a nursing home. . I cannot remember if I was his named nurse or the nature of his illness at that time.

I recall that he had lost a lot of weight and seemed to be frail and thin in comparison to when I had last met him.

I have been shown a copy of a document identified as Code A. This is the front page of a transfer details form. I can identify the handwriting as mine. This document is filled in when a patient is moved from one ward to another location. This could be another ward in the same hospital or to another hospital or to a care or nursing home
This transfer form relates to Code A and I have written the following under Section One, Personal Details. MULBERRY ward area A, DRYAD ward. This means that the patient was moved from Mulberry ward 'A' section to Dryad ward at the GWMH.

I have noted his pre-admission address as HAZLEDENE REST HOME, BURY RD, GOSPORT. P.527153

P. means Phone.

I have noted the date and time of transfer as being FRI-5-1-96 (05/01/1996), the patients name as Code A his forename as Code A and that he likes to be known as Code A

Under reason for admission I have put LOW IN MOOD-VERBAL AND PHYSICAL AGGRESSION.

I cannot remember the actual circumstances of Code A admission but from this entry I assume this

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relates to his behaviour in the nursing home. Under date of admission to hospital, I have written 13-12-95 (13/12/1995). This would have been the date that Code A came to Mulberry Ward.

Under name of Patient's Advocate, I have written Code A (DAUGHTER) Code A Code A TEL Code A OR Code A Code A (WIFE) Code A Code A

Under Section Two, Medical Details I have written the following.

Consultant, DR Code A, Named Nurse, Code A S/N.

From this I can see that I was Code A named nurse but I have no recollection of this.

The S/N stands for Staff Nurse.

I have noted Code A GP as DR Code A telephone number Code A

Under Relevant Medical History, I have written PARKINSON'S DISEASE. This means that Code A was suffering from Parkinson's disease.

Under Current Medication I have written the following, SERTRALINE 100MG NOCTE. This drug is an anti-depressant and was given at night (nocte) LITHIUM CARBONATE 400MG NOCTE. This drug is a mood stabilizer, it would be given for manic depression and mood swings and was again given at night. DIAZAPAM 2MG, T.D.S(8AM 5PM 10PM) (0800 1700 2200). This is a muscle relaxant and sedative and was given three times a day at 8am (0800), 5pm (1700) and 10pm (2200). THYROXINE 15MCG AM ONLY. This is given to people with a thyroid problem and was given in the morning. CEFACLOR 250mg- T.D.S. This is an anti-biotic and was given three times daily. SUBY G- BLADDER WASHOUT-TWICE WEEKLY. This is a brand name for a solution used to clean a patient's bladder.

I have been shown a copy of a document Code A This is the continuation of the transfer

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details form and the handwriting is mine.

This page is headed Section Three, Nursing Needs.

Under Physical I have written, POOR PHYSICAL CONDITION-BROKEN PRESSURE AREAS TO BUTTOCKS AND HIP. This means that Code A had open wounds on his bottom and his hip. FULLY CATHERTERIZED SINCE FLUID RETENTION ON 23-12-95 (23/12/1995). This means that he had been fitted with a catheter on 23-12-05 because he had difficulty passing urine. BROKEN SKIN ON SCROTUM. This means that he had open sores on his scrotum. NURSED ON A PEGASIS MATTRESS. This means that Code A had a special pressure relieving mattress. WEIGHT BEARING TO A VERY MINIMAL DEGREE. This means that Code A could stand and bear his own weight to a small degree.

From this entire entry I get the impression that Code A would only get out of bed to stand next to it with support and that he was nursed in bed most of the time. There is no mention of him requiring a sheep skin in a wheelchair.

Under Psychological I have written, LOW IN MOOD FOR MANY YEARS-ON ANTI-DEPRESSANTS. VERY SETTLED IN BEHAVIOUR DUE TO POOR PHYSICAL CONDITION.

By this I mean that Code A had been depressed for many years and that he was prescribed antidepressants for this and that He remained constant in what he did due to his poor physical state.

Under Nutritional I have written, POOR FLUID + DIET INTAKE ALTHOUGH FLUTTUATES AT TIMES AND SOMETIMES BECOMES QUITE GOOD. NEED TO PUSH 'FORTISIPS' DRINK-LES LIKES STRAWBERRY FLAVOUR. LES NEEDS FULL HELP WITH FEEDING/DRINKING. Code A SOMETIMES REQUIRES/USES A STRAW TO DRINK.

By this I mean that Code A was not eating and drinking much, but this could change and he would improve his intake. Where I have written 'need to push Fortisips drinks.' I mean that Code A was to

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Continuation of Statement of: Code A

Form MG11(T)(CONT)

be encouraged to drink these milkshake type drinks as they contained vitamins and nutrients.

Where I have written Code A needs full help with feeding/drinking I mean that he required help with his meals. This may just take the form of sitting with him and encouraging him to eat or it could mean that he needed to be physically fed.

Where I have written Code A sometimes requires/uses a straw to drink. By this I mean that Code A would sometimes use a straw to drink with. The ' requires/ uses' would indicate to me that sometimes he may need physical help to drink using the straw and sometimes he would drink by himself using the straw.

Under Social Domestic I have written ALWAYS HAS BEEN A BIT OF A LONER BUT SOMETIMES ASKS STAFF TO SIT WITH HIM. By this I mean that Code A didn't mix with the other patients but occasionally would request the company of a member of staff.

I have signed and dated this form 5/1/96 (05/01/1996). I would have completed it on the day of his transfer to Dryad ward.

Taken by:DC Code A

Signed: Code A

Signature Witnessed by:

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

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

This statement (consisting of 7 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 28/09/2004

I am 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 which is a Bachelor of Medicine and a BS which is a Bachelor of Surgery.

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

I have worked at the General Hospital, Colombo as a Senior House Officer and a Registrar in General Medicine up to 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 and September 1988 I was employed as a Registrar in Geriatric Medicine at St Mary's and Queen Alexandra Hospitals, Portsmouth .

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

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From the 31st March 1992 (31/03/1992) 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

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

I have been shown a photocopy of the microfiche exhibit ref Code A pages 5 and 10. I can confirm that I was the author of the typed letter dated 8/1/96 (08/01/1996).

In 1996 I was a consultant geriatrician. My responsibilities included, In Patients at Queen Alexandra Hospital, Daedalus Ward at Gosport War Memorial Hospital, Kingsclere Rehabilitation Ward at St Mary's Hospital. I also conducted a day hospital session at the Amulnee Day Hospital located at St Mary's Hospital and Dolphin Day Hospital at the Gosport War Memorial. The sessions alternated every week.

I also held an out patient sessions weekly at St Mary's Hospital. On the 1st, 3rd and 5th weeks I held sessions at the Gosport War Memorial Hospital.

I was the 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.

At that time in 1996 I believe it was Code A who was the Clinical Director of the department.

Firstly I must explain where other departments require an assessment and believe the patient's physical condition requires specialist geriatric assessment a referral is made to the Department of Medicine for Older People.

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It was in this context I was asked to see the patient Code A I do not recollect the patient or indeed the assessment of Code A on the 4th January 1996 (04/01/1996).

I am therefore reliant on my assessment letter. My usual practice includes examining the patient, reviewing the available medical and psychiatric notes. Liaising with the medical and nursing staff as appropriate.

This assessment was undertaken by myself in response to a referral from Dr Code A (Consultant in old age psychiatry) or a member of her team.

It was an overall assessment to determine whether the patient's best interest would be served by him remaining on the psychiatric ward or by his transfer to the Department for Medicine for Older People.

I can confirm that I wrote the following within the letter referred to as page 5 exhibit Code A

"Thank you for referring Code A whom I visited on Mulberry A on 4 January. He has had chronic resistant depression and long courses of ECT (Electro Convulsive therapy) in the past, have not been effective. He has recovered from a recent chest infection (A) but is completely dependent with a Barthel of O, is catheterised (B) and has superficial ulcers on the left buttock and left hip (C). He is also hypoproteinaemic with an albumin of 27 and is eating very little, although he will drink moderate amounts with encouragement. I feel he needs high protein drinks as well as a bladder wash out twice a week but overall feel that his prognosis is poor and would be happy to arrange transfer to Dryad Ward on 5 January. I gather that Code A Code A is also aware of the poor prognosis.

As he is unlikely to return to Hazeldene Rest Home I feel that his place there could be given up". (This entry signed by Code A.

With reference to this letter that I have written I have the following comments to make which

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may clarify parts of the letter.

He has had chronic resistant depression and long courses of ECT in the past have not been effective.

ECT means Electro Convulsive Therapy. This information would have been obtained from my review of his psychiatric notes. It provides background information as to why the patient was in Mulberry Ward A in the first place.

With reference to the sentence marked (A), "He has recovered from a recent chest infection".

I would have seen from the notes that this had resolved.

With reference to the entry marked (B), the Barthel score. This is a functional assessment of the activities of daily living. A score of 20 would indicate that a person was completely independent in their self care, able to do the stairs unaided and able to transfer in and out of the bath unaided. Also would be continent of urine and faeces. Therefore the Barthel score of 0 indicates that the patient would be completely dependent on nursing care for his daily living and also care for his bladder and bowels. The patient would have been unable to manage his catheter.

With reference to the entry marked (C), "and has superficial ulcers on the left buttock and left hip. The ulcers would represent pressure sores and indicate the need for good pressure relief and intensive skin care.

The letter continues "He is also hypoproteinaemic with an albumin of 27 and is eating very little although he will drink moderate amounts with encouragement. I feel he needs high protein drinks.

The word 'hyproproteinaemic' indicates a low protein level in the blood and reflects poor nutritional intake over a significant period of time. It often indicates chronic ill health in the

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absence of excessive protein loss from the body.

Albumin of 27, this is a measurement of the protein level in the blood. The normal reading is between 37 -50 grams per litre. The albumin level is obtained from the patient's blood test results recorded in the psychiatric notes.

In order to supplement the patient's nutritional intake I have suggested that he is given a protein supplement.

The letter continues ... 'as well as a bladder wash out twice a week ...'. I have made this comment on the basis of a review of the records and/or discussions with the nurses. In cases where the catheter frequently blocks, bladder wash outs are one of the ways in which to maintain potency.

The letter continues with the following '... but overall feel that his prognosis is poor and would be happy to arrange transfer to Dryad Ward on 5 January. I gather that Code A is also aware of the poor prognosis. As he is unlikely to return to Hazeldene Rest Home I feel that his place there could be given up'.

My conclusion that his prognosis was poor was based on the following factors:-

His extreme functional dependency in the absence of an acute medical problem such as a stroke. His poor nutritional state - pressure sores together with a background of long standing depression.

It was therefore my original impression that his physical needs outweighed his psychiatric problem and the transfer to Dryad Ward was appropriate.

I would have found out whether a bed was available on Dryad Ward to be in a position to arrange the transfer on the following day the 5th January.

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With regards to Hazeldene Rest Home I have stated that Code A bed could be given up.

This I would only do when I was satisfied that the patient's condition and prognosis was so poor that he would not be able to return to the rest home.

The transfer to Dryad Ward was in order to address the patient's physical needs as well as his psychiatric needs.

The letter relating to the patient Code A is a summary of my assessment of the patient. It is intended to provide interim guidance for the staff on Mulberry Ward pending transfer and initial guidance to staff on Dryad Ward after transfer.

Finally it is intended to inform any other teams involved in the patient's care. In this case the GP, Code A

I should make it clear that it is not intended to be a comprehensive care plan. The care plan would be devised by the medical and nursing staff after transfer to Dryad Ward.

There were 5 copies of this letter. The top copy went to Code A the referring psychiatrist, the other copies would have gone to Dr Code A Sister Code A, a copy placed with the patient's medical notes on Dryad Ward and a further copy filed in the Elderly Medicine office at Queen Alexandra Hospital.

I have reviewed the clinical notes of the patient Code A exhibit Code A. There are no other entries by me. I can see no references on the nursing notes to indicate any further involvement by me in this patient's clinical management.

Where I refer to a poor prognosis this would indicate that the patient's chances of survival were slim. Mr Code A was unlikely to survive for very long.

Taken by:DC Code A

Signed: Code A

Signature Witnessed by:

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

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

This statement (consisting of 12 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: 20/12/2004

I am employed by East Hants Primary Care Trust as a Consultant Geriatrician in Elderly Medicine and have been so employed since 1994.

From 1997 I continued in this position on a part time basis.

My General Medical Council registration number is Code A

In 1983 I graduated with an MBChB which is a combined Bachelor of Medicine and Surgery at the University of Edinburgh.

In 1986 I obtained a MRCP which is a post graduate medical qualification and became a member of the Royal College of Physicians.

From August 1983 to January 1984 I trained as a house officer in medicine at the City Hospital in Edinburgh.

In February 1984 I transferred to the Chalmers Hospital in Edinburgh where I trained as a house officer in surgery.

Between August 1984 and September 1986 I was Senior House Officer in Medicine at the New Cross Hospital in Wolverhampton. Then Senior House Officer in Medicine at the Lewisham Hospital in London.

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From April 1986 until September 1986 I was employed as Senior House Officer in Neurology at the Brook Hospital in London.

Between October 1986 and September 1988 I held the post of Registrar in Medicine at the Salisbury General Infirmary, Wiltshire and then at the Southampton General Hospital.

From October 1988 until November 1991 I worked as a research registrar under the supervision of Professor Code A at the Southampton General Hospital.

Between November 1991 and May 1994 I held the post of Senior Registrar in Geriatric medicine at hospitals in Portsmouth and at the Southampton General Hospital.

My current responsibilities as a Consultant Geriatrician include working on Mary Ward an acute ward at the Queen Alexandra (QA) Hospital. Patients admitted to this ward are in the main patients over the age of 65 who have suffered from a stroke.

I also hold an 'out patients' session once a week at St Mary's Hospital. I see general medical patients as well as stroke patients. I cover ward rounds on a rotational basis with other colleagues for the Medical Admission Unit at the Queen Alexandra Hospital.

If there are patients on the Medical Admission Unit or the Accident and Emergency Department whose likely diagnosis is a stroke, then subject to availability of a bed, the patient will be transferred to the Mary Ward at the QA.

Mary Ward is currently the responsibility of Dr Code A and myself. Patients admitted to this ward are seen on consultant ward rounds. Dr Code A and myself conduct two ward rounds per week.

Day to day medical care is provided by junior hospital doctors.

With regards to the one 'out patient' session held at St Mary's Hospital, Portsmouth.

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GP's and occasionally hospital DR's refer their patients to this Out Patients session.

I also conduct ward visits where patients are referred by other departments within the hospital to give advice, re elderly care.

