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Code A

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Code A

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SUPPLEMENTARY STATEMENT.

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 in it anything which I know to be false or do not believe to be true.

Signed: Code A Date: 10/09/2004

Further to my statements dated 2/2/2003 (02/02/2003) and 30/6/04 (30/06/2004). In my statement of the 30/6/04 (30/06/2004) I refer to pages BJC/16/PG277&278 of Code A medical records, these pages show that Code A prescribed the Fentanyl patch on 18.11.99 (18/11/1999). I then go on to say that there is no administration record of the drug. I have today been shown BJC/16/PG/276 which is a continuation sheet of the prescription sheet. This quite clearly shows that I administered the Fentanyl patch on the 18th November 1999 (18/11/1999) at 0915. I have signed with my initials and timed the administration record.

The recording of significant events and entries in health care plans are dictated to the care staff by government policy. There is a policy file that is held on every ward. Having been retired from the GWMH since February 2004 and not having worked there since May 2003 I am unable to say whether the policies on completing these records is in the folder.

Taken by: Code A

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 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 in it anything which I know to be false or do not believe to be true.

Signed: Code A Date: 30/06/2004

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. From memory and referral to the entries in her medical notes, identification reference BJC/16/PG222 and 223, BJC/16/PG228 and 229 and BJC/16/PG18 & 19.

BJC/16/PG222 and 223 is a summary of significant events for the patient Code A I have made four entries on this record which I have signed and dated, the entries are not timed as this was not the practice at the time. If a time was included it would appear in the body of the report. Significant events that were recorded was anything that was not the norm for the patient, eg, any medical condition, fits, vomiting, heart attack, visits by consultants, or social workers, if the family had been seen. The care of the patient was recorded on care plans for the patient and these would have been completed on a daily basis. I have recorded on this sheet BJC/16/PG222 and 223 PM see contact record.

This entry was made PM on 3-11-99 (03/11/1999) and relates to an entry that I made on Code A contact record (BJC/16PG228 & 229) that I will detail later.

15.11.99 (15/11/1999) seen by Code A referral made for Code A continue Thioridazone.

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This entry relates to a ward round by Code A when he saw Code A on 15-11-99 (15/11/1999). He required a referral to be made to Code A who was a psychiatrist based on Mulberry Ward. Code A had previously been a patient on Mulberry Ward. Thioridazone is a sedative that had been prescribed to Code A a sedative is a calming medicine.

19-11-99 (19/11/1999) marked deterioration over last 24 hours. Extremely aggressive this am refusing all help from all staff. Chlorpromazine 50 mg's given I.M at 0830 taken 2 staff to special syringe driver commenced at 0925 i/c Diamorphine 40 mgs and Midazolam 40mgms. Fentanyl patch removed. Code A son seen by Code A at 1300 and situation explained to him. He will contact Code A and inform her of Code A poor condition. He will visit later.

This entry relates to the fact that Code A kidneys were failing. This had been shown by a recent blood test. Code A had had a long history of renal (kidney problems) and was under Code A for this condition. Extremely aggressive this am, Code A had been throwing the staff into a book case, this was staff nurse Code A, during the night had been trying to pull patients out of bed, hitting out at anybody or anything. I can remember that due to her aggression Code A was given 50mgms of Chlorpromazine, so that this would calm her down and so that she didn't go on to harm herself or anybody else.

Chlorpromazine is also a sedative but more powerful than thioridazone. I.M is intra muscular and means that the drug was injected into the muscle so that it acts quicker. Code A Code A injected Code A. This drug was prescribed on the advice of Code A who I had phoned at her surgery for advice. It would have been given at 0830 hrs and I can remember that it was administered in the day room. 2 staff to special means that 2 staff, Code A Code A sat with her during the morning - special means staying with the patient the whole time. In Code A case I can remember that Code A had hold of their wrists and wouldn't let go. A syringe driver was started at 0925 hrs that morning, i/c means with diamorphine 40mgs, diamorphine is used for pain relief, it also has a side effect of sedating. Midazolan 40mgms is used to calm the patients. These quantities of drugs were

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administered through the syringe driver over a 24 hour period. Code A Fentanyl patch was removed, Fentanyl is the same as diamorphine an opiate and you don't use both together, diamorphine is stronger. Code A saw Code A at 1300 hrs and explained what had gone on and why she had given her the drugs that she had given her, ie, the deterioration of her health due to her kidney problems. The last part of the entry is self explanatory.

The syringe driver was set up and the diamorphine was administered to Code A on the advice of Code A This was because the Chlorpromazine injection had no affect. To fit the syringe driver Code A was moved to a bed in a single room. I can't recall if I spoke to Code A but it would have been either me or Code A as out of the four trained members of staff two were sat with Code A When fitting a syringe driver or renewing the drugs in the driver this is completed by two trained members of staff because of the use of a controlled drugs.

20-11-99 (20/11/1999) condition remains poor - family have visited and are aware of poorly condition, seen by Code A

Code A condition was still poor - Code A visited (he and his wife were the only two members of the family that I saw) Code A was the ward chaplain.

BJC/16/PG228/229 relates to a contact record for Code A An entry is made on a contact record when anybody comes into contact with the patient but mainly with staff members.

I have made two entries on this record that are signed and dated.

3-11-99 (03/11/1999) discussion with Code A daughter-in-law. Issues discussed safety of Code A returning home. Both expressed concerns about it. Unable to do stairs and hasn't been able to do so for a while. Code A unable to care for Code A when her husband returns from hospital. Both agree that R/H or dual registered is the only option.

Signed: Code A

Signature Witnessed by:

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Referral to be sent to Social Services tomorrow.

This entry relates to a conversation that I had with Code A had previously been in the QA Hospital and had been transferred to the Gosport War Memorial Hospital. Code A Code A wanted Code A to look after there mother, these were the issues discussed. Code A had concerns over Code A living with them as she was unable to walk up the stairs. Code A was unable to care for Code A as her husband had had a [redacted] and had to been isolated. Both sides of the family agreed that a rest home (R/H) or dual registered, ie, it could have been a rest home part nursing home was the only option. I asked for a referral to be sent to Social Services. That would have been done by her named nurse Code A.

19-11-99 (19/11/1999) Social Services informed to close the case. Mulberry Ward also informed.

At that time due to the deterioration in Code A condition, ie, the kidney problem it was not appropriate for Code A to be transferred. Social Services were told this along with Mulberry Ward, a psychiatric unit that Code A had been in previously.

BJC/16PG18&19 is a patient discharge form that is completed for all patients when they are discharged or when they have died. A copy is sent to the GP and would have the diagnosis, investigation, treatments or date of death recorded on to it. I have recorded under the diagnosis chronic renal failure. I would have taken the cause of death from Code A medical notes. I signed the form on the 22.11.99 (22/11/1999) and recorded the ate of death as the Code A Code A this was because Code A died at 2030 hrs when the night staff were on duty. It was practise at the time that the night staff did not complete patient discharge forms and as I was one of the trained staff on the following morning it fell to me.

I retired in February 2004 and now work part time, two nights a week, as a night sister at Peel House Nursing Home , I have been doing this for the past three weeks. Prior to retiring I had been off work for 18 months due to ill health.

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My responsibilities as a Clinical Manager in October 1998 when working on Dryad Ward were that I had 24 hour responsibility for the 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 a management role when there no managers at the hospital, ie weekends, evenings. I was responsible for all the staff on my ward, hiring them, training, discipline matters, staff rota's and leave, ordering, stocking and administering of drugs and that the trained staff on the ward had their drug competencies to allow them to administer drugs, this particularly applied to enrolled nurses and overseas students and nurses who had returned to nursing after a gap and student nurses. I was responsible for the running of the ward and general patient care. Code A was responsible for the medical care on a day to day basis, medical care means whether the patient had a medical condition, ie, a pain, infection or other complaint and she was also responsible for any admissions.

The consultants had the overall responsibilities for the patients.

I believe that Code A was my line manager at that time, she was a Code A Code A and based in an office in another part of the building. Having read the statement I believe that my manager was not Code A in 1991 but Code A Code A she was Code A and also had an office away from the ward.

Having been shown BJC/16/PG279&280 I can say that I signed on Code A prescription chart that I put up, administered the diamorphine 40mgs at 0925 hrs on 19-11-99 (19/11/1999) and the Midazolam 40mgs at 0925 hrs on 19-11-99 (19/11/1999).

With regard to BJC/16/PG277 & 278 this shows that Code A prescribed the Fentanyl patch on the 18-11-99 (18/11/1999) but there is no administration record of the drug. Although I believe that it would be recorded in the controlled drug register.

Signed: Code A

Signature Witnessed by:

RESTRICTED

Continuation of Statement of: Code A

I have been asked to explain the term named nurse, at that time, ie 1998 a named nurse was a trained member of staff that had the responsibility of the general patient care of a particular patient and would deal with any issue that arose with that patient, ie, arrange, x-rays, bloods, social services.

Taken by: Code A

Signed: Code A

Signature Witnessed by:

Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 9 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 09/12/2005

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

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

My Nursing and Midwifery Council Number is Code A

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

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

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

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

Signed: Code A Signature Witnessed by: Code A

RESTRICTED

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

In 1999 my line manager was either Code A

My position in 1999 was Clinical Manager (Senior Sister).

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

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

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

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

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

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

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

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

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Dryad Ward was a continuing care ward.

Daedalus Ward at GWMH was a rehab/stroke ward.

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

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

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

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

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

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

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well being with them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I cannot recall this patient.

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Continuation of Statement of: Code A

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

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

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

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

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

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

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

Signed: Code A Signature Witnessed by: Code A

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

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

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

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

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

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

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:

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: 17/02/2006

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

My nursing and midwifery council number is Code A

I started my career in nursing in 1965 as a cadet nurse and trained for three years, qualifying at Hackney Hospital, London in 1969. I worked on all wards until my qualification as a Registered Staff Nurse, (RSN) to the Surgical Ward.

I commenced employment at the Gosport War Memorial Hospital (GWMH) in1988 as a Staff Nurse, retiring in 2004 as a Clinical Manager (Senior Sister) at Dryad Ward, although I had been on sick leave since 2003.

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

Redclyffe Annexe was a short distance from the GWMH and the facility moved to the main hospital in 1994.

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

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My hours of duty were 0730-1615 or 1200-2030 hrs. I also worked alternate weekends or more if required.

In 1999 my line manager was either Code A My position in 1999 was Clinical Manager.

In 1999 syringe drivers were in use at GWMH. These are a device loaded with the patient's prescribed drugs and administered sub-cutaneously, i.e. under the skin, mechanically, over a twenty four hour period. This prevents peaks and troughs of pain in the patient. Syringe drivers were in use at GWMH since about 1990.

Code A was Code A at GWMH who started work at the Redclyffe Annexe around 1989.

Code A visited GWMH about 0730hrs Monday to Friday and would see every patient on ward rounds before going on to her general practice. I would accompany her if I was on duty, if I was not she would be accompanied by the senior nurse present.

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

On her visits Code A prescribed the drugs she felt were required by patients depending upon their medical condition. She set the parameters of the amount of any given drug prescribed and the administration of them was carried out by trained nursing staff.