On occasions I conduct domiciliary visits at the request of the elderly patient's GP.

I have been shown a photocopy of the microfiche exhibit Code A page 9 which is a provider spell summary (which every patient admitted to hospital should be provided with).

I can confirm that I was the consultant for the patient Code A, DoB Code A

I have checked the spell summary (page 9, Code A, I am unable to establish what the diagnosis was in relation to this patient as it is illegible.

I can state that I have no recollection of Code A or subsequent examinations.

On examination of this form I note there are codes relating to the specific diagnosis of the patient.

These codes are inputted by the coding department within the hospital. I am unable to decipher the codes.

On the 10th January 1996 (10/01/1996) I was the consultant for Dryad Ward, Gosport War Memorial Hospital . I had overall medical responsibility for the ward.

Dryad Ward largely contained frail and elderly patients who would be difficult to manage in a nursing home because of their medical and or nursing needs.

These patients would have been assessed prior to transfer to Dryad Ward by a Consultant

RESTRICTED

Geriatrician.

Dryad Ward was a long term care ward and generally patients were transferred from other wards within Portsmouth Hospital.

At this time in 1996 there was not a resident doctor for these patients on Dryad Ward.

Day to day cover was provided by the local GP. In the case of Dryad Ward this was Dr Code A and possibly others from her practice.

My responsibilities included a ward round on Dryad Ward once a fortnight. I would normally be accompanied by a senior member of the nursing staff and Dr Code A.

My usual routine when conducting a ward round would be see all patients. I would discuss the care of the patients with the ward team. I would talk to the patients and examine them if appropriate.

I would review drug regimes where relevant with the ward team. I would also review any blood test results, x-rays or other test results relating to the patient. I would check the medical notes thoroughly especially if the patient was new to me.

One of my responsibilities was to review the prescription of drugs on the Dryad Ward at Gosport War Memorial Hospital.

The majority of drugs can only be prescribed by a doctor. The day to day administration of drugs would be by qualified nursing staff.

As a consultant Geriatrician I covered Dryad Ward from 1994 until the end of 1996.

Drugs can only be prescribed by a doctor. Drug doses could be modified, current drugs stopped or new drugs added depending on the patient's condition.

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The drug regime would be reviewed by the consultant on the ward round as appropriate during the week by the General Practitioner (GP) where necessary.

There was no requirement to notify me of every change to drugs prescribed to a patient by the GP during his or her ward round unless the GP sought my advice.

From my experience it was very infrequent that a doctor would phone me for advice.

I have examined the drug chart page 16, a photocopy of the exhibit Code A in relation to Code A Code A

On the drug chart there is recorded the following entries as I understand them commencing on the 5th January 1996 (05/01/1996).

Sertraline 50mg which would have been administered with either 2 x tablets twice a day or 1 tablet once a day.

This drug is an anti-depressant which the patient was taking whilst on the Mulberry Ward at Gosport War Memorial.

Lithium Carbonate which I believe to be 400mg to be administered 1 x day. This drug is used for mood stabilising. It is a drug which was also prescribed prior to his transfer to Dryad Ward.

Diazepham 2mg given 3 x day. This drug is anxiollytic which is used to reduce anxiety. It has a side effect that can make a patient sleepy. Again this drug had been previously prescribed on Mulberry Ward.

Thyroxine 50mg 1 x tablet per day. This is a hormone replacement drug for an under active thyroid gland. This also would have commenced whilst the patient was on the Mulberry Ward.

RESTRICTED

Also recorded on the drug chart is Daktacot. This is a cream for treatment of skin problems. It contains steroids and an anti fungal agent. Only one application has been recorded as being given to the patient.

Arthrotec commencing on the 8/1/96 (08/01/1996). This is a pain killer. A non steroidal anti flammatory drug with susoprostol which helps protect the stomach against ulceration. This drug is in the form of a tablet given twice a day.

This was initiated by Dr Code A

On the 10th January 1996 (10/01/1996) I conducted a ward round together with Dr Code A and Sister Code A on the Dryad Ward.

Oramorph 5mg commenced @ 2200 hrs on the 10/1/96 (10/01/1996). 5mg @ 5 x a day. This is an opiate drug which is given orally. It is primarily used as a pain killer.
Oramorph was given as a result of the patient stating that he was in pain. It was given to alleviate the pain and also help alleviate any distress.

On the 11/1/96 (11/01/1996) the drug chart was re-written by Dr Code A The Diazepham has been increased to 5mg to be given 3 x a day.

Oramorph has been maintained at 5mg 4 x a day. The dose at night has been increased to 10mgs. This would be to try and render the patient pain free at night.
This dosage being given orally is maintained until the morning drug round conducted by Dr Code A on the 15/1/96 (15/01/1996).

On the 12/1/96 (12/01/1996) the Sertraline and Lithium Carbonate have been stopped by Dr Code A

On the 15/1/96 (15/01/1996) it appears that a syringe driver was commenced containing Diamorphine , an opiate drug. The dosage was recorded at 80mg over 24 hours.

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Diamorphine is used as a pain killer and to alleviate distress by making the patient more comfortable.

Also contained within the syringe driver was Hyoscine in the quantity of 400 micrograms. This is used to dry up secretions on the patients chest.

Midazalam 60mg over 24 hours was prescribed and put into the syringe driver. This drug is another anxiollytic drug used to reduce anxiety and agitation.

On the 16/1/96 (16/01/1996) the mixture of drugs in the syringe driver continues at the same dosage rate. However Haliperidol @ 5mgs over 24 hours was added to the driver. Haliperidol is an anti psychotic drug which can be used for acute confusion and agitation.

The above driver containing Diamorphine, Haliperidol, Midazalam, Hyoscine were only given as the patient was distressed. These drugs administered subcutaneously are intended to alleviate the patient's symptoms.

On the 17/1/96 (17/01/1996) it is noted at 0900 hrs that nurses records show the patient remaining tense and agitated and distressed on turning. The patient is seen by Dr Code A and a note recording the medication has been reviewed an altered.

However I am unable to read the entry for the prescribed dosage of drugs for the 17/1/96 (17/01/1996) as they are illegible. However it would appear the dosage of Diamorphine has been increased to 120mgs. From the 18th January 1996, 18/1/96 (18/01/1996) the following dosage of drugs are administered in the syringe driver for Code A

Haliperidol 20mg over 24 hrs
Diamorphine 120 mg over 24 hrs
Hyoscine 12000 micro grams over 24 hrs
Midazalam 80mgs over 24 hrs

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At this stage there were two (2) syringe drivers in operation delivering this dosage at a constant even rate.

Also added/included in the syringe driver at the same time was Nozinan 50mg over 24 hrs.

On page 27 of the nursing notes of the exhibit Code A Nurse Code A notes the fact that the patient's skin was marking easily despite hourly turning. The patient remained distressed on being turned. The patient was on a special mattress to help prevent pressure sores.

Mr Code A at this stage was very poorly.

My observation with regards to the initial dosage of drugs used when the syringe driver was set up is as follows.

I would have used a lower dosage of the Diamorphine and Midazalam.

However I must point out that I did not see the patient when this dosage was commenced.

At that time there was no resident doctor at Gosport War Memorial Hospital to review the medication and these dosages.

Therefore the prescribing doctor cannot always be present to change the dosage if and when required.

I will add that I am not an expert in palliative care.

From the 18/1/96 (18/01/1996) the doses of Midazalam, Diamorphine and Hyoscine were not changed.

The Haliperidol was stopped on the 20/1/96 (20/01/1996).

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The Nozinan was increased to 100mg over 24 hrs on the 20/1/96 (20/01/1996) as the patient's symptoms were still not controlled.

From the 20/1/96 (20/01/1996) the dosage of Diamorphine, Midazalam, Hyoscine and Nozinan remained the same and continued to be administered until the death of Mr Code A
On reviewing the nursing and medical notes it would appear from the 21/1/96 (21/01/1996) that the patient was much more settled.

Where I have stated that the patient, Code A was very poorly, from reading his notes it was likely that this patient was dying.

I have been shown and reviewed the photocopy of the microfiche of exhibit Code A page 13.

I can confirm that the entry dated 10/1/96 (10/01/1996) was written by me during a ward round at Dryad Ward, Gosport War Memorial Hospital.

The following has been written
10/1/96 (10/01/1996) - Depression)
- Catheter)
- Superficial illness) transfer from Mulberry
- Bartel O)
- Will eat and drink)

For TLC -
(1) D/W wife - agrees in view of v poor quality TLC
Signed Code A.

Where I have written 'Depression' I have observed that the patient was seen by Dr Code A on the Mulberry Ward. There is a letter from the Consultant Dr Code A on page 10 of exhibit Code A outlining the psychiatric and medical history of the patient which resulted in the transfer of Mr Code A to Dryad Ward. The letter states that Mr Code A diagnosis was chronic resistant

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depression. He had also suffered from a recent chest infection. At the time of transfer to Dryad Ward he was also hypoproteinmic.

This means that the proteins in his blood were low which might be due to his poor nutritional state.

The history of the patient has also been summarised by Dr Code A at the beginning of the medical notes on his admission to Dryad Ward on the 5/1/96 (05/01/1996).

Where I have written 'Catheter', I have reviewed the patient's notes and noted that due to his inability to pass urine a catheter was fitted on the 23/12/95 (23/12/1995) whilst he was on the Mulberry Ward.

Where I have written 'Superficial Ulcers', these were noted to be on the patient's left buttock and left hip. This is a sign of immobility and general poor health.

The nursing notes on page 12 state that the patient has broken skin on his scrotum.
Where it is written 'Bartel Score 0'. This means that the patient was completely dependent on nursing care. He had a catheter inserted and was incontinent.

It was also noted within Dr Code A letter that the patient is eating very little and will drink moderate amounts with encouragement.

Where I have written 'will eat & drink'. At this stage it was one of the few activities of daily living that Mr Code A was able to manage.

Where I have written 'Transfer from Mulberry Ward' this is self explanatory.

Where I have written 'For TLC', I mean that the patient is kept comfortable, that he is not in pain or distressed.

RESTRICTED

Where I have written 'D/W - wife agrees in view of v.poor quality = (scribble not legible) TLC'

This means I have discussed Mr Code A very poor condition with his wife at the time of the review of Mr Code A I have made her aware and she agrees with the care plan to be provided for her husband.

'TLC', I translate this to mean that the patient's prognosis was extremely poor'.

I believe that the relief of suffering for the patient is paramount. This does not preclude active treatment if the intervention would improve the patient's symptoms.
The overall prognosis that I have made has been reached as a result of reviewing available medical notes, discussions with members of the clinical team discussion with Mr Code A wife and examination of the patient.

My role as a consultant geriatrician is to check that both current and planned care is appropriate to their needs and where possible to verify in accordance with the patient's and family's wishes.

I note from the nursing notes on the 9/1/96 (09/01/1996) (page 25 of exhibit Code A) that the patient had told the nursing staff that he had generalised pain.

I also note that on the 9/1/96 (09/01/1996) in the clinical notes (page 13 of exhibit Code A refers) Dr Code A recorded the fact that the patient had pain to his right hand.

Dr Code A also recorded the fact that the patient was becoming increasingly anxious and agitated.

With reference to page 15 of exhibit Code A which relates to the final entries on the clinical notes, which are as follows.

18/1/96 (18/01/1996) 'Further deterioration' (The next two lines of this entry I am unable to read) the final entry is 'try Nozinan'.

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It is my understanding that Mr Code A symptoms were not controlled by his current drug regime. He was commenced on Nozinan, a drug used in palliative care to help control agitation and anxiety.

20.1.96 (20/01/1996) 'Has been unsettled on Haliperidol in syringe driver' the next part of this entry is unreadable. The last line of this entry reads 'Increase Nozinan 50mg → 100mg in 24 hrs (verbal order).

I note the Haliperidol has been stopped on this date 20/1/96 (20/01/1996).

The following entry dated the 21/1/96 (21/01/1996) appears to be written by the author of the entry dated 20.1.96 (20/01/1996) which is as follows.

'Much more settled - quiet breathing R Rate 6p min. Not distressed - continue - (entry signed by unknown doctor).

R Rate is the respiratory rate which is noted as 6 per minute which is slow. (The normal respiratory rate is between 10-15). It would appear that as the patient's symptoms were finally alleviated that it was felt appropriate to continue the current drug regime.

I have nothing to add with reference to the final entry on page 15 of exhibit Code A where the death of M Code A is verified by two members of nursing staff.

With regards to my observations concerning the initial dosage of Diamorphine and Midazalom given to Code A administered via a sub-cutaneous syringe driver I wish to clarify why I would have administered a lower dosage initially.

My normal practice is to use the lowest dosage likely to achieve the desired outcome for the patient thereby diminishing the possibility of adverse effects.

RESTRICTED

This dosage would be reviewed and increased as necessary. I note it proved necessary to increase the dose of diamorphine administered to Mr Code A

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: Code A

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

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: 16/02/2005

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

I am currently a self employed General Practitioner working at the Forton Medical Centre, Whites Place, Gosport PO123GP .

I joined the practice in October 1993.

My Medical Defence Union Number is Code A

I am fully registered with the General Medical Council since the 22nd August 1982 (22/08/1982) No. Code A

My medical studies were undertaken from October 1976 through to July 1982.

Pre-clinical studies at Lincoln College, Oxford where I also gained a Bachelor of Arts in Physiological Sciences (BA).

I moved to Downing College, Cambridge in October 1982 where I undertook a clinical medical course at Addenbrookes Medical School at the Cambridge School of Clinical Medicine, New Addenbrookes Hospital.

I took my final medical degree exams in November 1981 gaining a Bachelor of Surgery (B.Chir), I re-sat my final medicine exam in July 1982.

Signed: Code A Signature Witnessed by: Code A

RESTRICTED

During my professional career I have also obtained the following post graduate diplomas.

1989 A Diploma in Child Health (DCH) Royal College of Physicians, London.
1992 Family Planning Certificate (F P Cert)
1993 A diploma of the Royal College of Obstetricians and Gynaecologist.

From August 1982 until January 1983 I was employed as a pre registration house officer in geriatric medicine at the Chesteron Hospital, Cambridge.

From February 1983 until July 1983 I commenced working as a pre registration house officer in general surgery orthopaedic and hand surgery, gynaecology at the Huntingdon County Hospital.

From September 1983 until July 1985 I was employed as a Senior House Officer in General Surgery, Casualty Department of Anatomy, General Surgery Rotation and Junior Lecturer at The London Hospital and Medical School.

From August 1985 until January 1986 I was Senior House Officer domiciliary care of the terminally ill at St Joseph's Hospice, Hackney, London.

From February 1986 until October 1987 I was Senior House Officer, Community Medical Officer General, Neonatal, Community Paediatric Rotation at Old Church & Rush Green Hospital, Romford, Essex.

From November 1987 until January 1988 I was Senior House Officer Paediatric Neurology and renal medicine, infectious disease, burns unit, intensive care at Guy's Hospital, London.

From February 1988 until July 1988 I was Senior House Officer in General and Neonatal Medicine Rotation Neuromuscular disorders, cardiology, haematology neonatal, general and cardiac surgery.

RESTRICTED

From December 1988 until November 1989 I was employed as Registrar at Redhill and Crawley Hospitals.

Between December 1989 and January 1991 I was employed as registrar/community health officer at Newham General Hospital, London E13.

From February 1991 until July 1991 I was Senior House Officer in obstetrics and gynaecology at Charing Cross Hospital, The Westminster and West London Hospitals.

From September 1991 until August 1992 I was employed as Trainee General Practitioner at the Handforth Health Centre, Wilmslow Road, Cheshire.

Between August 1992 and October 1993 I held various locum posts with; Medic International London. Barking Haveing & Brentwood Health Authority as a paediatrician registrar.

St Joseph's Hospital, Hackney as Senior House Officer/Registrar in Palliative care.
From October 1993 to date I hold the position as Principle in General Practice, Dr Code A and partners, Whites Place, Forton Road, Gosport.

I have been asked to detail my involvement with the patient Code A dob Code A.

I have been shown the photocopy of the microfiche exhibit Code A which are the medical notes for Code A whilst a patient at Gosport War Memorial Hospital .

I can confirm on page 6 of exhibit Code A I was the authorising doctor for the entry relating to Nozinan 100mgs s/c = sub cutaneous in 24 hrs, dated 20/1/96 (20/01/1996), dose 100mgs, verbal order Dr Code A 1720 hrs which has been signed by a Code A (Staff Nurse) and countersigned by Code A This entry has, then, later on that day on 20/1/96 (20/01/1996) been signed by myself. I cannot recollect the time that I wrote this entry on the 20/1/1996 (20/01/1996).

RESTRICTED

The standard practice at that time when a sister/nurse in charge of the ward was concerned with a patient's clinical condition, was to ring the duty doctor to discuss the patient's problem.

The duty doctor could then make a decision based on the information given by the nurse regarding the patient's management, to change treatment and or visit the patient.

If an immediate change in medication was necessary this might require a verbal order to be given in order to avoid delay in carrying out a change of treatment to the patient.

At a later stage this verbal order should be countersigned and confirmed by the ordering doctor.

In this particular case the clinical problem arose when the syringe driver was due for recharging. The nurses review of the patient raised a concern about his clinical response to some of the medication previously prescribed. In particular Haloperidol .

It was thought that the patient was developing side effects from Haloperidol. These affects included agitation and movement disorder. Both of which are recognised with higher doses of this drug.

I was also concerned that several different drugs were being used in the syringe driver which might affect the pharmaceutical properties.

Since Haloperidol and Nozinan have broadly similar indications I felt it was appropriate to stop the dose of Haloperidol and replace it by increasing the dose of Nozinan.

The higher dose of Nozinan then has the added advantage of sedative properties which would be appropriate in this situation as the patient was agitated.

I did not physically see the patient Code A prior to the time the verbal order was carried out.

RESTRICTED

However I subsequently visited the ward, checked the patient, to ascertain whether he had responded/settled to the treatment change that I had made.

I have recorded my clinical decision on page 15 of exhibit Code A as follows.
20/1/96 (20/01/1996) - "Has been unsettled on Haloperidol in syringe driver. Discontinue, + changed to higher dose Nozinan".
"Increase Nozinan 50mg → 100mg in 24 hrs"
(Verbal order).

With regards to this entry I have stopped Haloperidol and ordered an increase in dosage of Nozinan.

This entry confirms the verbal order that I had given at 1730 hrs on the 20/1/96 (20/01/1996) to the nurse.

I have been shown page 7 of the microfiche of exhibit Code A which is the drug record for Code A

On the 20/01/96 (20/01/1996) at 1530 hrs it shows that the syringe driver was charged with Diamorphine 120mgs, Midazolam 80mgs, Hyoscine 1200 mcgs, Haloperidol 20mgs.

The syringe driver was subsequently charged at 1800 hrs the same day as per my verbal order.

(The 4th edition of the book of terminal care by the Countess Mountbatten House lists a dosage range for Haloperidol between 5-60mgs as an anti emetic. Nozinan has a dosage of 25 to 500 mgs in 24 hours.

It is also noted however that extra pyramidal side effects are likely to occur with dosages above 20mgs of Haloperidol.

The entry for Nozinan suggest a lowest effective dose to be used unless sedation is required).

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On this basis I felt that 100mgs of Nozinan in 24 hrs was appropriate for the patient's needs.

I was discontinuing Haloperidol and anticipated a compensatory increase would be necessary in the alleviate anti-emetic (Nozinan) tranquilliser.

To show that a change of drug regime has been made, the original syringe dosing has been crossed out in a manner, which does not obscure the previous dose record.

This allows a continuous retrospective analysis of administered drug dosage.

I presume this has been completed by the nurse at the time of changing the drug dosage and is entirely appropriate to the maintenance of an accurate record.

It is my understanding that the previous dose would have been disposed of according to standard hospital protocol.

With regard to the Haloperidol dosage recorded on page 7 of Code A this prescription has also been discontinued marked by a double hatched line (which I recognise as my usual way of indicating this). It also looks like my handwriting style. In this case I have not signed the entry (which is my usual practice).

The entries relating to Diamorphine 120mgs, Midazolam 80mgs, Hyoscine 1200mgs have been written/recorded by a member of the nursing staff.

I note that on page 6 of the microfiche Code A that the original 50mg dose of Nozinan appears to have been omitted when the driver was recharged at 1530 on the 20/1/96 (20/01/1996).

Had I noticed this error at the time when countersigning the verbal order to change the drug regime, it is quite possible that I would have revised my decision to increase the dose of Nozinan from 50mgs to 100mgs and in these circumstances I might have continued with the

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Haloperidol.

However in general I tend to favour Nozinan over Haloperidol and it is quite possible therefore that I may have let my decision to stand as the patient appeared to be well settled on the dosage he was receiving.

I would also have brought the error to the attention of the nursing staff in order that appropriate investigation and audit could be undertaken according to standard hospital procedure.

It is worth noting that the Nozinan is written up on the 'As required' section as opposed to the 'Regular' prescription which is on page 7.

I can confirm that I wrote the following entry on page 15 of the clinical notes.
'Much more settled. Quiet breathing'.
'R Rate 6 per min. Not distressed'.
'Continue'.

With regards to this entry 'much more settled' is self explanatory. 'Quiet breathing' means that he did not have any rattle, there was no excess labour in the breathing pattern.

'R Rate = respiratory rate 6 per minute' - I would have noted of the breathing was irregular or shallow. The rate of 6 per minute is slow but I would bear in mind that he was under the influence of Diamorphine and therefore this would have been expected.

I would also have noted whether his skin colour suggested excessive respiratory depression (ie, cyanosis, pallor, or sweating).

Where I have written 'continue', I mean 'to continue with the current drug regime'.

Where I have reviewed the drug regime and stopped the Haloperidol, this has been based on a report on the patient's clinical condition which I received from the nurse by phone.

RESTRICTED

This included a discussion with the nurse about possible causes. A senior nurse such as S/N Code A has extensive personal experience of palliative care, including a knowledge of different drugs and their specific side effects.

S/N Code A expressed a suspicion that Haloperidol may be causing a side effect.

I agreed with this opinion and gave a verbal order to change the drug regime.

I do not remember the patient Code A however I clearly remember the clinical issues involved and the reasons for my decision.

At this time in 1996 the medical cover for elderly care patients at Dryad, Daedalus and a limited number of Sultan Ward beds at GWMH was undertaken by my partnership.

This was a consequence of an agreement between one of our partners Dr Code A and the practice,(ie at that time Dr Code A and Partners) that the practice would undertake Dr Code A responsibilities as a clinical assistant in elderly care.

It is my understanding that in effect Dr Code A sub contracted on call responsibilities for the hospital to the practice when she was not on cover to the practice.

I would undertake all of my on call commitments and did not make use of deputising services. I would also therefore take responsibility for seeing any clinical problems arising in elderly care patients at the GWMH. Whilst I was on call for the practice. When this occurred I was in effect acting as a clinical assistant for the ward.

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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: NURSING SISTER G GRADE

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 02/02/2003

I am Code A and I reside at the address as given.

I first became involved in Nursing in 1963 as a Cadet and commenced a 3 year Qualification Course in 1965 at Hackney Hospital, East London working on all Wards until my Qualification as Registered Staff Nurse to the Surgical Ward.

I am currently employed by Fareham and Gosport Health Trust as a Clinical Manager (Ward Sister) on Dryad Ward at Gosport War Memorial Hospital , a position I have held since 1992.

I commenced employment at Gosport War Memorial Hospital in February 1988 in the capacity of Staff Nurse at Redclyffe Annex which was a 23 bedded unit for continuing care, terminally ill patients and share-care patients who's length of stay at the Hospital was variable, but basically to assist relatives and give them a period of respite from their caring.

Redclyffe Annex was situated a short distance from the main Hospital, as was Northcott Annex, a 12 bedded unit which has since closed, Redclyffe having then moved to the main Hospital in 1994 and thus becoming Dryad Ward.

I have attended and qualified over a 2½ week course in the care of the elderly and I am required to attend a further 3 to 4 days study courses every 2 years in order to keep updated and remain qualified in this field.

I'm not sure of the exact date but in October 1988 Doctor Code A became the Doctor

RESTRICTED

responsible for the patients, prior to this each patients General Practitioner was responsible for their individual patients on the ward.

As well as the Doctor, a Consultant would attend on a Monday each fortnight, and saw the patients, but if the Consultant was on holiday, then no visit would be made for at least a month.

Responsibility for medical care was ' Elderly Medicine' based at the Queen Alexandra hospital, Cosham.

Doctor Code A would visit at 7:30 (0730) a.m. each morning Monday to Friday and see every patient, and then visit the male ward of the main Hospital, before returning to her normal Practice.

She would only return to the Hospital to check in and arrange to see relatives either that day or later.

On her visits Dr Code A would prescribe the drugs that were required by each patient and at this time we had an excellent Pharmacist who would check the drugs charts every week, each Monday and comment if drugs had been written incorrectly and would advise us to contact Dr Code A who would then rewrite the prescription.

I am again uncertain of the date, but sometime in 1989 Diamorphine Syringe Drivers were introduced to those working on Redclyffe Annex and these were a new concept to the staff at this time.

Sister Code A, who was in charge at that time, brought the Syringe Drivers to the Annex and explained the system to the other Nurses and they would have learnt their use from her.

At this time there were no Courses in the use of Syringe Drivers, but because of concerns which have now been shown as to their use, Courses are now held and have been running for the past 6 years.

Signed: Code A

Signature Witnessed by:

RESTRICTED

I am uncertain as to what caused the concerns, but sometime in 1991, concerns were voiced amongst the staff with regards to the treatment of elderly patients, and in particular, in respect of Staff Code A who was a member of the night staff at that time working Sundays and Mondays each week.

The concerns were of her practice and treatment of elderly patients and I am aware that she was taken to one side and spoken to by the manager, who had concerns about her needing updating in her practices in the care of the elderly, even though she had been there for a long time.

I am also aware that she was also spoken to about leaving medication on lockers, which included controlled drugs, which isn't the correct procedure.

As previously stated, concerns were voiced over the use of syringe drivers in the care of patients on Redclyffe Annex, this was mainly the night staff in particular, which included Nurse Code A As the result of their concerns, the night staff were invited to attend the Consultants Ward Rounds to state their concerns to the Consultant, but whereby some did, Nurse Code A never did.

If I had ever doubted the drugs prescribed, or didn't like what was written up, then I would remark to Doctor Code A ' Hang on' and then I would get her to check it. You wouldn't give it if you weren't satisfied, you just wouldn't do it.

If I, or any other member of staff, voiced their opinion to Dr Code A she would listen and act accordingly, although she has proved me wrong on a couple of occasions.

Because of the continuing concerns, a meeting was arranged with members of staff to enable them to voice their concerns in relation to the Syringe Driver and Diamorphine.

I believe the subsequent meeting was Chaired by Code A who was the Patient Services Manager.

RESTRICTED

I am unable to remember who else attended this meeting, but I can remember that Code A the Nurse Manager was in attendance. He had the responsibility for palliative care on Charles Ward and was experienced in the use of Syringe Drivers.
Also at this meeting was Dr Code A, who was the Consultant at this time, and as he was in attendance I can only assume that the meeting occurred on a Monday, which is the Consultants visiting day.

I am aware that there were other meetings which took place in regards to the Syringe Driver, but I cannot remember attending these, or when they were held.

I have now been shown a number of correspondence in relation to meetings that have taken place and these are marked Code A

Having refreshed my memory from these correspondence and I can see that the meeting I attended where Code A Dr Code A and Code A were in attendance was the 20th August 1991 (20/08/1991).

I can see that meetings were also held on 11th July 1991 (11/07/1991) and 17th December 1991 (17/12/1991) and contained within the minutes are names of members of staff who attended those meetings amongst which my name appears.

I am unable to remember these meetings, even after I have been allowed to read the contents of the minutes, it just doesn't jog my memory at all.

I have never had any doubts over the use of Syringe Drivers to administer drugs to patients and I believe that in the main, this was a new concept which was adopted and which some members of staff were unable to accept.

The main reason for the use of a Syringe Driver is to administer drugs to the patient once oral medication has stopped, generally due to the patient's inability to swallow.

RESTRICTED

Drugs that I am aware of that have been administered in this manner are Midazolam (a sedative), Hyoscine and Cyclizine (to stop secretions and vomiting) and of course Diamorphine.

Also Haloperidol (to treat Psychosis), but this is very rarely used as its use has to be carefully checked as to which other drugs it is mixed with.

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: CLINICAL MANAGER

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 10/09/2004

Further to my statement dated 2/2/2003 (02/02/2003) I have been asked to detail my involvement in the case and treatment of Code A

I have been shown a photocopy of the microfich Code A

From this I can say that I made an entry on 10th January 1996 (10/01/1996) in Code A summary of significant events the entry reads.

10.1.96 (10/01/1996) condition remains poor. Seen by Dr Code A & Dr Code A. To commence on Oramorph 4 hourly this evening. Code A seen & is aware of poor condition. To stay on long stay bed.