Dryad Ward was a continuing care ward that is to say a ward where care is provided in order to ensure that the patients return to either their home or on to a nursing or rest home, or, if they required palliative care, i.e. they were expected to die, to be looked after in a manner which would ensure a dignified death.

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My role was to be in charge of twenty beds, the named nurse may have had four to six patients to deal with, conducting the day to day aspects of patient's care.

I also had my administrative role and I was kept very busy, however my priority was care of the patients as it should have been.

I was also continence adviser for the whole hospital. Any staff who had patients with bladder or bowel problems would call me and I would attend whenever required in the hospital and advise regarding treatment or management of the problem. As GWMH is almost all elderly patients I was also busy in this role.

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

There were occasions where Code A partners refused to attend when I asked them. I remember Code A as being the worst in this aspect. In those instances I would speak with a Consultant straight away regarding the issue.

I do not recall the content of any conversation between Code A and Code A I am aware, through other members of nursing staff that Code A withdrew a syringe driver which was given by Code A to an elderly lady patient who died at 1am in pain. I cannot recall this patient's name.

I believe that when Code A colleagues attended GWMH in the morning, prior to their GP duties, it was because Code A did this.

I have been asked about prognosis and diagnoses. A prognosis is what may be medically wrong with a patient, or what may develop. A diagnosis is the condition they actually have.

Diagnoses and prognosis are always determined by a doctor, never a nurse.

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Code A was responsible for both Dryad and Daedalus Wards.

Daedalus Ward was a rehabilitation ward, that is to say for the general rehabilitation and stroke rehabilitation of patients.

Code A line managers were the Consultants.

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

When Code A was on leave or off for any other reason, a member of her Practice deputised for her, although to my knowledge, never conducted ward rounds.

In those instances I would do the ward round myself, although I sought advice when I thought it was necessary, from a Consultant. In my case I would speak with Code A deputy, I should say that their attendance at GWMH was brief and before their GP surgery started.

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

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

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twenty four beds.

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

Ward rounds involve all the patient's needs, not only their types and levels of medication. My duties were the administration of drugs, the doctors to prescribe them.

If I felt a patient was being adversely affected by a drug I would speak with Code A or a Consultant. In some cases this would result in a decrease or cessation of a particular drug, in other cases drugs may have been changed or the amounts increased.

If the doctor decided to change the type or amount of drug to be given they would either come in at once or as soon as they could and write up the prescription. In exceptional cases, and this was rare, authorisation to change types or levels would be granted over the telephone. The doctor would then have twenty four hours to write the prescription and sign it. In the event of this happening in respect of telephone authorisation two trained members of nursing staff would accept the doctor's decision, enter it on the prescription chart and both sign the entry.

As a manager I was in charge of all aspects of the patient's care with the exception of the prescription of drugs.

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

No nurse is qualified to determine a patient's medical condition. Experienced members of nursing staff may voice an opinion to a doctor but no more.

In 1999 I would following the Wessex protocols and the analgesic ladder. At that time the protocols and the ladder were very similar and are guidelines as to medication. Basically the lowest drug for pain control or alleviation was Paracetamol. The scale increases using stronger

drugs, the highest being Opiates, ultimately Diamorphine . Drugs are given according to each patient's individual needs.

Code A would write up the types of drugs required by patients.

There are four types of prescription, one off, regular, daily review and as required. 'As required' prescriptions would have a set of parameters of the amount of any given drug. 'Regular' is one unvaried dose as is the 'daily review'.

'One off' may be if a patient required, for example a diuretic, where a patient had fluid retention.

I have today been referred to Police exhibit BJC/34 the medical notes of Code A . I do not recall him.

My writing on page 55 dated 30/8/99 reads, 'Recatheterised Bard pre filled. Size 14ch. Ref 226414 lot 49J1R198.'

His catheter may have been blocked or due for change.

A catheter is a tube inserted into the bladder in order to drain urine.

I refer to pages 62 to 64 of the notes. These are nursing notes.

My entry on 25/8/99 reads, 'passing fresh blood PR - ? Clexame. Verbal message from Code A Code A to withhold 1800 dose to review i/c Code A mané. Code A also vomiting. Metaclopromide 10mg given I/M at 1755 i/c good effect.'

My next entry is on 26/8/99 which reads, 'Fairly good morning. No further vomiting. Code A Code A contacted re Clexame. Advised to discontinue and repeat H/B today and tomorrow. Not for resuscitation. Unwell at lunchtime. Colour pale - c/o feeling unwell. Seen by Code A Code A this afternoon. Await results of HB. Further deterioration c/o query indigestion, pain

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in throat. Not radiating - vomited again this morning. Verbal order from Code A Diamorphine 10 mgms stat - same given at 1800, Metaclopromide 10mgms, given IM. Code A Code A informed - will visit this evening.

PR is 'pro rectum'.

Clexame is anti coagulant.

I/c means with.

Mané is morning.

Metoclopromide is an anti-emetic.

I/M is intra muscular.

HB is haemoglobin.

Not radiating means that the pain was not spreading.

Both entries were signed by me. I contacted both Code A and Code A regarding Code A condition. I may well have thought, because of his colour and the pain in his throat that he had a heart attack but I would not have written this as I am not a doctor.

My contact with Code A was that one telephone call.

On page 55, the medical notes I see that Code A has written, on 26/8/99 '? MI', that is to say query myocardial infarction, i.e. heart attack.

I also note that she stated he was too unwell to transfer to an acute unit. This was normal practice in cases where patients may well die in an ambulance. Code A was assessed at the Queen Alexandra Hospital as not for resuscitation.

On page 168 of the prescription sheet I wrote on 26/8/99 1800 Diamorphine IM 10 mgms. I confirm this was a verbal authority from Code A As was practice, if I was on duty as the only member of trained staff, I would not have a counter signatory. This would have been the case. It was not something I liked doing but it had to be done.

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When a patient cannot take medication orally the practice is for nursing staff to make contact with the doctor and propose the use of a syringe driver. Nine times out of ten the doctor agrees and we go ahead unless the doctor objects. An entry is then made in the nursing notes. In this case the entry is on page 63 dated 30/8/99 and is my entry. The entry reads, 'Condition remains poor. Syringe driver commenced at 1445 i/c Diamorphine 40mgs, Midazolam 20 mgms. No further complaints of abdominal pain - very small amount diet taken, mainly puddings. Recatheterised this afternoon, draining when possible, encourage fluids, dressings also removed.'

Referring to page 171 I see that the prescription was written up for Diamorphine, was written up by Code A on 26/8/99. Until 30/8/99 Code A was being given Oramorph as illustrated on page 172. I note that Midazolam was also written up on 26/8/99. Although it is not dated, I believe this was not administered until 30/8/99. Midazolam is a sedative. It can be given on its own but is often given with Diamorphine.

I believe that in this case Code A started on the above drugs on 30/8/99. I have been shown a photocopied page of a conversion scale of oral Morphine into Diamorphine. As Code A Code A was on 10mg six times daily, the scale is 20mg of Diamorphine. As this patient was in pain and had been on Oramorph which was not controlling his pain he was put on to 40mg of Diamorphine. As I made the syringe driver it was me who put him on to 40mg. I would have called Code A to agree this. If she was not there I would have left a message and she would have rung back at some point. Although I can see no record of a call, this was standard practise.

On page 64 dated 1/9/99 the entry reads, Code A here, Code A off ward. To discuss discharge plans with Code A OT & Physio. Code A To continue.' This entry was written in error and was written for some other patient.

'Syringe driver renewed at 1915 i/c Diamorphine 60mgs and Midazolam 60mgs as previous dose not controlling symptoms. Dressings renewed this afternoon. Code A has

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visited this afternoon and is aware of his poor condition. Code A being admitted to E1 ward at QA tomorrow for surgery. Please contact her son in the event of Code A death. No night calls please.' This is signed by me.

We ask next of kin if they wish to be called in event of death. In this case they did not.

On page 171 of the notes the increase in Diamorphine went to 40mg which was discarded as it was not controlling the patient's pain and the dose increased to 60mg.

The authority to do this would always be a doctor, either Code A or a member of her practice. You would not necessarily call the doctor first, as the parameters were set but a call would be made at some point.

The entries in the nursing notes are in red. This is so the Diamorphine dosage is easily read.

Code A dose was increased on 2/9/99 to 90mgs, the entry made by Code A . On page 171 I see that Code A made the entry for the increase. They were obviously working together.

On page 83 my entry of 25/8/99 reads, 'several loose bowel actions throughout the afternoon and evening - 7-8. Some fresh blood present ? due to medication. Same stopped. For review later.' This entry is covered on page 7 of this statement and refers to the Clexame.

My entry on page 85 dated 30/8/99 reads, 'Recatheterised - previous catheter blocked, washout unsuccessful. Bard prefilled Size 14 ch. Ref 226414. Lot 4 9S1R 198. Due to debris collecting in valve on S4 bag - cysto care bag applied.'

This means that the catheter was not draining as I explained previously. A Cysto care bag is a bag with a large drainage valve which is used when patients have a lot of debris in their bladder or blood clots.

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As for the increases in Diamorphine, in this case from 40mg to 60mg to 90mg, this is what I would describe as a sliding scale in the same way as the analgesic ladder.

A patient would not go from 20 to 200 mg in one jump. The amount given is incremental and in direct relation to their level of pain. To do so would kill the patient.

It would be practice to increase from 20mg to 40mg or less, the dosage administered to control the pain and no more. The doctor's authorisation is always required.

With reference to page 168 as stated on page 8 of my statement, I see that on 26/8/99, Code A Code A prescribed a one off dose of 10 mgms of Diamorphine to be given intra muscularly and again on 28/8/99. I gave the first dose and signed the treatment chart. The second dose was never given. It may have been that the first dose was required due to the fact that the analgesia was not controlling Code A pain but when the second dose was authorised it was not required. The second dose may have been prescribed by Code A as an emergency measure if required. Code A has recorded this in page 55 of the notes.

This was normal procedure. It is also recorded on page 3 of the Ward Controlled Drugs Record Book, exhibit JP/CDRB/48 . At 1800 hrs the Diamorphine was signed out by me and the entry countersigned by Code A

On page 171 I recorded the Oramorph prescription which was signed by Code A This entry was for 26/8/99 on, however on page 172, Code A has rewritten the dosage. The first entry on this page, written by Code A was for the day staff, the second for the night staff, in that case a double dose being given at 2200 hrs from 26/8/99 to 29/8/99.

The entries in relation to this are on page 54 of the Ward Controlled Drugs Record Book exhibit JP/CDRB/24.

I can say that Code A was given 10mg of Oramorph at 1000, 1400 and 1800hrs on 27th to 29th August 1999 and the night staff gave him 20mg at 2200hrs from 26/8/99 and 10mg at

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0600hrs 27/8/99.

On page 171 of the notes I see that as regards to the Metoclopromide which is an anti emetic, the patient was obviously vomiting, and is an uncontrolled drug, that on 25/8/99 I wrote the prescription. The authorisation was given by Code A and signed post authorisation by him. The signature is not timed however I believe he signed it that evening after his surgery. It is not practice for nursing staff to write the prescription however in this case it was a verbal order. I called Code A as the patient was vomiting and he prescribed the drug, which was given at 1755 hrs by Code A and again on 26/8/99 at 1740 hrs by Code A Code A This is recorded on page 62 of the notes.

I am now referred to pages 96 to100 of the notes this being a nursing care plan in respect of Code A Code A Page 96 is dated 24/8/99 and reads as follows:

'Geoffrey has several malodorous sores to buttocks and between thighs. Also blistered areas to both feet/heels - pressure sore no.5.

Pressure sore No.1, small lt. buttock.
No.2, large lt. buttock.
No.3, upper rt. buttock.
No.4, lower rt. buttock.

The desired outcome was: Him to heal wounds and prevent further tissue breakdown. His evaluation was daily.

Nursing Action reads - Refer to care plan sent from tissue viability adviser Code A for buttock sores (in care plan). Evaluate daily. If problems with dressings or healing review - consider asking above for further advice.

Code A was the tissue viability nurse.

Page 97 shows the named nurse to be Code A

The entries here are as follows:

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24/8/99, dressings reviewed today, swabs taken from wound sites this morning. This is signed by Code A

25/8/99, some dressings removed as coming off and contaminated æ faeces - non-adherent dressings applied on temporary basis - until wounds assessed again this pm.
This entry is signed by Code A

PM dressings removed as per care plan. This is signed by me and Code A

27/8/99, dressings removed to all areas - some improvement since Wednesday - especially to the two areas on the left buttock - area on rt. Buttock remains offensive and some exudate on larger of the two sores.
This entry is signed by me.

Nocte, dressing between thighs has slipped off wound, removed as per care plan and re-secured with bioclusive.
This is signed by staff nurse Code A

29/8/99, left heel redressed with Paramet. Wound clean.
This is singed by Code A

Dressings to buttocks intact, leakage of some fluid from under largest dressings.
Smell is offensive. For redressing tomorrow.
This is signed by Code A

PM, as dressing on top of right thigh and right buttock starting to come away secured with another Combiderm on exposed area (equated under) and also Duoderm. Wounds healing a lot of offensive exudates.
This is signed by Code A

Page 98 reads:-

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Continuation of Statement of: Code A

30/8/99 pressure sore no.1 - much cleaner - Duoderm applied.

Pressure sore no.2 cleaned, equated and Intrasite applied, covered by Combiderm large.

Pressure sore no.3, aquated - no Intrasite applied to area towards scrotum - Aquacel i/c Intrasite applied to remainder of wound. Combiderm applied - large.

Pressure sore no.5 - lt. Heel - dead skin removed - 1 tin Paramet used - criss-cross gauze squares and cling bandage applied.

These entries are signed by me.

31.8 99 PM, Areas (1) and (2) needed securing tonight as exudates copious and edges coming away, Aquacel dressings misplaced and removed. All areas to be redressed tomorrow.

This is signed by Code A

1/9/99 areas (1) and (2) redressed am/as contaminated with loose faeces ++ and dressings from yesterday evening coming away.

This is signed by Code A

PM, pressure sores (1) as above - Duoderm applied.

Page 99 is blank.

Page 100 is a continuation of the above entry and reads:-

Pressure sore no.3 - packed i/c 3 pieces of Aquacel and 2 Combiderm to secure.

Pressure sore no.4 - Slough removed - 3 pieces of Aquacel inserted - into track. Combiderm applied

Pressure sore no.2 wound cleaned - some slough removed - Paramet applied - gauze and then Combiderm to secure.

Pressure sore no.5 lt heel cleaned. 1 tin Paramet applied - cling to secure.

I have signed this entry.

2/9/99 pressure sore no.1 - Duoderm applied for protection area healed.

Signed: Code A

Signature Witnessed by: Code A

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Pressure sore no.2 area cleaned - Paramet applied, secured by Combiderm - (large).

Pressure sore no.4 area syringed - cavity packed i/c 5 pieces of Aquacel - secured i/c Combiderm.

Pressure sore no.3 packed i/c 2 pieces of Aquacel gauze and Combiderm.

Pressure sore no.5, lt heel, cleaned, Paramet 1 tin applied. Cling to secure.

This entry is signed by me.

Aquacel and Combiderm are dressings used in order to attempt to deslough.

Code A skin had broken down and he was not taking enough nutrition. This is a contributory factor to his sores not healing. His general health had deteriorated and this also did not help.

The entry on 30/8/99, page 98, also includes, 'pressure sore no.4, area of slough removed, large crater exposed - deep - good 1" packed i/c Aquacel. Aquacel i/c Intrasite applied to remainder of wound. Combiderm applied - large.'

Intrasite is a gel which is applied to deslough.

STATEMENT TAKEN - Code A

Code A

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

Age if under 18: (If over 18 insert 'over 18') Occupation: NURSING HOME NIGHT SISTER

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: 15/09/2005

I am Code A and I live at an address known to Hampshire Police. I am currently employed as a Night sister in a local Nursing Home. Up until February 2004 when I retired from the GWMH I was a Clinical Manager (Senior Sister) at Dryad Ward, my Nursing and Midwifery Number is Code A I did not work at that hospital however since May 2003 though, due to sickness.

In 1963 I became a Cadet Nurse and commenced a 3 year qualification course in 1965 at Hackney Hospital, East London. I worked on all wards until my qualification as a Registered Staff Nurse to the surgical ward.

I commenced employment at Gosport War Memorial Hospital in 1988 in the capacity of Staff Nurse

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management Redclyffe Annexe which was 23 bed unit caring for long stay palliative and terminally ill patients. We also shared care patients which gave relatives a break from caring and gave them a period of respite.

Redclyffe Annexe was situated a short distance from the hospital and moved to Gosport War Memorial in 1995 and thus became Dryad ward comprising of 20 beds.
Redclyffe then became a 15 bed unit which was taken over by the Mental Health department. When on duty at evenings and weekends we had managerial/ Clinical responsibility when required.

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In January 1996 I was working as a Clinical Manager at the GWMH. I worked 37½ hours a week on a shift rota, earlies being 0730 to 1615 and lates 12 midday to 2030.

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management of the Hospital and would take on management roles when there were no managers at the hospital, i.e. at weekends and evenings. I was responsible for all of the staff on the ward re the training, hiring discipline, staff rotas and leave issues.

My line manager at that time was Code A

In 1999, Diamorphine Syringe drivers were introduced to those of us working on Redclyffe Annexe and in 1998 Code A became the Doctor responsible for the patients, prior to this, each patients GP was responsible for their individual patients on the ward.

Responsibility for medical care was "Elderly Medicine" based at the Queen Alexandra Hospital Cosham.

Code A would visit at 0730 each morning Monday to Friday and see every patient, before returning to her own practice.

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

On her visits Code A would prescribe the drugs that were required by each patient. This was a new concept to staff at this time. Code A who was in charge at this time bought syringe drivers to the annexe and explained the system to the nurses and they would have learnt their use from her.

At this time there were no courses in the use of syringe drivers, but these have since been started. I am aware that there have been some concerns in relation to the syringe drivers and diamorphine , but I have not had any doubts myself. The main reason for the use of a syringe

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driver is to administer drugs to a patient once oral medication has ceased, generally due to the patient's inability to swallow.

Drugs that I am aware of that have been administered in this way as well as Diamorphine, are Midazolam , a sedative, Hyoscine , to stop secretions and Cyclizine to stop vomiting.

I have been asked about the "Wessex Protocols". I am unfamiliar with this name but am aware of certain protocols I relation to the setting up and use of syringe drivers and am unsure if they are one and the same.

The Named Nurse is the person with the responsibility for the nursing care of the patient. The named nurse would also be the person to whom the family would speak to, in order to keep them up to date on the patient's condition.

The time and date of all entries in the nursing notes would either be completed at the time if the patient was seriously ill, but in other cases they would be completed when there was time but in any case at the end of the tour of duty.

I have been asked to detail my involvement in the care and treatment of Code A Code A I cannot recollect this patient or the subsequent treatment that she received.

From referring to her medical records (exhibit ref BJC/21) page 7. I can confirm that I have written entries on the Spell summary.

The spell summary is the discharge summary, primarily for the benefit for the patient's own Doctor to inform them of the treatment the patient has received whilst in hospital.

A copy is also forwarded to Clinical coding at Portsmouth.

I can confirm that on the 22/11/99 I have written the following

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Diagnosis

 # NOF this is a Fracture to the neck of Femur. (That is the patient had broken the top half of the thigh)

Recorded on the spell summary are the patient's personal details and contact numbers.

Under the heading "Date of Discharge" I have written the date of death as *22/11/99* and signed the entry.

The patient Code A was diagnosed "broken neck of Femur" this procedure may well have contributed to her death. However from referring to the Clinical notes I note that Code A Code A has written down under her Past medical History (PMH) on page 66 of the records as having suffered from;

Cardiac Failure = (Heart Failure)

Hypothyroidism = (Under Functioning thyroid)

I note that on page 70 of the medical records that Code A has written "*Further CVA?*" CVA = (Cardiovascular Accident/Stroke). I cannot find any reference to a previous CVA. However cause of death in my opinion is most likely to be a CVA.

I can confirm that I have countersigned the entry written by Code A which is recorded on page 70 of the medical records (BJC/21). This entry confirms that the correct procedure for verifying death has been complied with. Two trained members of nursing staff need to be present.

Checks to the patient's vital signs were conducted which show that there was no Carotid artery pulse.

There was no Radial pulse. There was no heart beat when listening through a stethoscope.

There was no pupil reaction to light. No visible respiration was observed. There were no inspiratory sounds of breathing when using a stethoscope.

Relatives would be informed at the earliest opportunity.

I was not involved in the admission of this patient on the 3/9/99.

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Ward rounds were conducted on Dryad ward by Code A at 0730 Monday to Friday. She was accompanied by the senior trained nurse in charge of the ward which was normally myself. The ward round would have to be finished by 0810 as Code A would then have to conduct a ward round on Daedalus ward.

Consultant ward rounds were conducted once a fortnight on a Monday afternoon normally accompanied by Code A and the senior trained nurse on duty.
The treatment of each patient was based on the observations of all the nursing staff. These observations would then be passed onto the Consultant.

I can confirm that on page 136 of the medical records I have recorded that I have given Code A Code A a dose of Oramorph, the entry reads as follows;

17/11/99 2020 5mgs/2-5mls This was given orally to the patient.

Again on page 136 of the records I have recorded that I have given Metoclopramide to the patient the entry reads as follows;
11/11/99 1615 10mgs. This is not a controlled drug and would have been given for either nausea or vomiting. This was prescribed over the phone as a result of me ringing Code A and asking for something to stop the patient's vomiting or nausea.
There is no record within the nursing notes recording the fact that the patient was suffering from vomiting or nausea for this date. This drug was only administered on one occasion.

I can confirm that on page 151 of the medical notes I have written the following;

Magnesium Hydroxide 20mls BD =(Twice Daily) This was a verbal order taken on the phone from Code A which has subsequently been signed by Code A from the same practice who actually attended and authorised the prescription of Magnesium Hydroxide. This entry written by me was subsequently crossed out by Code A
On page 151 of the medical records there is an entry for Magnesium Hydroxide with a reduced dose of *10 mls BD.* This entry has been signed by Code A

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Magnesium Hydroxide is a bowel preparation which is quite gentle on the bowels and not as strong as other preparations.