I have then signed the entry.

This entry is on page 25 of the record.

On the 17th January 1996 (17/01/1996) at 2030 hrs I have made another entry that appears on page 27. This entry reads.

2030 further deterioration in already poor condition. Appears more settled. Although still aware of when he is being attended to. Syringe drivers running satisfactorily. Has been visited by ward chaplin this evening who will inform his wife.

Signed: Code A Signature Witnessed by:

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I have then signed this entry.

In January 1996 I was employed by the National Health Service working as a Clinical Manager on Dryad Ward at the Gosport War Memorial Hospital I worked 37½ hour a week, this would have been on a shift rota, earlies being 0730 hrs to 1615 hrs and lates 12 midday to 8.30pm (2030). I invariable worked on finishing off or handing over. I was responsible for 24 hrs care of the patients on Dryad Ward. If there was a problem when I wasn't on duty I could be contacted at home the night sisters were able to cope with patient care but I was contacted a couple of times with regard to staffing issues. I was on a duty rota list for the management of the hospital and would take on management roles when there were no managers at the hospitals, ie, evenings and weekends. I was responsible for all the staff on my ward hiring them, training, discipline matters, staff rotas and leave. Ordering, stocking and administration of drugs and that the trained staff on the ward had there drug competencies to allow them to administer drugs. This particularly applied to enrolled nurses, oversea students and return to nursing and student nurses. I was responsible for the running of the ward and general patient care. Dr Code A was responsible for the medical care on a day to day basis, medical care means when the patient had a medical condition, pain, infection or other complaint. She was also responsible for any admissions. The consultants had the overall responsibilities for the patients.

Code A was my line manager at that time, she was a service manager and had an office away from the ward.

The note dated 10.1.96 (10/01/1996) with regard to Code A means condition remains poor, this was a way of writing that the patient was very likely going to die. It would have not been appropriate for nursing staff to write 'patient is going to die'. Relatives have rights of access to a patients notes and to see that sort of comment written down would have been extremely insensitive. Mr Code A had been seen by both Dr Code A and Dr Code A. Dr Code A would have seen Mr Code A in the morning and then returned in the afternoon to do a ward round with Dr Code A. Dr Code A is a consultant geriatrician. To commence on Oramorph every 4 hours. Oramorph is an opiate, it is a liquid form of diamorphine and is given to ease pain.

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Oramorph was given instead of diamorphine while the patient could still swallow. Once the patient was unable to swallow or there was a risk of the patient choking on the liquid they were given the pain killer via a syringe driver. Code A seen and is aware of poor condition. It was not me who saw Code A I believe that it was the consultant who told her of the likelihood that Code A was going to die. To stay on long stay bed, means that Mr Code A would stay with us until he died.

By referring to the ward controlled drugs record book (identification reference Code A I can say that the Oramorphy oral solution 10mgs in 5mls was first administered on 10.1.96 (10/01/1996) at 10.20pm (2220) by a member of the night staff. The practice is that to administer controlled drugs two trained nurses, level one nurses would administer the drugs together. This is to ensure that they are administer correctly. In exceptional circumstances the second nurse could be a health care support worker, ie untrained, albeit they would have had the procedure explained to them and they would be experienced.

I have witnessed the giving of the Oramorph on the 11.1.96 (11/01/1996) at 1015 am, when 5mgms in 2.5mls was given, this is half the amount given at night. There are a number of reasons why the dose varied ie, he was in pain or the night the doses were higher to see him through the night. I also witnessed the administration on the 14.1.96 (14/01/1996) at 1000 and I actually administered it on the 11.1.96 (11/01/1996) at 1415 hrs.

The entry on the 17.1.96 (17/01/1996) at 2030 hrs, Code A at this time was fading fast (deteriorating). Appears more settled, this could have been his breathing, pain, chest was more settled. Code A was aware, ie, he knew what was happening to him. Syringe driver running satisfactory. Every time you turn a patient you check the syringe driver on this occasion I found that it was running correctly. Has been visited by the ward chaplain this evening. Patients when nearing the end of their lives were visited by the ward chaplain. She also spent a lot of time with the patients relatives. The ward chaplain was going to tell his wife of the deterioration of his health.

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From page 19 of the microfiche Code A I can say that the Oramorph was not given after 6am (0600) on 15.1.96 (15/01/1996). From page 18 I can say that I commenced a syringe driver consisting of 80mgms of diamorphine. This is also shown in the controlled drug record book (identification reference Code A pages 7 (20mgms) and page 11 (60mgms). I have signed both entries showing that I administered the drug at 0825 hrs that day.

At some stage Code A dose of diamorphine was increased to 120mgms and I witnessed the administration of the drugs on the 17.1.96 (17/01/1996) (page 16 and page 7) and administered the drug on the 18.1.96 (18/01/1996) and 1500 hrs (again page 16 & 7).

I have no personal recollection of Code A Oramorph is given every four hours to relieve pain. It is taken orally and its effects gradually wear off.

The entries that I have referred to in the ward controlled drugs record book Code A with regard to the Oramorph are found on pages 76 and 77.

Taken by:DS Code A

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

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

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: 01/12/2004

Further to my statements dated 2/2/2003 (02/02/2003) and 10/9/2004 (10/09/2004) when I stated that I commenced a syringe driver consisting of 80mgms of diamorphine I have been asked if there was a graph or chart to show the flow rate of the syringe driver with regard to the patient Code A

At that time, ie, January 1996 we weren't using charts/graphs showing the syringe driver flow rates.

I am unsure exactly when but I believe that it was some time in 2000 that Dr Code A asked me if I would trial the use of the charts on the ward.

Initially we used the chart on the ward Dryad, for three months. I am unaware of the results of the trial. After the first trial another form was trialled again for another three months. By then Dr Code A was involved in the design and usage of the charts. Over the next two years the charts evolved continually, Dr Code A and Dr Code A were involved along with the palliative care unit at Queen Alexander Hospital , Charles Ward. When I left the charts that they were using were still being trialled.

The introduction of these charts coincided with Dr Code A, Dr Code A drawing up a policy or a protocol with regard to the use of syringe drivers. So prior to 2000, there wasn't a policy or protocol with regard to the use of syringe drivers within the hospital.

Taken by: DS Code A

Signed Code A Signature Witnessed by:

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Continuation of Statement of: 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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: 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: Code A Date: 07/03/2003

I live at the address shown overleaf. I am an RGN Grade E. I am currently employed by the Fareham and Gosport Primary Care Trust as a Staff Nurse on Dryad Ward, Gosport War Memorial Hospital (GWMH), Bury Rd, Gosport.

I qualified as a SRN in 1972 and worked within the Ear, Nose and Throat Department in Hull.

In 1974, I moved to the Portsmouth Royal Hospital, Portsmouth. I left there to have my family. I then moved to the Plymouth area, where I joined a nursing bank and worked in various places. I returned to Gosport in 1979.

In November 1980, I began working for the Thalassa Nursing Homes Group.

In 1987, I began working for the South East Area Health Authority. I worked at the Northcott Annex, which was an annex of the GWMH for continuing care for the elderly. The annex closed shortly afterwards and I moved to the Redcliffe Annex.

The Redcliffe Annex was part of the GWMH. It was not part of the main hospital site and was set on two floors. I believe there were 23 beds, but they were not always taken. There were normally around 17 - 18 patients at any one time.

The Redcliffe Annex was not like a hospital. We would have strawberry teas in the garden for the patients and B-B-Q's in the grounds for patients, staff and relatives.

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The vast majority of patients were dependant on staff for their daily care. They were not able to participate and needed help with their feeding and their toileting.

Some patients would stay with us until their death. This could range from weeks to months to years.

I have been asked about medication in the unit.

Patients would bring their own medication with them and they would receive all of their medical treatment from their own GP's, who would come into the hospital. If a patient required a doctor, then we would summon their own GP.

The system then changed and Dr Code A became the doctor for the annex, the Clinical Assistant. This system was better because Dr Code A saw the patient much quicker.

Dr Code A worked under the consultant at the time. The consultants were Dr Code A, Dr Code A and Dr Code A.

When I began working at Redcliffe Annex, I was full time, working 37½ hours per week on the day shifts. These would be earlies, which were 7.30 (0730) - 4.15 p.m, (1615) half day which was 7.30 (0730) - 1.00 p.m, (1300) and lates which were 12.15 (1215) - 8.30 p.m (2030). I worked with Code A Code A, who were the trained staff, untrained were Code A Code A and Code A

I can remember that Code A and Code A Code A worked on the night shift. The sister in charge when I first arrived was Sister Code A. She was off sick for a lot of the time and then Code A. The sister was in charge of the annex and worked days. The sister at the main hospital would cover the night shift at the annex.

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I have been asked about the use of Diamorphine at the Redcliffe Annex. Diamorphine was used if necessary, to control the pain level of patients. It was given through subcutaneous injection. Other medication would be used and administered rectally or if the patient could swallow, orally.

I have been asked if syringe drives were used. They were. They were used regularly to deliver Cyclizine, which suppresses nausea, and Midazolam, which is a tranquilliser.

I have been asked about the administration of prescriptions. All drugs were given as per the prescription. The doctor on the prescription, dictated the amount, and method of administration. Trained nurses would have an input with the doctor as to the method of administering the drug, but they could not deviate from the prescribed method of delivery.

Diamorphine and syringe drives were in use at the Redcliffe Annex prior to my arrival. I believe there was one or possibly two at the annex. I think that they were expensive to buy.

I have been asked for my definition of Palliative Care. I would describe this as the sympathetic care of a patient with a debilitating and terminal disease, for example cancer, the end stages of dementia, Parkinson's disease and rheumatoid arthritis.

I have been asked if I had any concerns about the use of syringe drivers whilst I was working at the Redcliffe Annex. I did not. I felt that they were being used for the good of the patient. If I felt that I had any concerns, then I would have gone to Sister Code A or Dr Code A whom I found to be very approachable. I would have spoken up and said something. I remember that I was nervous when I first used a syringe driver, but I had someone with me and I felt confident in using it.

I have been shown a copy of minutes of a meeting dated 11/07/1991, Code A I remember that I did attend a meeting, but I cannot remember its content. Therefore I am unable to say if it was this meeting. Having read through the minutes, I am still unable to recall this meeting, but I know that I didn't have any concerns as

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outlined in the minutes.

I do remember that we had a meeting with a Pharmacist from the Q.A. Hospital who talked about syringe drivers and Diamorphine.

I have been asked what training I received in the use of the syringe driver. Sister Code A showed me in a brief demonstration and I was told of the drugs that didn't mix. I received further training some six - seven months ago in Palliative and Terminal Care. I attended lectures in Palliative and Terminal Care if I had the opportunity to do so.

I have been asked about the mortalities in the Annex. Of course, people died there due to the nature of the establishment, but I remember a period when we received more acute patients who were very ill. Some of them didn't last a week and I remember on one occasion, two patients died on the same day that they were admitted. Staff moral at this point was very low. We weren't getting to know the patients or their families.

The unit then moved up to the main hospital site. I didn't like this. I felt the unit lost its 'personal touch'. It moved into Dryad Ward and became a Continuing Care Ward.

We would also carry out long-term assessments of patients and provide slow stream rehabilitation with a view to them returning home if possible or being discharged to a nursing home.

We still have patients who require Palliative and Terminal care and syringe drivers are used on the ward where appropriate.

I have always included relatives in the decision-making concerning patient's treatments and have kept them fully informed. I believe the medical staff have done so as well.

I would like to add the following. I have been a nurse for thirty years. I came into nursing to help people. It is my opinion that patients are now dying in pain, because doctors are too scared

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to prescribe pain relief and relations won't allow us to help patients with their pain, because of what they have read in the papers.

Moral at the hospital is not good. I know of staff that will not wear their uniforms home, so as not to attract attention from the public. We are trying to do our best for the patients we have here.

I would also like to add the following:

I feel that Dr Code A is being used as a scapegoat so that the relatives who first started this vicious campaign can have a name on an official document. We are losing good nurses because of what is being said about the hospital. They would rather work somewhere else and who can blame them.

I feel that not enough is being said in the press to support the staff. The articles I have seen have been very bland and certainly not as forthcoming as the relatives have been allowed to be.

I have been working within elderly care for 23 years now and I have never felt as bad about being a nurse as I do now. I am proud of the uniform I wear but I don't know how much more I or my colleagues can take. The amount of verbal abuse we take from relatives is becoming worse and I personally don't see why that just because I wear a nurses uniform I have to take it and do nothing. We are supposed to have a policy of zero tolerance to violence whether it be verbal or physical, well I feel that it's not really working.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

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

This statement (consisting of 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: Code A Date: 11/08/2004

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

I qualified as a SRN in 1972 at the Hull Royal Infirmary.

I have 17½ years experience as a Registered General Nurse (RGN).

In 1987 I was working at the Redcliffe Annexe as an RGN.

I believe it was in 1994 that the Annexe was closed and the patients and staff were transferred to the Dryad Ward at the Gosport War Memorial Hospital (GWMH). At this time I was an E Grade RGN.

I am currently an E Grade staff nurse on the Dryad Ward at the GWMH.

My nursing Midwifery Council Pin No is Code A

My current responsibilities on the Dryad Ward are tending to the day to day running of the ward. This includes supervision of junior staff, caring for the patients, administration of prescribed medicines.

I have been using syringe drivers since 1987 or 1988. I was given on the job training by the Clinical Manager on the ward at the Redcliffe Annex by Sister Code A . I was shown how the syringe driver worked, how to book the prescribed drugs out from the drugs register

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which were to be used in the syringe driver. I can recollect that we were also informed which prescribed drugs could be mixed in the syringe driver and which drugs were not suitable for mixing.

The only prescribed drug that I would not put together in a syringe driver are Haloperidol and Cyclazine. This is because when these two drugs are mixed the solution turns a milky colour. Nursing staff also received tutorials from pharmacists who came on to the ward.

We were advised which drugs were not to be mixed, especially when administering large doses. For example Hyacine was pointed out as being toxic and had to be diluted more thoroughly. It would be administered in another syringe driver.

I work a 37½ week on the ward. The shift pattern consists of early which either starts 0730 to 1530 or 0730 to 1300. Lates are 1215 to 2030. Nights commence 2015 to 0745.

Dryad Ward consists of 20 beds. The majority of the patients are aged over 75. Currently the Dryad Ward is closed as a continuing care assessment ward.

I should mention that with regards to syringe drivers it is policy that two trained nurses are present when the driver is set up with the required prescribed drugs.