I can confirm that I have written the following entries in the medical notes of Code A Code A commencing on page 238 which are as follows;

4/10/99 Seen by Code A *continue to encourage food and fluids. Physio to commence this week.*

This entry is self explanatory.

7/10/99 Generally unwell. C/o = (Complains of) *acute pain on top of head and side of face. Feeling nauseated. Rested on bed feeling better.*

This entry is again self explanatory.

15/11/99 Seen by Code A *- Thyroidizine discontinue.*

I note from the medical records that Thyroidizine was last given on the 7/10/99 at 0200. From memory Thyroidizine was no longer being used in Elderly care as it was being withdrawn.

I can confirm that I have written the entry on page 238 which is as follows;

19/11/99 - Poorly but stable morning -c/o shortness of breath this afternoon.

Frusemide 40mg given start at 1530. No residual urine. Drained 200mls in the first ½ hour following Catheterisation. Continue Oramorph.

To clarify this entry - Although Code A was unwell she was stable. She had complained of shortness of breath. Fruesmide which is a Diuretic was prescribed by Code A Code A on the 19/11/99 at 1530hrs.

This is recorded on page 184 as a verbal message taken by me and countersigned by Staff Nurse Code A

If a verbal order is given over the phone then where possible a second trained nurse was required to countersign any entry for the prescription of drugs.

As shown in this case Fruesmide was prescribed because it will relieve the fluid in her kidneys

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and around her lungs which in turn will hopefully improve her breathing.

I have written the following entry on page 239 of the medical records

20/11/99 (I believe this entry was written in the morning) *Some deterioration during the morning Grand daughter advised to visit AM Vomited also- Cyclizine 50mgs IM* = (Intramuscularly) *1315 I/C* = (with) *good effect* (This was a one off dose that was given)

PM Good relief from Cyclizine IM Syringe driver commenced at 1700 with Diamorphine 20mgs and Cyclizine 50mgs. Please contact Code A *during the night if sudden deterioration.*

To clarify this entry - The patient was obviously getting worse. I would have rung her grand daughter and advised her to visit Code A

She was prescribed Cyclizine as she had previously been vomiting.

Diamorphine was prescribed and given at this time to relieve her distress and discomfort.

At this stage Code A was dying.

I can confirm that I have signed the following entries within the Dryad ward Drugs register exhibit JP/CDRB/48 commencing on page 4 as follows relating to the administration of Diamorphine.

20/11/99 1700 Code A *20mg* Code A *witnessed by* Code A

I can confirm that I have written the following entries in the Drugs register for Dryad ward for the administration of Oramorph which are as follows;

18/11/99	*1030*	Code A	*5mgs/2.5mls*	Code A	*witnessed by*	Code A
18/11/99	*1430*		*5mgs/2.5mls*		*witnessed by*	
19/11/99	*1020*		*5mgs/2.5mls*		*witnessed by*	

I would not necessarily check the nursing notes or clinical notes of the patients on the ward

Signed: Code A

Signature Witnessed by:

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when I came on duty. However there was always a handover from nursing staff from the previous shift who would report on all patients. All changes would be reported to the incoming staff.

At a later stage normally when I was writing my notes in the patient's medical records I would check the previous entries of the nurses and Doctors if they were legible.

I had no further dealings with Code A

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Diagnosis

 # L humerus = Broken left upper arm

End stage CCF = Congestive cardiac failure

Renal failure

Liver failure

Treatment/Recommendation

Syringe driver 16/10/98

This shows the treatment which was administered by the patient. In this case the commencement of the syringe driver which was on the 16/10/98.

This diagnosis has been obtained by me, as a result of reading the medical records, which accompanied the patient.

Prior to a patient being transferred to my ward, Elderly Services at the QA hospital would ring the ward and let us know of the forthcoming admissions.

At this stage, normally, the ward clerk at Dryad, would ring the transferring ward, to obtain a more detailed diagnosis of the patient awaiting transfer. This procedure made sure that we had a suitable available bed and any other equipment that was needed.

On referring to the notes of this patient Code A I noted that he had multi organ failure. The prognosis that I made was that he was being admitted for terminal care at Dryad Ward.

When a patient is being transferred from another hospital the patient would have already been seen by a Consultant Geriatrician. It may not be the same consultant that works on Dryad Ward.

I have written the following entry under the heading Diagnosis.

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 # broken L arm - self explanatory

End stage CCF - Congestive cardiac failure.

This means that the heart is not functioning properly. There was a build up of fluid around the heart.

This diagnosis is based on entry at page 168 of the medical records which details that Code A Code A was in QA hospital in 1997 with heart problems.

Code A is shown as the Consultant Geriatrician for Code A

Code A conducted ward rounds once a fortnight on a Monday with Code A and me, or whichever trained nurse was on duty at the time.

The diagnosis is also based on the transfer letter which accompanies the patient. However I cannot find the transfer letter in the medical notes of Code A

Renal failure - This means that the patient's kidneys are not functioning - As a result fluid builds up within the body such as the legs of Code A which were oedematous.

Liver failure - This is indicated by yellowing of the skin. It can be due to gall stones.

Treatment/Recommendation

Syringe driver has been commenced by the medical staff which would have been Code A initially.

The doctors rely on the nursing staff admitting the patient to do the initial assessment. The doctor will then subsequently write up the drug treatment chart for that patient.

The final entry on the spell summary that I have written is the date of death of the patient, which I have recorded as *18/10/98 2340*. This entry was signed by me as being entered on the

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19/10/08.

I have been shown the prescription chart on p.262 of the medical record, I note that at 0515 17/10/98 that 20 mgs of Diamorphine , 600 mcgs of Hyoscine were administered to the patient by Staff Nurse Code A and witnessed by Senior Staff Nurse Code A

At 1550 hours that day I have increased the dose of Diamorphine to 40 mgs and increased the Hyoscine to 800 mcgs. I have also added 20 mcgs of Midazolam.

The previous dose of Diamorphine and Hyoscine has been destroyed. A record of the controlled drugs destroyed is normally recorded next to the entry showing the original dose administered.

It is easier to destroy the dose which is already in situ and then administer the new dosage in a fresh syringe driver.

I have checked the drugs register for the 17/10/98 which show that Staff nurse Code A and Code A recorded the entry.

The stock of controlled drugs was transferred to a new drug register on the 17/10/98.
I have not been shown the drug register that follows on from the 17/10/98

Where there is a reference to drugs being destroyed the drugs are poured down the sink which is witnessed by two nursing staff.

The prescription of Oramorph which is a liquid form of Diamorphine I note was prescribed by Code A (PRN means whenever necessary).

The Diamorphine, Hyoscine and Midazolam as recorded on p 262 were prescribed by Code A Code A There is no date recorded showing when this was written.

Signed: Code A

Signature Witnessed by:

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At the bottom of pg 262 of the Prescription Chart there is an entry relating to Hyoscine 1200 mcgs - SC - (subcutaneous) in 24 hrs.

This was a verbal order that I have taken from Code A at 1430 hrs on the 18/10/98. This entry was subsequently countersigned by Code A when he came into the ward later that day.

I have been shown the entry recorded at 17/10/98 on p 265 - 0515 - This relates to the renewal of the syringe driver containing 20 mgs of Diamorphine and 600 mcgs of Hyoscine. The Diamorphine remained the same, the Hyoscine was increased from 400 to 600 mcgs.

Hyoscine is used to dry up the secretion where fluids collect on the lungs. This condition normally occurs when a person is dying.

The dosage of 400 mcgs was not controlling the secretions that were occurring. I therefore, increased the dosage up to 600 mcgs to try and dry up the secretions.

The dosage of Diamorphine was increased from 20 mgs to 40 mgs at 1550 on 17/10/98. The Hyoscine was increased from 600 to 800 mcgs. Also we added 20 mgs of Midazolam to the syringe driver.

The dose of Hyoscine was increased to cope with the increase of secretions on the chest which is recorded as per my entry on 17/10/98. The Diamorphine was increased because of pain. The Midazolam was administered to relieve the anxiety.

This dosage of Diamorphine, Hyoscine and Midazolam was administered by Staff Nurse Code A

The Midazolam was given because the patient had a tube inserted down his throat to relieve the secretions. It is an unpleasant procedure.

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I can confirm that I have written the following entry on p 265 of exhibit BJC/55.

Pm - slow deterioration in already poor condition requiring suction very regularly copious amounts suctioned syringe driver renewed at 1550 o/c (= with) Diamorphine 40 mgs, Midazolam 20 mgs and Hyoscine 800 mcgs. Code A *visited again this evening and is aware that his condition is poorly. She will remain on the ward overnight.*

This entry is self explanatory; Code A condition has continued to deteriorate.

Neither I, nor my staff, have recorded the reason for the increase in Diamorphine in the nursing notes. However it would have been increased due to pain level not being controlled by the previous dose.

I can confirm that I have written the following entry on p 266

18/10/98
Further deterioration in already poor condition, wife has remained overnight, seen by Code A Code A *who spoke to* Code A *Syringe driver renewed at 1450 °/c Diamorphine 60 mgs, Midazolam 40 mg, Hyoscine 1200 mcgs.*
Continues to require regular suction. His children had also visited.

Signed Code A

The Diamorphine has been increased from 40 mgs to 60 mgs . This would have been to control his pain. I must point out that as well as multi organ failure, Code A was suffering from a fractured upper L arm.

Midazolam was increased from 20 to 40 mg. This was increased because he was suffering from liver failure, and as a result, the medication would not be working as effectively. Therefore the dosage was required to be increased.

The same applied to the Hyoscine which was increased to 1200 mcgs.

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With reference to the above entry I would have been present when Code A was called out to see the patient Code A.

The reason Code A was called out was because an increase in Hyoscine was required. This can only be authorised by a Doctor.

Ward rounds were conducted on Dryad Ward normally by Code A at 0730 Mon to Fri accompanied by the trained nurse in charge of the ward which was normally myself. The ward round would have to be finished by 0810 as Code A would then have to conduct a ward round on Daedalus ward.

Consultant ward rounds were conducted once a fortnight, on a Monday afternoon. The consultant was normally accompanied by Code A and a senior trained nurse.

The treatment of each patient was based on the observations of all the nursing staff. These observations would then be passed onto the consultant.

I have been shown the Dryad Ward Controlled drug register book for administration of Oral solutions exhibit ref JP/CDRB/24 .

I can confirm that I have written the following entries on page 53 of the medical records which are as follows.

15/10/98 -1015 Code A *10mgms 0.5mls* this was administered by me and witnessed by Staff Nurse Code A.

To clarify this entry the actual strength of the solution of Oramorph is 20mgs in 1ml. Code A Code A was only being prescribed 10mgs therefore he was only given 0-5ml.

15/10/98 - 1410 Code A *10mgs 0-5mls administered by me and witnessed by Staff Nurse* Code A

RESTRICTED

Continuation of Statement of: Code A

I can confirm that I have written 2 entries on page 261 of the medical notes which is the Prescription chart.

Against the controlled drug Oramorph I have administered the drug at 1000 and 1400 hours on the 15/10/98 I have initialled both entries.

Oramorph was administered to Code A due to the pain from his fractured arm and also because he was an alcoholic- By this, I mean that, his Liver was not functioning as well as it should be. He was also suffering from Renal and liver failure.

I can confirm that I have written the following entry on page 85 in the Ward Controlled drugs register for Dryad ward exhibit ref JP/CDRB/23.

17/10/98 1550 Code A *30mgs administered by me and witnessed by Staff Nurse* Code A Code A

This is also confirmed by the entry that I have written on page 262 of the medical notes which is the prescription chart.

17/10/98 1550 40mgs Diamorphine. I cannot confirm the additional 10mgs of Diamorphine as I have not been shown the drugs register relating to the remaining 10 mgs dosage of Diamorphine.

(Diamorphine is supplied in 10 mg and 30 mg ampoules and the record of there administration is recorded separately within the register under the appropriate dosage.)

The amount of Diamorphine administered on the 17/10/98 was initially 20mgs this was doubled to 40mgs.

As I have mentioned this was to control the patient's pain.

Signed: Code A Signature Witnessed by:

RESTRICTED

The practice for administering Diamorphine to control pain was to double the dosage.

However other factors had to be taken into account, these would include the weight of the patient plus the diagnosis of the patient.

The dosage could only be given up to the maximum that the Doctor had prescribed.

I have been shown page 262 of the medical records exhibit ref BJC/55. I have been asked to comment in relation to the doses of Diamorphine and Hyoscine administered at 1610 on 16/10/98 to Code A

I note that the syringe driver commenced and that 20mg of Diamorphine and 400 mcg of Hyocsine were administered, the entry was initialled by Senior Staff Nurse Code A Code A

On the 17/10/98 0515 the syringe driver was renewed with 20mgs of 600mcgs of Hyoscine.

The previous dose of Diamorphine and Hyoscine of the 16/10/98 was destroyed by the night nurses Code A and Code A at 0515 on the 17/10/98.

The dosage administered at 0515 17/10/98 was then subsequently destroyed by myself and Staff Nurse Code A at 1550 on the 17/10/98.

I have made no record in the wastage section at the back of the Controlled Drug Register. I can not recollect the reason for not making a record showing that this dose was destroyed by me and witnessed by Staff Nurse Code A

At 1550 hours on the 17/10/98 I have recorded an increase of Diamorphine to 40 mgs, Hyoscine to 800 mcgs, I have also included 20 mgs of Midazolam to the syringe driver. This entry at 1550 hours has been initialled by me.

Signed: Code A

Signature Witnessed by:

RESTRICTED

I have also at the same time written an entry showing that the 0515 hours dose of Diamorphine and Hyoscine has been destroyed by me which has been initialled by me.

I had no further dealings with this patient.

Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

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

Signed: Code A Date: 30/09/2005

I am Code A and I live at an address known to Hampshire Police. I am currently employed as a Night sister in a local Nursing Home. Up until February 2004 when I retired from the Gosport War Memorial Hospital I was a Clinical Manager (Senior Sister) at Dryad Ward, my Nursing and Midwifery Number is Code A I did not work at that hospital however since May 2003 though, due to sickness.

In 1963 I became a Cadet Nurse and commenced a 3 year qualification course in 1965 at Hackney Hospital, East London. I worked on all wards until my qualification as a Registered Staff Nurse to the surgical ward.

I commenced employment at Gosport War Memorial Hospital in 1988 in the capacity of Staff Nurse

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management Redclyffe Annexe which was 15 bed unit for elderly mentally ill patients.

Redclyffe Annexe was situated a short distance from the hos
hospital in 1994 and thus became Dryad Ward.

In January 1996 I was working as a Clinical Manager at the
week on a shift rota, earlies being 0730 to 1615 and lates 12

I was responsible for 24 hr care of the patients on Dryad Ward. I w

Signed: Code A Signature Witnessed b

2004(1)

wessex princess
Mrs Smart she says she doesn't know who may are she other sisters she says she refered mam + refers to them by name

Code A (2)

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

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

Signed: Code A Date: 30/09/2005

I am Code A and I live at an address known to Hampshire Police. I am currently employed as a Night sister in a local Nursing Home. Up until February 2004 when I retired from the Gosport War Memorial Hospital I was a Clinical Manager (Senior Sister) at Dryad Ward, my Nursing and Midwifery Number is Code A I did not work at that hospital however since May 2003 though, due to sickness.

In 1963 I became a Cadet Nurse and commenced a 3 year qualification course in 1965 at Hackney Hospital, East London. I worked on all wards until my qualification as a Registered Staff Nurse to the surgical ward.

I commenced employment at Gosport War Memorial Hospital in 1988 in the capacity of Staff Nurse

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management Redclyffe Annexe which was 15 bed unit for elderly mentally ill patients.

Redclyffe Annexe was situated a short distance from the hospital and moved to the main hospital in 1994 and thus became Dryad Ward.

In January 1996 I was working as a Clinical Manager at the GWMH. I worked 37½ hours a week on a shift rota, earlies being 0730 to 1615 and lates 12 midday to 2030.

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the

RESTRICTED

management of the Hospital and would take on management roles when there were no managers at the hospital, i.e. at weekends and evenings. I was responsible for all of the staff on the ward re the training, hiring discipline, staff rotas and leave issues.

My line manager at that time was Code A.

In 1999 , Diamorphine Syringe drivers were introduced to those of us working on Redclyffe Annexe and in 1998 Code A became the Doctor responsible for the patients, prior to this, each patients GP was responsible for their individual patients on the ward.

Responsibility for medical care was "Elderly Medicine" based at the Queen Alexandra Hospital Cosham.

Code A would visit at 0730 each morning Monday to Friday and see every patient, before returning to her own practice.

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

On her visits Code A would prescribe the drugs that were required by each patient. This was a new concept to staff at this time. Sister Code A who was in charge at this time bought syringe drivers to the annexe and explained the system to the nurses and they would have learnt their use from her.

At this time there were no courses in the use of syringe drivers, but these have since been started. I am aware that there have been some concerns in relation to the syringe drivers and Diamorphine , but I have not had any doubts myself. The main reason for the use of a syringe driver is to administer drugs to a patient once oral medication has ceased, generally due to the patient's inability to swallow.

Drugs that I am aware of that have been administered in this way as well as Diamorphine, are Midazolam , a sedative, Hyoscine , to stop secretions and Cyclizine to stop vomiting.

RESTRICTED

I have been asked about the "Wessex Protocols". I am unfamiliar with this name but am aware of certain protocols in relation to the setting up and use of syringe drivers, I am unsure if they are one and the same.

The Named Nurse is the person with the responsibility for the nursing care of the patient. The named nurse would also be the person to whom the family would speak to, in order to keep them up to date on the patient's condition.

The time and date of all entries in the nursing notes would either be completed at the time if the patient was seriously ill, but in other cases they would be completed when there was time but in any case at the end of the tour of duty.

Further to my previous statement of 11th June 2005. I have been asked whether I remember having a conversation concerning the usage of Diamorphine with Code A who was my senior staff nurse on Dryad Ward at Gosport War Memorial Hospital.

I cannot recollect having a conversation with staff nurse Code A relating to concerns about the usage of Diamorphine on Dryad Ward whilst she was employed as a senior staff nurse.

However there were concerns when syringe drivers were introduced around 1988 or 1989 at the Redclyffe Annexe, The Avenue, Gosport.

I remember a number of staff in particular the night staff nurse Code A being very reluctant to use Diamorphine via a syringe driver.

Sister Code A was in charge of the unit at the time arranged numerous meetings and study sessions with various palliative care team members from the palliative care ward at the Queen Alexandra Hospital, Portsmouth . All staff at the Redclyffe unit were required to attend. I

RESTRICTED

remember Code A, a palliative care charge nurse, together with Dr Code A from the Queen Alexandra attending a number of meetings with staff to allay their fears over the use Diamorphine via a syringe driver.

They explained the benefit of using a syringe driver and also gave practical demonstrations on how to use/administer Diamorphine via a syringe driver.

I am aware of at least 2 or 3 sessions where Code A and Dr Code A ttended the Redclyffe Annexe. I also remember Dr Code A a consultant specialist in palliative care attending at the Dryad Ward who gave a couple of talks relating to the use of syringe drivers, care of the dying and the drugs that could be used in palliative/terminal care.

Trained and untrained staff were present for these sessions.

I have been asked to comment about the increased dosage of Diamorphine I administered on the 17/10/98 to the patient Code A

I would have assessed the patient's condition and deemed it necessary to increase the Diamorphine to 40mg and also add in Midazolam 20mg and increase the Hyoscine to 800mcg.

This increase was necessary due to the patient's increased pain and anxiety.

However there is no written record within the nursing notes recording that Code A pain and anxiety.

The practice of increasing the dosage to alleviate pain and anxiety was not always recorded as it was evident that the patient needed the increase.

A record was always made in the ward drugs register showing the actual amounts of controlled drugs administered to each patient.

RESTRICTED

I would always inform the doctor (normally Code A) of the change in medication given and explain the reason to the doctor.

I would not necessarily inform Code A at the time, if the change in circumstances occurred to the patient at night.

I would inform Code A the following day.

I was happy to increase the dosage of Diamorphine on a sliding scale, ie, from a small starting dose initially administered to the patient a) to alleviate the pain, b) to monitor its effectiveness.

The drugs such as Diamorphine, Midazolam and Hyoscine normally used in a syringe driver were prescribed by Code A in a range according to the patient's needs as assessed by Code A Code A

In this case these drugs were prescribed on admission of this patient to Dryad Ward on the 14/10/98.

It was policy and the guidelines to double the dosage of Diamorphine as per the Wessex Guideline book (a small green book).

The important factor was the assessment of the patient, ie, if the patient was frail, then the dosage would only be increased a small amount to alleviate the problem.

With regards to this patient Code A was a large man who was an alcoholic; it therefore took longer for the drugs to have effect, which is the reason why he needed bigger doses.

Code A had been admitted to Dryad Ward for palliative care as he had multi organ failure as recorded on the spell summary.

Code A

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 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: 11/06/2005

I am Code A and I live at an address known to Hampshire Police. I am currently employed as a Night sister in a local Nursing Home. Up until February 2004 when I retired from the Gosport War Memorial Hospital was a Clinical Manager (Senior Sister) at Dryad Ward, my Nursing and Midwifery Number is Code A did not work at that hospital however since May 2003 though, due to sickness.

In 1963 I became a Cadet Nurse and commenced a 3 year qualification course in 1965 at Hackney Hospital, East London. I worked on all wards until my qualification as a Registered Staff Nurse to the surgical ward.

I commenced employment at Gosport War Memorial Hospital in 1988 in the capacity of Staff Nurse.

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management Redclyffe Annexe which was 23 bed unit for continuing care, terminally ill patients, who's length of stay at the hospital was variable, but basically to assist relatives and give them a period of respite.

Redclyffe Annexe was situated a short distance from the hospital and moved to the main hospital in 1994 and thus became Dryad ward.

In January 1996 I was working as a Clinical Manager at the GWMH. I worked 37 ½ hours a week on a shift rota, earlies being 0730 to 1615 and lates 12 midday to 2030.

RESTRICTED

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management of the Hospital and would take on management roles when there were no managers at the hospital, i.e. at weekends and evenings. I was responsible for all of the staff on the ward re the training, hiring discipline, staff rotas and leave issues.