I am aware of the Analgesic ladder, ie, the pain ladder. Basically this refers to the strength and type of drug given to a patient. This starts from the simple paracetamol through to drugs containing codeine, then onto weak opiods then onto the opiates, ie Oromorph and Diamorphine

.

Drugs and dosages given to patients are sometimes based on the 24 hour observations of nursing staff. These observations are passed onto the doctor when he or she are doing their ward round. Or if necessary if in more urgent cases the Doctor may well be phoned.

From 5pm (1700) to 7am (0700) the hospital is covered by Primecare deputising Doctors

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Service.

Syringe drivers are used when patients cannot swallow that is take oral medication. The driver is an effective way of delivering pain and or sedation relief over a 24 hour period without the peaks or troughs.

I have been asked to detail my involvement with the patient Code A who was admitted to the Dryad Ward on the 5th January 1996 (05/01/1996).

Firstly I do not remember this patient.

I have been shown a printed record from a microfiche exhibit Code A

I can confirm that on page 25 I made the following entry.

9/1/96 (09/01/1996) small amount of diet taken, very sweaty this evening but is apyrexial, has stated that he has generalised pain, to be seen by Dr Code A in the morning.

With reference to the above entry apyrexial means 'The patient's temperature is within normal limits.

I can confirm that I wrote the following entry on page 26.

16/1/96 (16/01/1996) - 2000 hrs - condition remains very poor, some agitation was noticed when being attended to S/B Dr Code A Haliperidol 5mg - 10mg to be added to the driver.

The next entry is timed at 1300 hrs that day.

Previous driver dose discarded driver recharged with diamorphine 80mg Medazalam 60mg, Hyacine 400mcg and Haliperidol 5mg given at a rate of 52 mmol/hly. Visited by daughter (not Sister Code A who is now aware of poorly condition. All nursing care cont'd. (R) ear found to

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be blistered along upper edge, please nurse only on back and (L) side, marking very easily please turn 1½ - 2 hry.

S/B means seen by.

Where I have referred to 52 mmol/hly this relates to the rate that syringe driver dosage is to be set over the 24 hour period, ie the hourly rate.

(R) = right. (L) = Left.

At this stage I should point out that it was my practice to record all my notes concerning patients on a little note book which I carried in my pocket. I would then write up the Nursing notes from pocket note book at the end of my tour of duty.

Where I have stated 'Previous driver dose discarded'. This means that Dr Code A had requested a change to the constituents in the driver. Therefore the previous dosage was discharged in the presence of two nurses.

Then a new dosage (in this instance) containing the additional Haliperidol was then set up and administered to the patient.

I have been shown the ward controlled drugs record book for the Dryad Ward.

On page 7, dated 16/1/96 (16/01/1996), timed 1300 there is an entry showing 20mgs (This is 2 x 10mg ampoules) of diamorphine that I have taken out from the drug cupboard. The entry is signed by me and witnessed by staff nurse Code A . The entry relates to Code A Code A

On page 11 on the same date in the drugs register there is an entry dated 16/1/96 (16/01/1996), 1300, showing 60mgs (this is 2 x 30mg ampoules) of diamorphine that I have taken out from the drug cupboard. The entry relates to the patient Code A , which is signed by me and

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witnessed by staff nurse Code A

The above amended and addition on dosage for the syringe driver was authorised by Dr Code A

The discarded dosage from the syringe driver is then disposed of down the sink, witnessed by two members of staff.

I can confirm that I wrote the following entry on page 27.

18/1/96 (18/01/1996) 2000 - poorly condition continues to deteriorate. All nursing care cond.

Cond is an abbreviation for continued.

1500 driver recharged with Diamorphine 120mgs. Midazolan 80mg, Hyoscine 1200mcg, Haliperidol 20mgs and Nozinan 50mg. Wife has visited for most of the day. Appears comfortable in between attention. Oral suction given with some effect.

Oral suction relates to where the patient has had chest secretions removed from the back of the throat using a suction machine. This procedure is done to alleviate distress of the patient.

The above entry would have been written at the end of the late shift by me from my note book.

I have been shown the drug register page 7 dated the 18/1/96 (18/01/1996), 1500 patient Code A Code A The entry confirms that 20mg of Diamorphine (2 x 10mg ampoules) were taken out from the drug cupboard by Code A witnessed by myself.

On page 16 of the register for the same day and time there is an entry showing 100mg of Diamorphine signed by Code A and witnessed by myself.

I will also add that I have made a mistake with regards to an entry on page 7 which shows

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another entry dated 18/1/96 (18/01/1996), 1500 against Code A 20mg signed by me and witnessed by Code A.

This entry should be dated the 19/1/96 (19/01/1996) 1500 and not the 18/1/96 (18/01/1996) 1500.

I wish to add that under no circumstances would I alter, add or change prescribed drugs to a patient without the authorisation of a Doctor.

I have noted that there is no record on the nursing notes for the 18th January 1996 (18/01/1996) showing there was a visit on the ward by a Doctor which would have led to the changes, ie increase in doseage of prescribed drugs to the syringe driver of Code A at 1500 hrs that day.

There is no written note showing that a Doctor has visited. It is my opinion that an entry for the early turn/shift for the 18th January 1996 (18/01/1996) has been omitted.

I cannot give any other reason as to why there is no record of the reason requesting an increase in the doseage to the patient of Code A on 18/1/96 (18/01/1996) at 1500.

I can confirm that I wrote the following entry on page 28.

1505 19.1.96 (19/01/1996) marked deterioration in already poorly condition all nursing care cond, position change strictly 2 hly. All pressure areas intact except for a small discoloured area at the base of big toe. Mouth care performed at each position change, breathing very intermittent, colour poor.

1500 syringe driver recharged with Diamorphine 120mg, Midazlam 80mg, Nonzine 50mg, Haliperidol 20mg, Hyscine 1200 mcg at a rate of 48 mmols/hly.

Code A has phoned and will visit later.

Signed: Code A

Signature Witnessed by:

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I have checked the drugs chart record for the 18th January 1996 (18/01/1996) and I recognise the signature and handwriting as that of Code A She was on duty Monday to Friday.

With regards to the way I wrote my nurses notes. I complete the notes at the end of the shift as previously stated. Firstly I record a general overview of the patient during the shift. I then record any significant events such as Doctors visits and recharging syringe drivers. As a rule I normally time and date my entries.

I can confirm that I wrote the following entry on page 29 commencing.

22.1.96 (22/01/1996), poorly but very peaceful, all care given today, Daughters have visited and spoken to Sister Code A

1515 Driver recharged with Diamorphine 120mgs, Midazalam 80mgs, Hyoscine 1200mcg. Nozinon 100mgs at a rate 43/mmols/hly.

I can confirm that I have written the following entry on page 29 commencing.

23/1.96 (23/01/1996), poorly condition remains unchanged has remained peaceful all care has contd, Pastor Code A has visited.

(Pastor Code A would have been called as the patient Code A was believed to be near to death).

1545 Driver recharged with Diamorphine 120mg, Midazalon 80mgs, Hyoscine 1200mcg, Nozinan at a rate of 43 mmols/hly, signed by myself.

The Haliperidol was stopped by Dr Code A on the 20/1/96 (20/01/1996) which is recorded on the drugs chart.

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There is no record made on the nursing notes relating to a visit by Dr Code A (The Dryad Clinical Practitioner) on the 19/1/96 (19/01/1996). This does not mean that Dr Code A did not visit the patient. An entry would only be made if Dr Code A had made alterations to the patients drug regime.

With regards to the entry dated 16/1/96 (16/01/1996), 2000 this is the time the entry was written not the time Dr Code A visited the ward.

As a general rule Dr Code A would conduct visits in the morning usually between 0730 - 0800 Monday to Friday or when specifically called in by Nursing staff.

With regards to my clinical manager at the Redcliffe Annex initially it was Sister Code A, she however went on long term sickness and subsequently left. Her position was then taken over by sister Code A

I would add that when a patient is unable to communicate to staff that he or she was in pain Nursing staff would use non verbal indicators such as facial expression, body language and position. Insomnia (not sleeping), lack of appetite and obvious distress. These non verbal indicators would be indicators to nursing staff that a review of the treatment/medication for the patient may be required.

Therefore nursing staff would refer this for the attention of Dr Code A

Taken by: DC Code A

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

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

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 04/01/2005

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

I qualified as a SRN in 1972 at the Hull Royal Infirmary.

I have 17½ years experience as a Registered General Nurse (RGN).

In 1987 I was working at the Redcliffe Annexe as an RGN.

I believe it was in 1994 that the Annexe was closed and the patients and staff were transferred to the Dryad Ward at the Gosport War Memorial Hospital (GWMH). At this time I was an E Grade RGN.

I am currently an E Grade staff nurse on the Dryad Ward at the GWMH.

My nursing Midwifery Council Pin No is Code A

My current responsibilities on the Dryad Ward are tending to the day to day running of the ward. This includes supervision of junior staff, caring for the patients, administration of prescribed medicines.

I have been using syringe drivers since 1987 or 1988. I was given on the job training by the Clinical Manager on the ward at the Redcliffe Annex by Sister Code A I was shown how the syringe driver worked, how to book the prescribed drugs out from the drugs register

which were to be used in the syringe driver. I can recollect that we were also informed which prescribed drugs could be mixed in the syringe driver and which drugs were not suitable for mixing.

The only prescribed drug that I would not put together in a syringe driver are Haloperidol and Cyclazine. This is because when these two drugs are mixed the solution turns a milky colour. Nursing staff also received tutorials from pharmacists who came on to the ward.

We were advised which drugs were not to be mixed, especially when administering large doses. For example Hyoscine was pointed out as being toxic and had to be diluted more thoroughly. It would be administered in another syringe driver.

I work a 37½ week on the ward. The shift pattern consists of early which either starts 0730 to 1530 or 0730 to 1300. Lates are 1215 to 2030. Nights commence 2015 to 0745.

Dryad Ward consists of 20 beds. The majority of the patients are aged over 75. Currently the Dryad Ward is closed as a continuing care assessment ward.

I should mention that with regards to syringe drivers it is policy that two trained nurses are present when the driver is set up with the required prescribed drugs.

I am aware of the Analgesic ladder, ie, the pain ladder. Basically this refers to the strength and type of drug given to a patient. This starts from the simple paracetamol through to drugs containing codeine, then onto weak opiods then onto the opiates, ie Oromorph and Diamorphine .

Drugs and dosages given to patients are sometimes based on the 24 hour observations of nursing staff. These observations are passed onto the doctor when he or she are doing their ward round. Or if necessary if in more urgent cases the Doctor may well be phoned.

From 5pm (1700) to 7am (0700) the hospital is covered by Primecare deputising Doctors

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Service.

Syringe drivers are used when patients cannot swallow that is take oral medication. The driver is an effective way of delivering pain and or sedation relief over a 24 hour period without the peaks or troughs.

Further to my previous statement with reference to the treatment of Code A, DOB Code A whilst a patient on Dryad Ward, Gosport War Memorial Hospital.

The guide lines for obtaining prescribed drugs to be administered to patients whilst on Dryad Ward is rigidly controlled.

Drugs can only be prescribed by a doctor, a record of drugs is written into the patients prescription chart.

Controlled drugs are stored in a locked cupboard within a locked cupboard. The keys to these cupboards are only held by trained nursing staff.

It requires two trained staff firstly to check the prescription chart relating to the patient to ascertain that the controlled drug is still required and that it has been authorised by a doctor.

The next step was to check the time of the previous administration of the drug(s) given to the patient. Then both of the trained nurses would take the drug chart to the drugs cupboard where the drugs are stored. A check would be made to ensure that the correct drug is withdrawn and verify the dosage required.

Once both members of staff were satisfied that the drug and dosage was correct then the drug register was completed but not signed at this stage.

In the case of controlled drugs to be administered through a syringe driver the drug(s) have to be mixed with a measured amount of sterile water. In 1996 the standard amount of sterile water

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mixed with the drug was 10mls.

The quantity of solution containing the drugs has to be sufficient to last over the 24 hours that the syringe driver is delivering the required hourly dose.

When the syringe driver was initially set up the connecting line from the syringe driver to the patient had to be charged, ie, filled with the solution from the driver. This usually takes about ½ ml of the solution.

It therefore follows that the initial dosage takes less than 24 hours to complete. This is because there is a quantity of the solution still left within the plastic line connected to the patient.

Subsequent driver administrations given to the patient will then take the 24 hour period to deliver the required dosage.

At the completion of each syringe driver administration the plastic line will always contain ½ ml of the solution.

The amount of sterile fluid solution mixed in the syringe driver has now been reduced to 8mls which is a set standard.

The subcutaneous needle which is inserted into the patient is usually changed every 72 hours. This is just to make sure that the patient is comfortable with the needle and there is no soreness.

With reference to the mmls (milli mols per hour). The standard delivery rate today is 48mmls which will deliver the dosage through the syringe driver in 24 hours.

In 1996 the normal rate for setting the syringe driver was between 50 and 52 mmls per hour. This was because there was a larger volume of fluid contained within the syringe driver.

Where I have administered syringe driver dosages to the patient Code A the sterile

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solution contained within the syringe driver was set at 10mls delivered at the rate shown.

With reference to my entry on page 29 of exhibit Code A dated 23/1/96 (23/01/1996), @ 1545. The delivery rate is shown as 43 mmls per hour. I can only presume that the sub cut needle was changed, therefore a new line had to be primed which meant that the fluid in the syringe was reduced which altered the delivery rate.

Mr Code A at this stage was very poorly, he was being turned on a regular basis to prevent breakdown of pressure sores. On occasions the line and needle would be pulled out. This meant that a new needle and line had to be inserted and then recharged. Consequently the delivery rate would be lowered.

The dosage and delivery rate of drugs prescribed to a patient could only be authorised by a doctor.

In the case of Code A whilst on the Dryad Ward in 1996 the prescribing doctor was Dr Code A

On the occasion where it was noted that the patient Mr Code A was still showing signs of pain and distress despite being given the prescribed dosage, then the trained staff would discuss the problem with Dr Code A on the phone or when she visited the ward.

Dr Code A would give authority to increase the dosage within the specified range, which had originally been set by her on the prescription chart.

The absolute maximum that the dosage could be increased was 50% of the previous dosage. However it was a very rare occurrence.

The practice of setting a range of the dosage amount of prescribed drugs on the prescription chart is no longer in place.

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Each dosage of prescribed drugs given to the patient Code A were authorised by Dr Code A

The standard procedure today to increase or decrease the dosage now requires the physical presence of a doctor to attend the patient on the ward.

A specified amount has to be recorded in the prescription chart.