My line manager at that time was Code A

In 1999, Diamorphine Syringe drivers were introduced to those of us working on Redclyffe Annexe and in 1998 Code A became the Doctor responsible for the patients, prior to this, each patients GP was responsible for their individual patients on the ward.

Responsibility for medical care was "Elderly Medicine" based at the Queen Alexandra Hospital Cosham.

Code A would visit at 0730 each morning Monday to Friday and see every patient, before returning to her own practice.

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

On her visits Code A would prescribe the drugs that were required by each patient. This was a new concept to staff at this time. Code A who was in charge at this time bought syringe drivers to the annexe and explained the system to the nurses and they would have learnt their use from her.

At this time there were no courses in the use of syringe drivers, but these have since been started. I am aware that there have been some concerns in relation to the syringe drivers and Diamorphine, but I have not had any doubts myself. The main reason for the use of a syringe driver is to administer drugs to a patient once oral medication has ceased, generally due to the patient's inability to swallow.

RESTRICTED

Drugs that I am aware of that have been administered in this way as well as Diamorphine, are Midazolam , a sedative, Hyoscine , to stop secretions and Cyclizine to stop vomiting.

I have been asked about the "Wessex Protocols". I am unfamiliar with this name but am aware of certain protocols in relation to the setting up and use of syringe drivers, I am unsure if they are one and the same.

The Named Nurse is the person with the responsibility for the nursing care of the patient. The named nurse would also be the person to whom the family would speak to, in order to keep them up to date on the patient's condition.

The time and date of all entries in the nursing notes would either be completed at the time if the patient was seriously ill, but in other cases they would be completed when there was time but in any case at the end of the tour of duty.

I have been asked to detail my involvement in the case of Code A
I do not remember the patient Code A

I have been shown page 119 of exhibit BJC/55 and I can confirm that I have written the following entries on the spell summary of the medical notes.

The spell summary is the discharge notes which outline the diagnosis/treatment and follow up if necessary for the patient. This is ultimately sent to medical records at GWMH and then onto clinical coding either at QA or St Mary's Hospital.

The spell summary is typed on the day, or day after admission, which not only details the patient's personal details, but the diagnosis and the relevant medical codes showing the patient's medical history. It is also based on the transfer letter which accompanies the patient. The transfer letter appears to be missing from Code A medical notes.

I have written the following diagnosis.

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: NURSING HOME SISTER

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: 10/06/2005

I am Code A and further to my previous statement made to the Police on 16/3/05 I would like to clarify the following points:

I know that the drugs prescribed to Code A were written up by Code A in consultation with Code A because when we collected the patient from Dolphin Day Hospital the two were talking together about the patient and what medication he was to have. This was normal practice in any event. I have perused the medical notes for this patient but am unable to find the discharge letter from DDH to Dryad Ward which would have been written up by Code A and would have covered these points.

As a matter of course the Doctor to be contacted in the event of any change outside the range of prescribed drugs would be Code A if during the day or Code A if she was at DDH. If this decision was to be made during the evening then the duty GP would be contacted.

In this case I can see that on page 756 of the notes that Code A has written this up on the prescription chart.

In my opinion Code A step son did not have a problem with the syringe driver in its use, the issue was that he was unable to talk to his father whilst it was in use. He did state to me that he didn't have a problem with the syringe driver.

The term I have used in my previous statement, "that it was clearly not holding him" means that the dose was clearly not controlling his pain. He could have been calling out whilst he was

RESTRICTED

being attended to, in moving procedures, such as turning, or changing dressings, or visual, when the patient moved himself.

Code A was prescribed Diamorphine by Code A as is stated in the medical records, it is not my decision. However if a patient was in such severe pain then Diamorphine would be the most suitable. I know that this patient had a sacral sore so there would be more pain, probably a great deal of pain.

A variable dose means that an increase or lower dose can be administered as necessary. The nursing staff can decide if they consider the pain is too severe and needs increasing. If that be the case then Code A would be informed. In the case of a lower dose Code A would have consulted with Code A I can see from the notes that the patient was on a lower dose for four days before it was increased.

On the prescription chart at page 756, PRN has been written by Code A the words regular prescription has been crossed out. PRN means as required.

In relation to Diamorphine the nurses who have administered it are as follows;
At 2310 on 21/9/98 20 mgs are Code A and Nurse Code A

At 2020 on 22/9/98 20 mgs are Code A and Code A signed by Code A Code A in prescription chart and by Code A in the controlled drug record book.

At 0925 on 23/9/98 20 mgs are Code A and Code A signed by Code A in the prescription chart and also on the controlled drug record book (This dose is shown as being destroyed at 2000hrs that day, written in red pen by myself).

At 2000 on 23/9/98 20 mgs are Code A and I, signed by me in both the prescription chart and the controlled drug record book.

At 1055 on 24/9/98 40 mgs are Code A and I, signed by me in both the prescription chart

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and the controlled drug record book.

At 1015 on 25/9/98 60mgs are Code A and Code A signed by Code A in the prescription chart, and by Code A in the controlled drug record book.

At 1150 on 26.9/98 60 mgs are Code A and Code A, signed by Code A in both the prescription chart and the controlled drug record book.

At 1150 on 27/9/98 20mgs are Code A and Code A this is only shown in the controlled drug record book and signed by Code A. There appears to be no entry in the prescription chart for that day.

There also appears to have been an error in the prescription chart, the reading for the 24/9/98 on page 756 showing 60 mgs of Diamorphine timed at 10.1, I believe should read 1015 25/9/98 60 mgs., this being administered as I have said by Code A and Code A

In relation to Oramorph the nurses who have administered it are:

At 1450 on 21/9/98 5mgs/2.5 mls signed by me in the prescription chart and also in the controlled drug record book, where it is witnessed by Code A

At 2015 hrs also on 21/9/98 10mgs/5mls signed by Code A in the prescription chart and by Code A in the controlled drugs record book where it is witnessed by Code A Code A

Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

Age if under 18: Over 18 (if over 18 insert 'over 18') Occupation: NURSING HOME NIGHT SISTER

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: 16/03/2005

I am Code A and I live at an address known to Hampshire Police. I am currently employed as a Night sister in a local Nursing Home. Up until February 2004 when I retired from the GWMH I was a Clinical Manager (Senior Sister) at Dryad Ward, my Nursing and Midwifery Number is Code A I did not work at that hospital however since May 2003 though, due to sickness.

In 1963 I became a Cadet Nurse and commenced a 3 year qualification course in 1965 at Hackney Hospital, East London. I worked on all wards until my qualification as a Registered Staff Nurse to the surgical ward.

I commenced employment at Gosport War Memorial Hospital in 1988 in the capacity of Staff Nurse

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management Redclyffe Annexe which was 23 bed unit for continuing care, terminally ill patients, who's length of stay at the hospital was variable, but basically to assist relatives and give them a period of respite.

Redclyffe Annexe was situated was situated a short distance from the hospital and moved to the main hospital in 1994 and thus became Dryad ward.

In January 1996 I was working as a Clinical Manager at the GWMH. I worked 371/2 hours a week on a shift rota, earlies being 07:30 to 1615 and lates 12 midday to 20:30.

RESTRICTED

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management of the Hospital and would take on management roles when there were no managers at the hospital, i.e. at weekends and evenings. I was responsible for all of the staff on the ward re the training, hiring discipline, staff rotas and leave issues.

My line manager at that time was Code A

In 1999, Diamorphine Syringe drivers were introduced to those of us working on Redclyffe Annexe and In 1998 Code A became the Doctor responsible for the patients, prior to this, each patients GP was responsible for their individual patients on the ward.

Responsibility for medical care was "Elderly Medicine" based at the Queen Alexandra Hospital Cosham.

Code A would visit at 07:30 each morning Monday to Friday and see every patient, before returning to her own practice.

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

On her visits Code A would prescribe the drugs that were required by each patient. This was a new concept to staff at this time. Sister Code A who was in charge at this time bought syringe drivers to the annexe and explained the system to the nurses and they would have learnt their use from her.

At this time there were no courses in the use of syringe drivers, but these have since been started. I am aware that there have been some concerns in relation to the syringe drivers and diamorphine, but I have not had any doubts myself. The main reason for the use of a syringe driver is to administer drugs to a patient once oral medication has ceased, generally due to the patient's inability to swallow.

RESTRICTED

Drugs that I am aware of that have been administered in this way as well as Diamorphine, are Midazolam, a sedative, Hyoscine, to stop secretions and Cyclizine to stop vomiting.

I have been asked about the "Wessex Protocols". I am unfamiliar with this name but am aware of certain protocols I relation to the setting up and use of syringe drivers and am unsure if they are one and the same.

The Named Nurse is the person with the responsibility for the nursing care of the patient. The named nurse would also be the person to whom the family would speak to, in order to keep them up to date on the patient's condition.

The time and date of all entries in the nursing notes would either be completed at the time if the patient was seriously ill, but in other cases they would be completed when there was time but in any case at the end of the tour of duty.

I have been asked to detail my involvement in the care and treatment of Code A Code A. From memory and referral to his medical notes (Exhibit BJC/15) I remember this patient. I think he came from the Thylassa Rest Home and had huge bed sore on his back, through to his spine. He was seeing Code A at the Dolphin Day Hospital and she rang me and asked me to take him on the spot because of the bed sores. I actually collected him from the DDH myself and Code A helped me push his bed to Dryad Ward.

I remember Code A to be an extremely uncooperative patient, as he was at Thalassa Nursing Home at Alverstoke and as I recall at the other nursing homes he had been resident at locally.

I recall that the whole of his sacral area had a deep recess and this was due to the fact that he was non compliant in all aspects with regard to his sitting/laying, and that he would pull off his dressings and throw them across the floor.

On page 756 of the medical notes is a prescription chart for the patient. The entries of the

RESTRICTED

24/9/98 (24/09/1998) show that the patient was administered variable doses via syringe driver of Diamorphine, 20 to 200 Mgms, Hyoscine, 200 to 800Mcgms and Midazolam, 20 to 80 Mgms. He was given 40 Mgms of Diamorphine at 1055 hrs by and initialled by me and 60Mgms at what appears to be 10.1 which is a wrong time and is not initialled. He was administered 20Mgms on 21/9/98 (21/09/1998), 20Mgms on 22/9/98 (22/09/1998), 20mgms on 23/9/98 and was clearly not holding him . The administration of 60Mgms on 24/9/98 (24/09/1998) was possibly done by night duty . I am certain that the two doses were not given at the same time. The dose administered could be anything from 20 to 200 Mgms, so the doses administered were well within acceptable limits, and could only be increased in consultation with the Doctor .

The patient was given 800 Mcgms of Hyoscine at 1055 hrs that day by and initialled by me, and also 80Mgms of Midazolam at 1055 hrs that day by and initialled by me. It would appear that he was given no further doses of neither Hyoscine nor Midazolam.

The Diamorphine is a pain killer.

The Hyoscine is used in chest infections to clear secretions

The Midazolam would be used to calm the patient

The drugs were written up by Code A in consultation with Code A. At 1300 on 23/9/98 (23/09/1998) I have written, Code A seen by me - Code A & SN Code A Very angry that driver has been commenced. It was explained yet again that the contents of his syringe driver were to control his pain. It was also explained that the consultant would need to give her permission to discontinue the driver & we would need an alternative method of giving pain relief. Has also been seen by Code A for 11/2 hours this afternoon. He is now fully aware that Code A is dying and needs to be made comfortable. Driver renewed at 20:00 I/c Diamorphine 20 Mgms, Midazolam 60 Mgms, Hyoscine 400 Mcgms. Family have visited."

RESTRICTED

Continuation of Statement of: Code A

Page 868 of the medical notes is a Summary regarding Code A

At 1300 on 23/9/98 (23/09/1998) I have written, ' Code A seen by me - Code A Code A & Code A Very angry that driver has been commenced. It was explained yet again that the contents of his syringe driver were to control his pain. It was also explained that the consultant would need to give her permission to discontinue the driver & we would need an alternative method of giving pain relief. Has also been seen by Code A for 11/2 hours this afternoon. He is now fully aware that Brian is dying and needs to be made comfortable. Driver renewed at 20:00 I/c Diamorphine 20 Mgms, Midazolam 60 Mgms, Hyoscine 400 Mcgms. Family have visited."

I have signed this entry.

I/c means with

Code A is Code A

Any text entry in nursing notes with the word Diamorphine is written in red, it is always in red.

I believe that the main feature that the step son had in relation to this, was that he couldn't talk to his Father;

I believe that the syringe driver use WAS not an issue .

Code A was offhand with the nursing staff on some occasions and I do remember his wife apologising to us for his behaviour.

The previous entry to that which I have mentioned, also on 23/9/98 (23/09/1998). "SB Code A Code A Has become chesty overnight to have Hyoscine added to driver. Stepson contacted and informed of deterioration. Code A asked if this was due to the syringe driver and informed that Code A was on a small dosage which he needed. To phone him if any further

Signed: Code A

Signature Witnessed by: Code A

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deterioration."

This entry was signed by Code A

Page 869 of the medical notes BJC 15 dated 24/9/98 (24/09/1998) is an entry written by me, "Report from night staff that Code A was in pain when being attended to, also in pain I/c day staff especially his knees. Syringe driver renewed at 1055 I/c Diamorphine 40 Mgms Midazolam 80 Mgms & Hyoscine 800 Mcgms. Dressing renewed this afternoon, see care plan. Code A Code A seen by Code A this afternoon and is fully aware of Code A condition. In the event of death Code A is for cremation"

I have signed this entry.

This entry corresponds with the entry on the prescription chart on page 756 of the notes.

On page 867 of the medical notes dated 21/9/98 (21/09/1998) the initial entry states,"Admitted from DDH with history of Parkinson's, Dementia and Diabetes. Diet controlled diabetic. Catheterised on previous admission for retention of urine. Large necrotic sore on sacrum. S/B Code A

Code A has signed this entry

"Dropped left foot. Back pain from old spinal injury"
Code A has initialled this entry.
"1450 Oramorph 5Mg given prior to the wound dressing"
Code A has initialled this entry.
Code A wrote up this prescription

Code A and I administered the doses of Oramorph given to the patient at both 1450 and 2015 hrs on 21/9/98 (21/09/1998). We have initialled the entries .

RESTRICTED

Continuation of Statement of: Code A

The patient was not eating nor drinking.

DDH is Dolphin Day Hospital

S/B means Seen by.

STATEMENT TAKEN - Code A

Signed: Code A

Signature Witnessed by: Code A

Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: 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 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 Code A was involved in the design and usage of the charts. Over the next two years the charts evolved continually, Code A and 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 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: Code A

Signed: Code A Signature Witnessed by:

RESTRICTED

Continuation of Statement of: Code A

Signed: Code A
2004(1)

Signature Witnessed by:

Code A

(2)

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 BJC/71.

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 Code A & 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:

RESTRICTED

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. 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. Code A had been seen by both Code A and Code A Code A would have seen Code A in the morning and then returned in the afternoon to do a ward round with 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 Code A Code A would stay with us until he died.

By referring to the ward controlled drugs record book (identification reference JP/CDRB/20) 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.

RESTRICTED

Continuation of Statement of: Code A

From page 19 of the microfiche BJC/71 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 JP/CDRB/21 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 (JP/CDRB/20) with regard to the Oramorph are found on pages 76 and 77.

Taken by: Code A

Signed: Code A

Signature Witnessed by:

Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: 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 Code A became the Doctor

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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.

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 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 Code A 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.

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.

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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 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 Code A 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, 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 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 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.

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I am unable to remember who else attended this meeting, but I can remember that Code A the Code A 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 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 JEP/GWMH/1/COPY2 .

Having refreshed my memory from these correspondence and I can see that the meeting I attended where 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

Continuation of Statement of: Code A

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.

Oct. 95

Good medical practice

GENERAL MEDICAL COUNCIL

Guidance to doctors

Being registered with the General Medical Council gives you rights and privileges. In return, you must meet the standards of competence, care and conduct set by the GMC.

This booklet sets out the basic principles of good practice. It is guidance. It is not a set of rules, nor is it exhaustive. The GMC publishes more detailed guidance on confidentiality, advertising and the ethical problems surrounding HIV and AIDS.

Providing a good standard of practice and care

1. Patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence, good relationships with patients and colleagues and observance of professional ethical obligations.

Good clinical care

2. You must take suitable and prompt action when necessary. This must include:

   - an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination;
   - providing or arranging investigations or treatment where necessary;
   - referring the patient to another practitioner, when indicated.

3. In providing care you must:

   - recognise the limits of your professional competence;
   - be willing to consult colleagues;
   - be competent when making diagnoses and when giving or arranging treatment;
   - keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed;

Look at what she didn't do but should have done as well as what she did but should not have done -

- keep colleagues well informed when sharing the care of patients;
- pay due regard to efficacy and the use of resources;
- prescribe only the treatment, drugs, or appliances that serve patients' needs.

Treatment in emergencies

4. In an emergency, you must offer anyone at risk the treatment you could reasonably be expected to provide.

Keeping up to date

5. You must maintain the standard of your performance by keeping your knowledge and skills up to date throughout your working life. In particular, you should take part regularly in educational activities which relate to your branch of medicine.

6. You must work with colleagues to monitor and improve the quality of health care. In particular, you should take part in regular and systematic clinical audit.

7. Some parts of medical practice are governed by law. You must observe and keep up to date with the laws which affect your practice.

Teaching

8. The GMC encourages you to help the public to be aware of and understand health issues and to contribute to the education and training of other doctors, medical students, and colleagues.

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9. All doctors should be prepared to supervise less experienced colleagues.

10. If you have special responsibilities for teaching you should develop the skills of a competent teacher. If you are responsible for training junior colleagues you must make sure they are properly supervised.

Maintaining trust

Professional relationships with patients

11. Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:

- listen to patients and respect their views;
- treat patients politely and considerately;
- respect patients' privacy and dignity;
- give patients the information they ask for or need about their condition, its treatment and prognosis;
- give information to patients in a way they can understand;
- respect the right of patients to be fully involved in decisions about their care;
- respect the right of patients to refuse treatment or take part in teaching or research;

- respect the right of patients to a second opinion;
- ask patients' permission, if possible, before sharing information with their spouses, partners, or relatives;
- be accessible to patients when you are on duty;
- respond to criticisms and complaints promptly and constructively.

12. You must not allow your views about a patient's lifestyle, culture, beliefs, race, colour, sex, sexuality, age, social status, or perceived economic worth to prejudice the treatment you give or arrange.

13. If you feel that your beliefs might affect the treatment you provide, you must explain this to patients, and tell them of their right to see another doctor.

14. You must not refuse or delay treatment because you believe that patients' actions have contributed to their condition, or because you may be putting yourself at risk.

15. Because the doctor-patient relationship is based on trust you have a special responsibility to make the relationship with your patients work. If the trust between you and a patient breaks down either of you may end the relationship. If this happens, you must do your best to make sure that arrangements are made promptly for the continuing care of the patient. You should hand over records or other information for use by the new doctor as soon as possible.

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Confidentiality

16. Patients have a right to expect that you will not pass on any personal information which you learn in the course of your professional duties, unless they agree. If in exceptional circumstances you feel you should pass on information without a patient's consent, or against a patient's wishes, you should read our booklet 'Confidentiality' and be prepared to justify your decision.

Abuse of your professional position

17. You must not abuse your patients' trust. You must not, for example:

    - use your position to establish improper personal relationships with patients or their close relatives;
    - put pressure on your patients to give money or other benefits to you or other people;
    - improperly disclose or misuse confidential information about patients;
    - recommend or subject patients to investigation or treatment which you know is not in their best interests;
    - deliberately withhold appropriate investigation, treatment or referral.

Your duty to protect all patients

18. You must protect patients when you believe that a colleague's conduct, performance or health is a threat to them.

19. Before taking action, you should do your best to find out the facts. Then, if necessary, you must tell someone from the employing authority or from a regulatory body. Your comments about colleagues must be honest. If you are not sure what to do, ask an experienced colleague. The safety of patients must come first at all times.

If your health may put patients at risk

20. If you have or are carrying a serious communicable condition, or if your judgment or performance could be significantly affected by a condition or illness, you must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, you should modify your practice. Do not rely on your own assessment of the risk to patients.

21. If you think you have or are carrying a serious communicable condition you must have all the necessary tests and act on the advice given to you by a suitably qualified colleague about necessary treatment and/or modifications to your clinical practice.

If in doubt...

22. The GMC publishes further advice on what to do when you believe that you or a colleague (including a health care worker for whom you are providing medical care) may be placing patients at risk in a note about the GMC's health procedures, and in its booklet 'HIV infection and AIDS: the ethical considerations'.

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Working with colleagues

23. You must not discriminate against colleagues, including doctors applying for posts, because of your views of their lifestyle, culture, beliefs, race, colour, sex, sexuality, or age.

24. You must not make any patient doubt a colleague's knowledge or skills by making unnecessary or unsustainable comments about them.

Working in teams

25. Health care is increasingly provided by multi-disciplinary teams. You are expected to work constructively within such teams and to respect the skills and contributions of colleagues.

26. If you are leading a team, you must do your best to make sure that the whole team understands the need to provide a polite and effective service and to treat patient information as confidential.

27. If you disagree with your team's decision, you may be able to persuade other team members to change their minds. If not, and you believe that the decision would harm the patient, tell someone who can take action. As a last resort, take action yourself to protect the patient's safety or health.

Delegating care to non-medical staff and students

28. You may delegate medical care to nurses and other health care staff who are not registered medical practitioners if you believe it is best for the patient. But you must be sure that the

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person to whom you delegate is competent to undertake the procedure or therapy involved. When delegating care or treatment, you must always pass on enough information about the patient and the treatment needed. You will still be responsible for managing the patient's care.

29. You must not enable anyone who is not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor.

Arranging cover

30. You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors.

31. General practitioners must satisfy themselves that doctors who stand in for them have the qualifications, experience, knowledge and skills to perform the duties for which they will be responsible. A deputising doctor is accountable to the GMC for the care of patients while on duty.

Accepting posts

32. If you have formally accepted a post, you should not then withdraw unless the employer will have time to make other arrangements.

Decisions about access to medical care

33. You should always seek to give priority to the investigation and treatment of patients solely on the basis of clinical need.