I have examined entries recorded on the prescription chart for the patient Code A on page 18 of exhibit Code A

I can confirm that on the 16/1/96 (16/01/1996) at 1300 hours I administered 80mg of Diamorphine, 400mg of Hyoscine, 60mg of Midazolam, these entries have been signed/initialled by myself.

I can also confirm that on the 16/1/96 (16/01/1996) at 1300 hrs I recorded on page 20 of exhibit Code A that I administered 5mg of Haliperidol to Code A

The above drugs were prescribed by Dr Code A who had seen Mr Code A on the 16/1/96 (16/01/1996).

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

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

This statement (consisting of 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: 12/06/2003

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

I am employed as a Grade E Staff Nurse on Dryad Ward at the Gosport War Memorial Hospital . I have worked at the hospital since March 1992. My role can include taking charge of the ward in the absence of a Senior Staff Nurse or Sister.

In my opinion the general patient care is very good at the hospital and we have received compliments from patients family.

I have been trained in the use of syringe drivers and I am competent in their use. I have never had any concerns about the use of syringe drivers at the hospital, they were always used correctly and when necessary. Diamorphine was also used when necessary and correctly. My only concern now is that I feel that the use of syringe drivers and diamorphine is not enough. This is due to the bad publicity in the press about the hospital and the ongoing investigation. I feel that this is to the detriment of the patients that may need pain relief.

I am aware of the previous police investigations and I was part of an independent review into the death of Code A who was the daughter of Code A . I was not interviewed regarding the CHI report.

I wish to add that the morale at the hospital is very low due to this ongoing investigation. The hospital not only has problems recruiting but families are reluctant to place their loved ones at the hospital because of the bad publicity at the hospital.

Signed: Code A Signature Witnessed by:

RESTRICTED

Continuation of Statement of: 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: Code A

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

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 06/08/2004

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

I am a registered general nurse. My Nursing Midwifery Council Number is Code A

I qualified as a registered nurse for mentally handicapped nurse in 1975. This was in Lennox Castle Hospital, Lennox Town, near Glasgow.

I then qualified as a registered general nurse in 1977 at the Argyle and Bute College of Nursing and Midwifery in Greenock. To obtain this qualification I undertook an 18 month post registration course.

I worked for a further year in Broadfield Hospital Port Glasgow, Scotland, I finished working at this hospital in July 1978.

I then left the nursing profession in 1978 and then had a variety of nursing jobs until March 1992.

In March 1992 I started work as a staff nurse at the Redcliffe Annex, The Avenue, Gosport which was part of the Gosport War Memorial Hospital.

I believe it was in 1995 the Annex was closed down and all our patients were transferred to the Dryad Ward as were the staff.

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I have been working at the Gosport War Memorial Hospital since 1992. I commenced as a D Grade Staff Nurse. In 1994 I then qualified as an E Grade Staff Nurse.

I am currently working on the Dryad Ward as an E Grade Staff Nurse.

My role responsibilities on the ward in the absence of senior staff. I then take charge of the ward. I supervise health care support workers and junior staff. I am also responsible for the training of student nurses who are on placement at the ward.

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

I have received on the job training from other trained senior staff with regards to the usage of syringe drivers . I believe I first starting using these drivers in or around 1992. I have also attended study days in connection with the manufacturers requirements relating to syringe drivers.

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

The only person who can authorise the usage of drugs administered through a syringe driver is a doctor. As far as I can recollect it was policy in the early years to allow up to 3 different drugs to be administered via the syringe driver in one dosage over a set period of time.

The policy has been changed since the (CHI) Commission for Health Improvement enquiry which was conducted around 2000.

It is now standard practice to only mix 2 different drugs in the one syringe driver. If more than

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2 drugs are required to be administered then either another syringe driver is set up for the patient or the drug is administered directly by injection by a trained nursing member of staff.

I have been asked to detail my involvement in the care and treatment of Code A, dob Code A who was a patient on Dryad Ward in 1996. Firstly I cannot remember anything about this patient. From memory and referral to entries in his medical notes.

I have been shown a printed copy of a microfiche exhibit reference Code A

I can confirm that I have made an entry on page 24 of this exhibit commencing as follows.

Past History - long term psychiatric problems (depression). Has been in Hazledene Rest Home for past 7 months as wife unable to cope with decreasing mobility.

Has had recent falls due to decreasing mobility.

Reluctant at times to eat and drink.

Catheterised on the 23/12/95 (23/12/1995) due to fluid retention.

This observation has been written on the rear of the admission notes for the patient, Code A Code A

In relation to this entry 'catheterised', this means that patient has had a tube inserted through the penis into the bladder in order that urine can be drained from the bladder.

I can confirm that I have written an entry on page 25 dated 5/1/96 (05/01/1996) as follows:-

Transferred from Mulberry Ward at lunchtime. Appears to have settled well. Wife and daughter visited this afternoon. Code A has a sore on (R) buttock which has granuflex on - same left intact. (L) buttock dressing removed and granuflex applied. Scrotum sore and broken, left

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dry. Has taken a small amount of puree as reluctant to eat sandwiches, needs to be encouraged with diet and fluids. Catheter bag changed and dated.

Where I have written (R) this means right. Granuflex is the name of a type of dressing used on the ward for the treatment of pressure sores. (L) = left.

With regards to the entry commencing 'Scrotum', I have noted that the skin on the scrotum is very dry and the skin is cracked. 'Left dry' means I have not given any treatment.

I can confirm that I have written the following entry on page 35 of Code A nursing care plan as follows

'Bed bath' given, liquid paraffin to penis, scrotum and sacrum (small of the back). This entry is dated 15/1/96 (15/01/1996). The next entry is dated 19/1/96 (19/01/1996) commencing

'Bed bath - navel cleaned and mouth care given.

Liquid paraffin to scrotum and penis given.

Navel relates to the belly button.

I can confirm that the patient, Code A (after reading his notes) had the following care plans administered to him after examination on his initial admission to Dryad Ward. They were as follows

Hygiene care plan - ie, the patient's washing personal hygiene.

Catheter care plan - ie, the care of the patient's fluid output.

Pressure or wound care plan - this would be the monitoring of the patient's skin condition and any sores, specifically this related to Code A scrotum, his sacrial area (small of

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back).

There was also a diet and fluid intake care plan. The patient was monitored with regards to what he eats and drinks.

There was a sleep care plan. The patient was monitored during sleep time. They would be asked how they like to be settled during the night.

The above care plans would be adhered to by all the nursing staff treating the patient Code A Code A

I have checked the drugs chart for this patient. I can confirm that I did not administer any drugs.

The care plans as shown above detail what treatment Code A received whilst on Dryad Ward.

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: Code A

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

This statement (consisting of 7 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 12/08/2004

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

My Nursing Midwifery Council Pin Number is Code A

Further to my statement dated the 9th October 2003 (09/10/2003) I can confirm that I qualified as an RGN in 1988.

In 1993 I worked as a bank nurse on all the wards at the Gosport War Memorial Hospital (GWMH). These included the Redcliffe Annex, Daedalus Ward and Sultan Ward. I worked on these wards where ever I was needed for 6 months.

For the next 3 months I worked at the Redcliffe Annex on a 3 month temporary contract.

I then worked at the QA Hospital on permanent nights on the elderly ward in South block.

I returned to Dryad Ward GWMH in 1995 as an F Grade RGN. I worked on the Dryad Ward until November or December of 1996 when I took a [redacted]

Upon my return from [redacted] I worked on the Sultan Ward until September 2003. At the time of leaving I was an E Grade Staff Nurse.

I have been using syringe drivers on a regular basis when I started working on the Dryad Ward in 1995.

Signed: Code A Signature Witnessed by:

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I was given on the job training by another trained nurse with regards to how a syringe driver worked, how it was to be loaded with the various prescribed drugs and which drugs were commonly used in the drivers.

It was policy at that time that required two trained nurses to set up a syringe driver.

A syringe driver is administered subcutaneously and normally delivers a constant dosage over a 24 hour period.

The controlled drugs were kept locked within a secure cupboard within another secure cupboard located in the treatment room on the ward.

A register was kept recording the administration, dosage of each type of controlled drug used for each patient.

I received/attended an ENB (ie, English National Board) course at the Hospice School of Nursing at St Mary's in Newport, Isle of Wight. This course commenced in January 1996 and finished in July 1996. I attended this course covering palliative care for approximately 1 week every month during the course.

The ward sister for Dryad at that time was Code A

My responsibilities as an F Grade Staff Nurse on Dryad Ward involved general nursing care, ward management, ie of staff, running of the ward, recording patients notes, drug administration. Dealing with the patient's relatives.

Dryad Ward consisted of approximately 17 beds caring for patients aged 65 and over who required continuing care.

I have been shown a printed copy of a microfiche ref Code A, page no.6.

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I can confirm that I have made a written entry on page 6 as follows on the medication drug chart.

Nozinan 100mgs s/c in 24 hours (dose) 100mg, (date) 20/1/96 (20/01/1996) (where it states signature - I have written the following) 'verbal order - Dr Code A 1720 hrs, Code A (countersigned) Code A

In the columns next to the above entry it is dated 20/1/96 (20/01/1996), 1800, 100mg TD - This entry has been signed by Dr Code A

The above entry relates to prescribed drugs to the patient Code A

In relation to the above entry where I have written S/C this refers to subcutaneous doseage of this drug to be given in 24 hours.

Where I have written 'verbal order'- from my memory I would have phoned the on call doctor as a result of a change in the patient's, Code A condition.

The doctor called was Dr Code A. He authorised verbally over the phone an increase in the dosage of Nozinan to 100mg. This would then have been reiterated to staff nurse Code A verbally by Dr Code A

I can confirm that the entry on page 8 of the printed record of Code A is an entry written by me as follows - 20/1/96 (20/01/1996), 1530, Haloperidol - omitted Dr Code A request, (signed by) Code A, Code A

On the request of Dr Code A (after informing him of Code A change in medical condition) the drug Haloperidol was stopped.

I cannot recollect exactly what change or deterioration of the patient Code A had occurred.

Signed: Code A

Signature Witnessed by:

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I would add that with reference to the time recorded as 1530 on page 8. This is an error written by me. I believe, as far as I can recollect, that this entry should have been 1730 NOT 1530.

There is no record written on the patients summary explaining the reason for calling Dr Code A that I have recorded. However Dr Code A has made an entry on the medical notes.

I have been shown the controlled drug register for the Dryad Ward, GWMH, issued 6/3/95 (06/03/1995) -

On page 7 there is a written record by Nurse Code A which has been signed by me and countersigned by Code A The entry is as follows.

20/1/96 (20/01/1996) - 1530 Code A 20mg - discarded.

On page 16 of the drug register there is a written record by Staff Nurse Code A which has been signed by me and countersigned by Code A The entry is as follows.

20/1/96 (20/01/1996) - 1530, Code A 100mg - discarded.

I cannot recollect whey these two doseages of Diamorphine were discarded at this time.

On page 7 there is an entry in the drug register there is a further written record by Staff Nurse Code A Code A which has been signed by me and countersigned by Staff Nurse Code A - The entry is as follows -

20/1/96 (20/01/1996), 1800, Code A 20mg.

On page 16 of the drug register there is again a further entry by Staff Nurse Code A and signed by me countersigned by S/N Code A The entry is as follows.

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20/1/96 (20/01/1996) 1800 Code A 100mg.

With regards to the above entry it is at this time that I believe the syringe driver for the patient Code A was recharged as per the entry by S/Nurse Code A on page 28, dated 20/1/96 (20/01/1996).

I can see from the records having checked the entries on page 7 of Code A that I have completed making up a syringe driver for Code A at 1530 on 20/1/96 (20/01/1996). For some reason that I cannot specifically recollect this doseage was discarded.

Dr Code A was spoken to reference Code A at 1720 hrs and the syringe driver was administered with the reviewed medication at 1800 hrs.

I can confirm that I wrote the following entry on page 26 of Code A which is as follows.

15/1/96 (15/01/1996), 1900 hrs, daughter informed of father's deterioration during the afternoon. Now unresponsive, unable to take fluids and diet, pulse strong and regular - Code A Code A

I can confirm that I wrote the following entry on page 27 Code A which is as follows -

17/1/95 (17/01/1995) (which should be 1996) 0900 - S/B Dr Code A medication increased 0825 as patient remains tense and agitated, chest very 'bubbly' suction required frequently this morning. Patient bed bathed, mouth care tolerated, well skin marking easily despite hourly turning and use of Pegasus mattress and remains distressed on turning. 1430 S/B Dr Code A medication reviewed and altered, syringe driver reviewed at 1535 (two drivers), one set 47mm/24 hr - (2) 50mm/24hr.

Daughter informed of deterioration.

With reference to this entry where I have recorded the time 0900 (S/B) seen by Dr Code A

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this would have been after Dr Code A had completed her ward round, which was normally between 0815 and 0845.

I have recorded that I administered the doseage at 0825 on the 17/1/96 (17/01/1996) in the medication drug chart on pages 18 and 20.

However on checking the drug register for the administration of Diamorphine which has been written by Staff Nurse Code A then signed by me and countersigned by Code A I can see that she has written the 16/1/96 (16/01/1996), this should have been 17/1/96 (17/01/1996) at 0830. This entry is recorded on pages 7 of Code A and page 16 giving a total of 120mg of Diamorphine given to the patient. The date is wrong on both pages.

The following drug doseages were increased as follows - Diamorphine was increased from 80mg to 120mg. Hyoscine was increased from 400mcg to 600mcg. Haliperidol was increased from 5mg to 10mg. The Midazalam remained the same doseage. This is recorded on pages 18 and 20 of Code A

The doseage was increased as a result of my observations of the patient's medical condition. I would have informed Dr Code A whilst she was conducting her rounds.

The doseage was increased for the patient Code A as a result of Dr Code A examination.

I have been asked to explain why I set two (2) syringe drivers.

Firstly a syringe driver would at that time only hold 10mils of fluid.

On reviewing the patient Code A drugs chart for 17/1/96 (17/01/1996) the quantity of fluid in which the prescribed drugs were diluted/mixed exceeded the capacity of the syringe driver. Therefore as far as I can recollect I would have used two syringe drivers. Another reason would because of the concentration of the mixture of drugs within the driver.

Signed Code A

Signature Witnessed by:

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Continuation of Statement of: Code A

I am not able to state which drugs were in each driver.

Taken by: DC Code A

Signed: Code A

Signature Witnessed by:

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

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

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 29/10/2004

I am employed by the Fareham and Gosport Primary Care Trust at the Gosport War Memorial Hospital , Gosport. My current role is as staff nurse (grade E). I have held this position since 1996 (I cannot remember the exact month that I obtained this grade).

I undertook pupil nurse training at Southampton University Hospitals of the Royal South Hants and the Southampton General Hospitals from January 1983 to October 1985 where I qualified as an Enrolled Nurse (EN).

My Nursing Midwifery Council No. is Code A which is due for renewal in August 2006.

I only worked for a short period in 1985 before I gave up work later that year to have a family.

I returned to work as an EN in 1989 where I worked at Ashview, a home for mentally handicapped people situated in Bury Road, Gosport.

I then worked at Hollam House Nursing Home.

I commenced working at the Gosport War Memorial Hospital as a C Grade EN on the female ward in June 1990. At this time the ward consisted of 24 beds, the patients were mainly elderly women. This included 6 beds which were allocated for patients undergoing minor surgical work.

Whilst I was working on the ward I upgraded to a D Grade Enrolled Nurse.

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I believe it was in April 1994 that the female ward was transferred to the new building at the Gosport War Memorial Hospital and was renamed Sultan Ward. The male ward was also relocated and was called Daedalus Ward (GWMH).

At the same time Redcliffe Annex transferred all their patients to the new wards at the GWMH which was called Dryad Ward.

As a D Grade EN my responsibilities increased on the ward, these included dispensing medication to patients, liaising with GP's, social workers, occupational therapists.

I was responsible for the direct care of the patients on the ward. I also supervised the nursing auxiliaries and student nurses that worked on the ward.

It was part of my responsibilities to keep myself updated with regards to training in basic procedures such as basic life support, fire procedures, manual handling of patients (ie, lifting patients in and out of bed).

Between October 1994 and November 1995 I completed a conversion course from an EN to a Registered General Nurse (RGN). I qualified as a D Grade. I continued working on Sultan Ward as a D Grade RGN. My responsibilities remained the same.

The sister of Sultan Ward at this time was Code A I believe it was sometime in 1996 that I applied for and was successful in obtaining E Grade Staff Nurse.

My responsibilities as an E Grade included managing/running the ward (in the absence of an F or G Grade RGN, ie, senior staff nurse or manager). This included the administration of medication, liaising with the multi-disciplinary team, ie, occupational therapists, physiotherapists, GP's, consultants, social workers and relatives.

Sultan Ward is currently divided into the two teams which are called the green team and the

RESTRICTED

blue team.

I am the staff nurse in charge of green team.

The reason the ward has been divided into two teams is to make it easier for the continuity of care and to make it easier for the patients.

In my role as a staff nurse I would accompany the doctor on their ward rounds. I would record/note any changes in mediation into the nursing notes within the patients records. This included any changes to the patients care plan or suggestions made by the Doctor whilst on the ward round. I would also handover the patients care to the next shift. I would detail any changes to patients care or to their medication.

As previously mentioned I have worked at the Sultan Ward for the past 14 years.

There has been a few occasions when I have worked on other wards when there has been a staff shortage.

I have been asked to detail my involvement with regards to the patient Code A .

I do not remember this patient or any care that may have been administered to him.

I have been shown the drug register, exhibit Code A for controlled drugs relating to the patient Code A dated the 19/1/96 (19/01/1996) page 7 and page 16 refer.

I can confirm that I have witnessed the entry by Staff Nurse Code A confirming that 20mgs of diamorphine has been drawn up together with 100mgs of the same drug on the 19/1/96 (19/01/1996) for the patient Code A

It is policy that two (2) trained nurses must check and record firstly that the quantities of the controlled drugs have been accurately recorded. That the amount remaining that is recorded in

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the controlled drug register is correct.

Once this has been established the patients prescription chart would be checked by both nurses to ensure the amount of controlled drug to be given to the patient is appropriate.

Should I note that there was a large discrepancy from the previous dosage administered I would firstly not agree to give the amount out to the patient and then document the reason on the prescription chart and in the nursing notes why this had been done. I would also try to contact the Doctor who had prescribed the drugs initially. However if the initiating Doctor was not available then I would contact the on call Doctor.

If the patient was able to understand I would inform them of the reason for not giving the medication. If this was not possible I would contact the next of kin.

I can confirm that I witnessed the entry by Staff Nurse Code A where 100mgs of diamorphine (1x100mg ampoule) has been drawn up, this entry is dated the 19.1.96 (19/01/1996) @ 1500 for the patient Code A

Although I was working on Sultan Ward it is apparent to me that I was called down to Dryad Ward to witness S/N Code A checking and giving controlled drugs to a patient. There was obviously only one trained nurse working on Dryad Ward at that time.

As S/N Code A had signed for the controlled drugs together with other medication to be given via the syringe driver , I would be required to witness the whole procedure. That is I would physically check each ampoule of medication for the amount, the expiry date and the name of the drug to ensure that the correct dosages are drawn up and given to the patient.

I have been using syringe drivers since starting as an enrolled nurse at the female ward at Gosport War Memorial Hospital since 1990.

I was initially given training by other staff nurses competent to use syringe drivers. I would

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have watched/observed trained staff administering medication via a syringe driver. Then I would have administered drugs via a syringe driver under direct supervision of a trained nurse.

I have since attended study sessions on use of the syringe driver at various places. The training has normally been given by the palliative care team.

We were given updates with regards to the new syringe drivers which were introduced approximately 2 years ago.

It is one of my responsibilities to keep myself updated with regards to any changes in procedures.

I had no other dealings with the patient Code A

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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: TEAM LEADER SOCIAL SERVICES

This statement (consisting of 6 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 25/10/2004

I am currently employed as a team leader for home care for the elderly (over 65's) by the Social Services Department. This is the Fareham and Gosport home service. I run the rapid response team for both areas.

Between May 1976 and May 1979 I trained as a student nurse, I qualified as a State Registered Nurse in May 1979. During this period I worked for the Portsmouth and South East Health Authority. I worked at St Mary's and the Royal Hospital.

My Nursing Midwifery Council PIN number is Code A. From May 1979 I worked on B3 the female geriatric ward at St Mary's Hospital as a junior staff nurse.

In 1981 I commenced by midwifery training (which was an 18 month course). I did not complete this course due to [redacted] I left in either November or December of 1982.

During the period between 1983 to 1986 I worked part time as a staff nurse on night duty at the Thalassa and Bury Lodge both nursing homes for the elderly, situated in Gosport. At this time I only worked 2 night duties per week.

Around June 1986 I left nursing to start up my own business running a shop for the sale of baby goods and clothes called Bambino's in the Precinct, Gosport.

I ran this business until the beginning of 1990.

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From the beginning of 1990 until September 1991 I was employed by the Ministry of Defence as a clerical officer at HMS Centurion which was the pay and pensions department for the armed services.

From September 1991 I then re applied to work as a nurse with the Portsmouth Health Care Trust. I started work at Redcliffe Annex in The Avenue, Gosport . This unit was a long stay unit for the elderly, ie, patients over the age of 65 years.

Initially I was only working part time as a D Grade registered general nurse (RGN).

Prior to restarting as a nurse I was required to re register with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

At this time whilst working at Redcliffe Annex I was working with Code A the Senior Staff Nurse F Grade RGN, Code A E Grade RGN and Code A G Grade RGN who was the Ward Manager.

As a D Grade RGN I was a junior staff nurse. I always worked with a Senior Staff Nurse.

During this initial period that I was working at the Redcliffe Annex I updated my knowledge concerning nursing and healthcare by reading the Nursing Standard and Nursing Times.

Although I know I received training in connection with the use of syringe drivers I cannot remember the dates or where this training took place. However I would not have been allowed to use or set up a syringe driver without the appropriate training.

I cannot specifically remember using syringe drivers at the Redcliffe Annex.

With regards to the use of a syringe driver I am aware that it can only be used on the authority of a prescribed prescription written by a Doctor.

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The use of a syringe driver is only authorised after discussions amongst the medical team and nursing staff have reviewed the patient's pain relief/control and the analgesic ladder had been followed re starting with simple paracetamol, distalgesics, then co-dyramol, a codeine based analgesics and when the ladder had been followed then morphiates would then be the next consideration.

Once the authority for a syringe driver was given ie, when it was written in the prescription chart, normally also written in the clinical notes. There should be an entry in the nursing notes which would state what controlled drugs were to be administered to a patient, what the quantity/dosage. The period of time the dosage was to be administered (normally over 24 hours).

The procedure for setting up a syringe driver was that it required two qualified nurses.

The controlled drugs were taken from a secure drugs cupboard the amount/doseage of the controlled drug was checked against the prescription sheet.

The appropriate amount of drug withdrawn was then recorded in the controlled drugs book which was recorded and witnessed by the same two trained nurses that had withdrawn the drugs.

The drug solution containing the prescribed drug(s) was made up in sterilised water.

In the case where it was a mixture of drugs then the compatibility of the drugs would be checked in the British National Formulary (BNF). On occasions the pharmacist would be contacted for advice.

Once satisfied that the drugs mixture compatibility were correct then the syringe driver would together with the prescription chart and drug controlled book be taken to the patient.

At the patient's bedside a check was made to confirm it was the right patient for the prescribed

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drugs.

A small butterfly needle was inserted below skin level (sub-cutaneous) and the syringe driver applied which delivered a set quantity over a 24 hour period.

I cannot remember which year that the Redcliffe Annex closed down. All the patients and staff transferred to the new ward, Dryad, at Gosport War Memorial Hospital. At the time of transfer I was an E Grade Staff Nurse.

My responsibilities at this time were deputising in the absence of the senior staff nurse or ward manager, supervising staff and delegating work loads.

Assessing, implementing and evaluating individual patient's care.

Accompanying doctors, consultants on their ward rounds and passing on new treatments and information ordered by the doctors. That is informing, documenting other staff and patients/relatives.

Ordering and safe storage of drugs and dispensing safely drugs to the patients.

I have been asked to detail my involvement in the case and treatment of the patient Code A Code A. From referral to an entry on page 29, a photocopy of Code A nursing notes, exhibit ref Code A I can state the following.

I can confirm that I have written the following entry for the 21/1/96 (21/01/1996).

Condition remains unchanged, Code A phoned, driver recharged at 1745 Diamorphine 120mgs, Midazalom 80mgs, Hyoscine 1200 micro grams, Nozihan 100mgs, one syringe running at 50mms per 24 hours the other at 58 mms, appears comfortable.

This entry has been signed by me.

Signed: Code A

Signature Witnessed by:

RESTRICTED

Firstly I do not recollect this patient Code A or remember the subsequent care given.

With regards to the above entry the patient's condition has not changed during my shift. Mrs Code A has phoned because she is obviously aware that Code A is very poorly, ie, prognosis is poor.

The syringe driver has been set up and commenced prior to my shift. I have recharged the syringe driver as per the prescription chart written by Doctor Code A clearly shows that this doseage and mixture of drugs can be administered to the patient.

However if as trained nurses we felt that the amount of drugs was no longer required, ie, there were signs of improvement then I would not administer these drugs. I would firstly phone the doctor on duty for advice.

In my experience contacting a doctor for advice in these circumstances was a rare experience.

With reference to the different rates that I have recorded - both syringe drivers were set to run over a 24 hour period.

With reference to where I have written 'appears comfortable' I understand this to mean that there were no obvious signs of pain or discomfort.

I have written under the initial entry on page 29 of Code A the following:-

2015 no change in condition - which is self explanatory.

To summarise the patient Code A at this stage was obviously very poorly, the family were aware of his condition. That during my shift the patient's condition had not changed.

I have been shown the drug controlled record book relating to Dryad Ward exhibit

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Continuation of Statement of: Code A

Code A

I can confirm that on page 7 on the 16.1.96 (16/01/1996) at 0830 hrs I witnessed and recorded 20mgs 2x10mg ampoules being withdrawn by Staff Nurse Code A for the patient Code A Code A

Again on page 16 on the 16.1.96 (16/01/1996) at 0830 hrs I witnessed and recorded 100mg 1x100mg ampoule of diamorphine withdrawn by Staff Nurse Code A for Code A

On the 21.1.96 (21/01/1996) at 1745 hrs I can confirm that I have recorded 20mgs 2x10mg ampoules of diamorphine which was witnessed by Staff Nurse Code A.

Also on page 16 on the 21.1.96 (21/01/1996) at 1745 hrs I have recorded that 100mgs 1x100mg ampoule of diamorphine has been withdrawn for the patient Code A this record was witnessed by Staff Nurse Code A

As far as I am aware I had no further dealings with this patient.

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: Code A

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 Code A 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 Code A 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 Code A

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: Code A

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

This statement (consisting of 12 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: 01/12/2004

I am Code A 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

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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 Code A

I have been asked if I recall anything about a patient called Code A born Code A who was at Gosport War Memorial Hospital from 13th December 1995 (13/12/1995) where he was originally on 'Mulberry Ward'. He was then transferred to 'Dryad Ward' on 5th January 1996 (05/01/1996) and died on Dryad Ward Gosport War Memorial Hospital on 24th January 1996 (24/01/1996). I have no personal recollection of this patient.

I have been shown copies of Medical Records bearing the name Code A bearing the exhibit reference of Code A which consists of 49 pages. I have examined each page in turn and can find no entry on these records that I have been the author of or have countersigned.

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

I have also been shown two Controlled Drug Record books, exhibit reference Code A and exhibit reference Code A

On my examination of these Record Books for the period of Mr Code A stay at Gosport War Memorial Hospital I can say that with regard to Mr Code A I have made no entries in the Controlled Drug Record Book, exhibit Code A

From my examination of the Controlled Drug Record Book exhibit Code A I note that on 3 occasions I have acted as 'witness' to controlled drugs being administered to Mr Code A

The entries appear on pages 76 and 77 of exhibit Code A and are dated as follows:-

i 10th January 1996 (10/01/1996)
ii 11th January 1996 (11/01/1996)
iii 12th January 1996 (12/01/1996)

On each of the above occasions the controlled drug was 'Oramorph ' - 'oral solution'. On each occasion I acted as 'witness' to the administering of the drug to Mr Code A by staff nurse Code A.

The full details of these entries should be read as follows:

On 10th January 1996 (10/01/1996) a dose of 'Oramorph' 10mgs in 5mls solution was checked against prescription at 2220 hours. The medication was given to the patient Code A by staff nurse Code A and the whole procedure was witnessed by me.

On 11th January 1996 (11/01/1996) a dose of 'Oramorph', 5mgs in 2.5mls solution was checked against prescription at 0610 hours. The medication was given to the patient Code A by staff nurse Code A and the whole procedure was witnessed by me.

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On 12th January 1996 (1/01/1996) a dose of 'Oramorph', 5mgs in 2.5mls solution was checked against prescription at 0615 hours. The medication was given to the patient Code A by staff nurse Code A and the whole procedure was witnessed by me.

I have checked a copy of the medical records of Code A exhibit Code A

I note that at page 17 of 49 and at page 19 of 49 a prescription of 'Oramorph', 5mgs in 2.5mls solution to be given 4 hourly at 0600 hrs, 1000 hrs, 1400 hours and 1800 hrs appears. It was normal practise for 10mgs in 5mls solution to be given at 2200 hours in order that the patient need not be disturbed at 0200 hours to be given a dose of medication. It was normal practise for the prescribing doctor to write up the prescription chart in order to allow this to be done.

On my examination of the prescription charts I note that the doses shown in the controlled drugs record book correspond with the prescription charts.

The procedure for administering controlled drugs at Gosport War Memorial Hospital was as follows:-

All controlled drugs are stored in a locked cupboard within a locked cupboard on the ward.

Details of the movements of 'Controlled Drugs' are recorded in the 'Controlled Drug Record Books'.

Before ANY drug can be administered to a patient it must first be prescribed by a doctor.

ALL 'Controlled Drugs' are required to be checked and witnessed by TWO nurses. One of whom must be a 'Registered Nurse'.

The two nurses check the prescription chart of a patient. Then take the prescription chart to the drug store where the drug in question is checked against the prescription chart.

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The drug is then checked to ensure that the correct dose is available and is in date. The drug is then taken with the prescription chart to the patient.

A further check is then made that the patient is the correct patient to administer the drug to.

This is done by checking the patients identification band against the prescription chart.

This check is usually done by the witnessing nurse, who may have come from another ward and may not be familiar with the patient.

Both nurses will then 'witness' the patient taking the medication or one nurse will 'witness' the medication being administered to the patient by the other 'nurse'.

Both nurses then return to the drug cupboard where the register is then completed and signed by the nurse giving the medication and the nurse who acted as 'witness'.

At the same time the prescription chart is completed and initialled by the nurse who administered the medication.

The Controlled Drugs Record Book records the following information.

1. Date (Drug checked against prescription)
2. Time (Drug checked against prescription and withdrawn from store)
3. Name of patient (To whom drug to be given)
4. Amount given (Dose of medication as per prescription chart)
5. Given by (Signature of trained nurse giving drug to patient)
6. Witnessed by (Signature of nurse who 'witnessed' the full procedure)
7. Stock balance (Running total of remaining doses of drug/medication)

All the above headings 1-7 are under the heading of the drug/medication and its dose.

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All of the above sections are required to be completed by the nurses administering the drug/drug.

It was part of my responsibilities to be available to 'witness' or administer controlled drugs to patients during the period of my duty. However this was not one of my main priorities, therefore if I was engaged in other duties then another member of nursing staff could be called to 'witness' this procedure.

Before withdrawing from store any prescribed medication I would ensure that the prescription was completely legible and clear. I would also satisfy myself that the prescription was in my opinion appropriate for the patient in the circumstances. If I had any concerns regarding any of the above points then I would not administer or allow to be administered the medication until I had discussed the matter with a doctor.

In my experience this has only occurred on a few occasions when I have been unable to read the writing of the prescribing doctor.

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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: HEALTH CARE SUPPORT WORKER

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: 13/10/2003

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

I work as a Health Care Support Worker on Sultan Ward at the Gosport War Memorial Hospital and have done so since 1994. A Health Care Support Worker is the modern name for an auxiliary nurse and as such I have not received nursing training. My responsibilities are that of general patient care.

I would describe the standard of general patient care at the hospital as excellent, in fact second to none.

I have not received any training in the use of syringe drivers so am not involved in their set up or use. Syringe drivers are used on the ward as is the drug diamorphine . Again in my current role I am not allowed to dispense drugs.

I have no concerns about the use of syringe drivers or diamorphine on Sultan Ward when I have been working there. They are both very effective ways of giving pain relief. If I had had any concerns I would have brought this to the attention of my line manager immediately and if this had not been to my satisfaction I would have gone to the union.

I have no knowledge of any internal investigations at the hospital. I am aware of an ongoing police investigation at the hospital as are all the staff. I only know what I have seen in the papers or on television.

Signed: Code A Signature Witnessed by:

RESTRICTED

Continuation of Statement of: Code A

The effect of this investigation on the morale at the hospital is terrible.

Signed: Code A

Signature Witnessed by:

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: HEALTH CARE 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: 23/09/2004

I am a Health Care Support worker currently working on Sultan Ward at the Gosport War Memorial Hospital which is under the Fareham and Gosport Primary Care Trust.

I have been so employed in this role since 1994. My role as a health support worker comprised of helping, supporting trained Registered General Nurses (RGN) and State Enrolled Nurses (SEN).

This included the day to day care of patients on the various wards. I would report to the Senior Nurse on duty any concerns I had with regards to the well being of patients, such as deterioration in the patients health. Any concerns that the patient's had would be notified to the senior staff nurse on duty at that time.

I would deal with relatives enquiries relating to a patient's health care. Once I had been informed of the relatives concern I would then refer the enquiry to the staff nurse on duty who would then deal with the enquiry.

As a support worker I would also clean the beds/mattresses after the patient had vacated their bed. One of my responsibilities was feeding the patients where required.

Where a patient had died on the ward that was expected I would prepare the deceased with another member of staff ready to be taken to the mortuary. In the event of a patient who died unexpectedly the deceased would be left in the bed. I would have no involvement in dealing with this patient until the set procedure had been complied with.

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Once the procedure of notifying a doctor had been completed and the deceased had been examined by the doctor and senior staff nurse I would then be detailed to prepare the body for the mortuary.

It was often the case that removal of the body would be completed by a support worker from the next shift.

Death was always and is currently verified by a Registered General Nurse normally with another member of staff present.

I do not remember the patient Code A .

I have no involvement in the administration of prescribed drugs whether orally or intravenous or those given by syringe driver .

I have over the years undertaken mandatory study days and voluntary study days where I have been updating my knowledge as a support worker.

In 1996 I was working night shift on a permanent basis. I would work on Sultan, Dryad or Daedalus Wards which were all elderly care wards.

Sultan Ward at that time was a GP medical ward. Dryad Ward was a continuing care ward. Daedalus was a stroke rehabilitation ward.

I have been shown a photocopy of the microfiche exhibit ref Code A page 15.

I can confirm that I was present with Staff Nurse Code A on the 24th January 1996 (24/01/1996). I have seen the entry timed at 1.45am (0145) in relation to the patient Code A Code A

RESTRICTED

I recognise Staff Nurse Code A handwriting stating that the patient's death was verified in my presence. Death is verified following a set procedure which is that Staff Nurse Code A would have shone a light into the deceased's eyes to ascertain if there was any reaction to the light. She would have checked to see if there was any pulse on the patient's carotid artery. She would have then checked with her stethoscope the patient's/deceased heart.

Once all the vital signs had been checked Staff Nurse Code A would ask if I agreed that there were no visible signs of life. Once this was established that there were no signs of life, Staff Nurse Code A verified the death of the deceased Code A

As this was an expected death I would remove any excess pillows and lay the patient down.

Approximately ½ to 1 hour later I would then with another member of staff prepare the body to be sent to the mortuary. Where necessary we would wash the body leaving the deceased in their own nightwear. In come cases we would put a white hospital shroud covering the body.

We would then put an identification label on the deceased's foot and one on the stomach area.

Then we would wrap the body in a hospital sheet which also had a label with the deceased's name.

Then at least 2 members of staff would list and bag all the deceased's personal property. A list would be signed by both members of staff and put inside the property bag.

Once all this had been completed the porter would be called to bring the trolley for transferring the deceased to the mortuary.

If this procedure was completed during my night shift I normally would accompany the porter to the mortuary where I would assist the porter to transfer the body into the mortuary cold store. The porter would then write the deceased's name on the door of the cold store.

RESTRICTED

Continuation of Statement of: Code A

Form MG11(T)(CONT)
Page 4 of 4

The deceased's personal property was then taken to the Patients Affairs Office where they secured and the room locked.

I cannot remember whether this patient, Code A was transferred to the mortuary during the night shift that I was on duty.

I had no other involvement in dealing with this patient.

On the label identifying the deceased would be included the deceased religion, date, time of death, the ward and whether the body was to be cremated or buried.

It was the responsibility of the Staff Nurse to notify the next of kin of the death.

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: Code A

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

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 18/08/2004

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

I retired as a RGN (E Grade) in 2000. My Nursing Midwifery Council No. was Code A

I qualified as a RGN in 1978 after completing 3 years of training at the Queen Alexander Hospital in Portsmouth.

I believe it was towards the end of 1979 that I went to work at the GWMH . At that time I was working on the male ward. I worked on the male ward for approximately 6 months.

I then went to work at the Northcott Annex (which was part of the GWMH) situated in Bury Hall Lane, Gosport. I worked at the Annex for about 4-5 years.

I believe it was in 1985 that I went to work at St Christophers Hospital in Fareham as a staff nurse working permanent nights. I worked at this hospital for approximately 3 years.

In 1988 I then returned to work as a staff nurse at the Redcliffe Annex.

I believe it was in 1994 that the Redcliffe Annex was closed and the patients and staff were transferred to Dryad Ward.

I was permanent nights duty staff nurse at the Annex and also when I transferred to Dryad Ward.

RESTRICTED

Dryad Ward consists of 20-21 beds for elderly long term patients. There were also some patients who were admitted for respite care.

My night shift commenced at 2045 and finished at 0745 hours. There was a hand over period at the beginning of the shift from the day shift and again when we were finishing our night shift. There were 3 staff on nights, one trained, ie RGN and two auxiliaries. On occasions there would be an (SEN) State Enrolled Nurse.

My responsibilities on the ward consisted of the management of the ward, caring of the patients, administering drugs where applicable. I was responsible for contacting the Doctor of a patient where necessary.

At that time I would contact the patients own GP up to 10pm (2200). After 10pm (2200) it would be a locum Doctor. I will add that it was on very rare occasions that a Doctor was called out.

With regards to the use of syringe drivers I can recollect that I first starting using these whilst I was at the Redcliffe Annex in 1988. All the trained nurses were given a half day's training in the use and preparation of a syringe driver.

A syringe driver can only be set up by two trained nurses. One of the reasons for this was because controlled drugs were administered in the syringe driver. A record of these controlled drugs was strictly recorded in the ward drugs register.

I have been asked to detail my involvement with the patient Code A . Firstly I cannot recollect anything about this patient.

I have been shown a printed copy from a microfiche bearing the reference Code A

I can confirm that I have written the following entry on page 15 as follows.

RESTRICTED

'24.1.96 (24/01/1996) Death verified at 1.45am (0145) by S/N Code A in the presence of Code A (and then signed by me)'.

The procedure for verifying death was first to check the patient's vital signs, lack of radial pulse, pupils fixed and dilated and no lung or heart sounds when tested with a stethoscope.

If it was an expected death which in the case of this patient Code A it was, I would contact the family immediately to inform them of the death.

The patient's GP would be contacted in the morning by the day staff.

If the death was unexpected we would not verify death. A doctor would be called out to attend to the patient.

With reference to the entry I have made above on page 15. This entry has been written in the clinical notes. It is the only time that a nurse will write an entry in the clinical notes. That is to confirm that the death of a patient has been verified.

Death could only be verified by a trained nurse.

Death of a patient is verified by a trained nurse which has to be witnessed by another member of staff, normally an auxiliary. This was the policy on the ward at the time.

I can confirm that I signed for and withdrew Oramorph on the 10/1/96 (10/01/1996) at 1020pm (2220). This entry had been written by Dr Code A. This is recorded on page 17 as follows.

Oramorph 10mg/5mls route given was to be oral - 2.5mls 4 hourly.

This drug was administered to the patient after the consultant's round who in this case was Dr Code A accompanied by Dr Code A Oramorph was prescribed by Dr Code A and

RESTRICTED

recorded in the drugs chart on page 17.

The reason for administering the drug at this time is simply that the drug round was usually at 10pm (2200). This drug was kept in a locked cupboard which was within another locked cupboard.

I can confirm that I withdrew 10mg in 5mls (This Oramorph is a standard doseage delivered in a bottle from the pharmacy) at 1020pm (2220) for the patient Code A This entry is signed by me and witnessed by Code A. This is recorded in the drug register for Dryad Ward.

I can confirm that I wrote the following entry on page 26 as follows.

Night - condition remains poorly, all care continued, syringe driver running satisfactorily. Signed by me.

Any involvement that I had with the patient Code A will be recorded on the patients notes.

I can confirm that I have written the following entry on page 27 as follows.

Night - Little change in poor conditions, appears more peaceful. Turned frequently and suction given when necessary.

Suction is given to a patient when they have excess fluid on their lungs. The excess fluid is extracted using an electric machine.

I can confirm that I have written the following entry on page 29.

Night - Patients condition deteriorated suddenly at 1.40am (0140) and Mr Code A died at 1.45am (0145). Code A (daughter) informed at 1.50am (0150). Death verified by S/N Code A Code A in the presence of Code A For cremation.

RESTRICTED

Continuation of Statement of: Code A

I cannot remember the patient Code A After reading this entry concerning his death I still cannot remember anything about this patient.

I will add that I worked on Dryad Ward for 18 months approximately. I then moved, moved to work on the Sultan Ward as night duty staff nurse later in 1996.

I can also confirm that I withdrew Oramorph at 0610 on the 11/1/96 (11/01/1996) for the patient Code A The doseage was 5mg per 2.5mls as previously administered and recorded in the Dryad drug register book.

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: Code A

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

This statement (consisting of 1 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 03/03/2005

I am Code A Detective Constable Code A of the Hampshire Constabulary currently attached to the Major Crime Department.

At 0915 hours on Thursday 3rd March 2005 (03/03/2005) in company with Detective Constable Code A I conducted a tape recorded interview of Dr Code A in an office within the Fraud Squad at Support HQ, Netley . Also present was Doctor Code A solicitor Mr Code A Code A

The interview was concluded at 0940 hours that morning. During the interview Doctor Code A 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

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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: DETECTIVE CONSTABLE Code A

This statement (consisting of 1 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tended in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 06/04/2005

At 0915 hours on Thursday 3rd March 2005 (03/03/2005) in company with Detective Constable Code A we conducted a tape recorded interview of Dr Code A in an office within the Fraud Squad at Support HQ, Netley . Also present was Doctor Code A 's solicitor Mr Code A Code A

The interview was concluded at 0940 hours that morning. During the interview Doctor Code A 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

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