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Referring patients between a general practitioner and a specialist

34. A general practitioner referring a patient should give the specialist all relevant information about the patient's history and current condition. Specialists who have seen or treated a patient should, unless the patient objects, tell the general practitioner the results of their investigations, the treatment provided, and any other information necessary for the continuing care of the patient.

35. Specialists should not usually accept a patient without a referral from a general practitioner. If they do, they must inform the patient's general practitioner before providing treatment, unless the patient tells them not to or has no general practitioner. In these cases the specialist must be responsible for providing or arranging any aftercare which is necessary until another doctor agrees to take over.

36. In some areas of practice – accident and emergency, genito-urinary medicine, contraception and abortion services, and refraction – there may be good reasons for specialists to accept patients without referrals from general practitioners. In these circumstances specialists must keep general practitioners informed unless the patient tells them not to. If the general practitioner is not informed the specialist must provide any necessary aftercare until another doctor agrees to take over.

Probity in professional practice

37. You must be honest and trustworthy.

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Financial and commercial dealings

38. You must be honest in financial and commercial matters relating to your work. In particular:

- if you charge fees, you must tell patients if any part of the fee goes to another doctor;
- if you manage finances, you must make sure that the funds are used for the purpose they were intended for and are kept in a separate account from your personal finances;
- you must not defraud patients or the service or organisation you work for;
- before taking part in discussions about buying goods or services, you must declare any relevant financial or commercial interest which you or your family might have in the purchase.

Conflicts of interest

39. You must act in your patients' best interests when making referrals and providing or arranging treatment or care. So you must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect your judgment. You should not offer such inducements to colleagues.

40. If you have financial or commercial interests in organisations providing health care or in pharmaceutical or other biomedical companies, these must not affect the way you prescribe for or refer patients.

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- ***Financial interests in hospitals, nursing homes and other medical organisations***

  If you have a financial or commercial interest in an organisation to which you plan to refer a patient, you must tell the patient about your interest. When treating NHS patients you must also tell the health care purchaser.

- ***Accepting gifts or other inducements***

  You should not ask for or accept any material rewards, except those of insignificant value, from companies that sell or market drugs or appliances. You must not ask for or accept fees for agreeing to meet sales representatives.

- ***Hospitality***

  You may accept personal travel grants and hospitality from companies for conferences or educational meetings, as long as the main purpose of the event is educational. The amount you receive must not be more than you would normally spend if you were paying for yourself.

Signing certificates and other documents

41. Registered medical practitioners have the authority to sign a variety of documents, such as death certificates, on the assumption that they will only sign statements they believe to be true. This means that you must take reasonable steps to verify any statement before you sign a document. You must not sign documents which you believe to be false or misleading. Similarly, when providing references for colleagues, your comments must be honest and you must be able to back them up.

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Advertising – providing information to colleagues and the public

42. If you advertise your services your advertisement must be honest. It must not exploit patients' vulnerability or lack of medical knowledge and may provide only factual information. All doctors' advertisements must follow the detailed guidance in the GMC's booklet 'Advertising'.

Research

43. If you are taking part in clinical trials of drugs or other research involving patients you must make sure that the research is not contrary to the patients' interests. Check that the research protocol has been approved by a properly constituted research ethics committee.

44. You must keep to all aspects of the research protocol and may accept only those payments approved by a research ethics committee. Your conduct in the research must not be influenced by payments or gifts.

45. You must always record your research results truthfully and maintain adequate records. In publishing these results you must not make unjustified claims for authorship.

46. You should read the guidance on confidentiality in research in the GMC's booklet 'Confidentiality'.

You must always be prepared to explain and justify your actions and decisions.

October 1995

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Index

note: numbers refer to paragraphs

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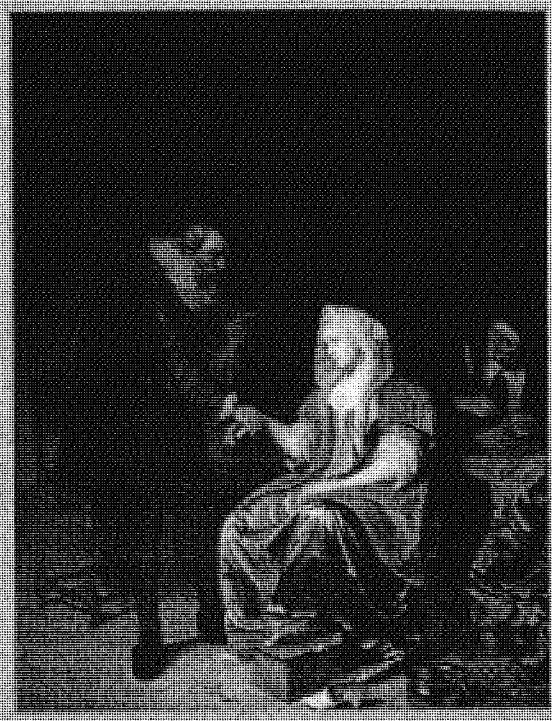
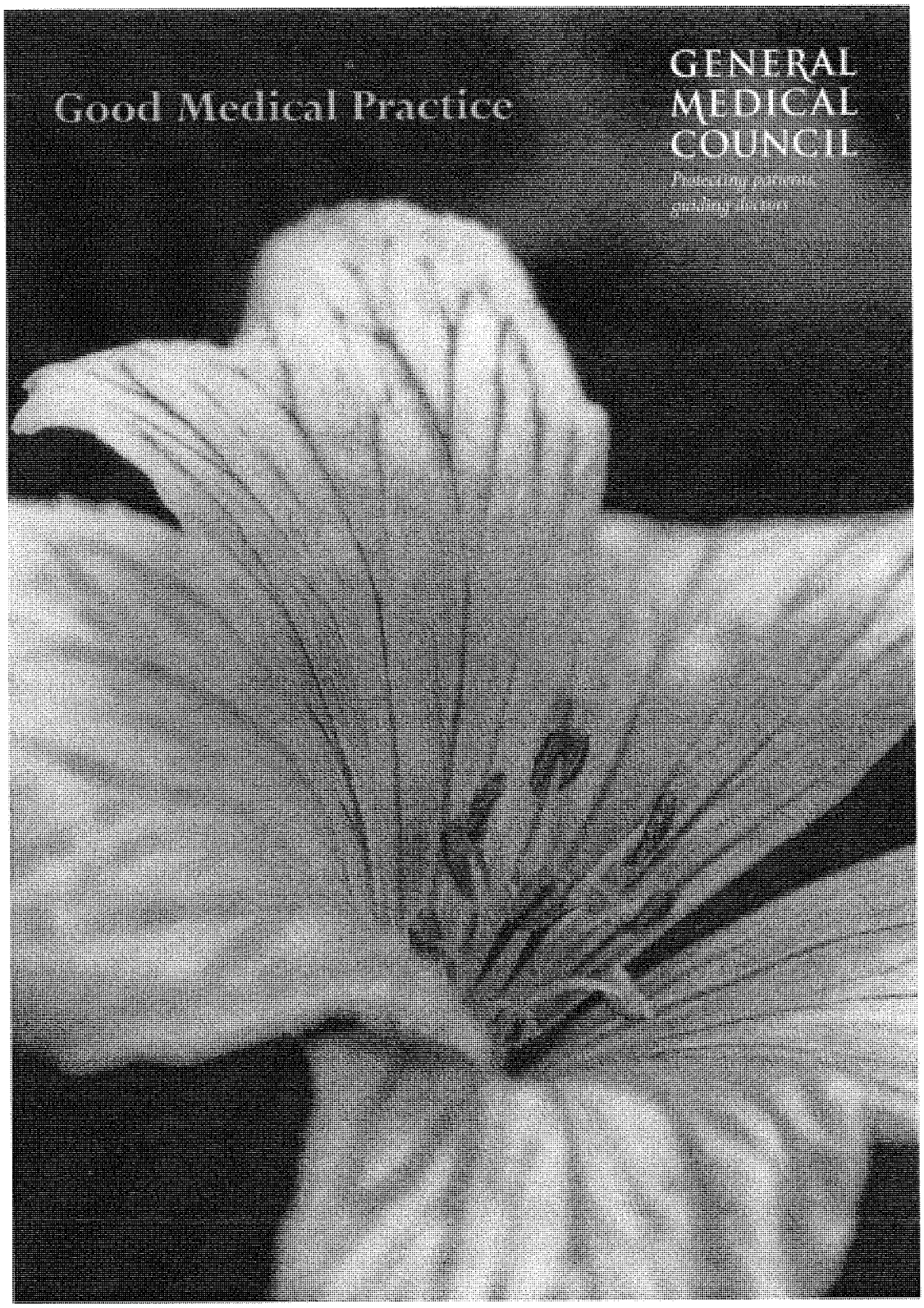


Cover shows a detail from the painting
'Doctor taking a young woman's pulse'
by Michael van Musscher (1645-1705)
Private collection

Picture courtesy of the Bridgeman Art Library, London

July 98 (2001)



Duties and responsibilities of doctors

Being registered with the GMC gives you rights and privileges. In return you must fulfil the duties and responsibilities of a doctor set by the GMC.

The principles of good medical practice and the standards of competence, care and conduct expected of you in all aspects of your professional work are described in this booklet. They apply to all doctors involved in health care.

If serious problems arise which call your registration into question, these are the standards against which you will be judged.

Providing a good standard of practice and care

1. All patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations.

Good clinical care

2. Good clinical care must include:

   - an adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination;
   - providing or arranging investigations or treatment where necessary;
   - taking suitable and prompt action when necessary;
   - referring the patient to another practitioner, when indicated.

3. In providing care you must:

   - recognise and work within the limits of your professional competence;
   - be willing to consult colleagues;
   - be competent when making diagnoses and when giving or arranging treatment;

- keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed;

- keep colleagues well informed when sharing the care of patients;

- pay due regard to efficacy and the use of resources;

- prescribe only the treatment, drugs, or appliances that serve the patient's needs.

Treatment in emergencies

4. In an emergency, you must offer anyone at risk the treatment you could reasonably be expected to provide.

Maintaining good medical practice

Keeping up to date

5. You must keep your knowledge and skills up to date throughout your working life. In particular, you should take part regularly in educational activities which develop your competence and performance.

6. Some parts of medical practice are governed by law or are regulated by other statutory bodies. You must observe and keep up to date with the laws and statutory codes of practice which affect your work.

Maintaining your performance

7. You must work with colleagues to monitor and maintain your awareness of the quality of the care you provide. In particular, you must:

   - take part in regular and systematic medical and clinical audit, recording data honestly. Where necessary you must respond to the results of audit to improve your practice, for example by undertaking further training;

   - respond constructively to assessments and appraisals of your professional competence and performance.

Teaching and training

8. The GMC encourages you to help the public to be aware of and understand health issues and to contribute to the education and training of other doctors, medical students and colleagues.

9. If you have special responsibilities for teaching you must develop the skills, attitudes and practices of a competent teacher. You must also make sure that students and junior colleagues are properly supervised.

10. You must be honest and objective when assessing the performance of those you have supervised or trained. Patients may be put at risk if you confirm the competence of someone who has not reached or maintained a satisfactory standard of practice.

References

11. When providing references for colleagues your comments must be honest and justifiable; you must include all relevant information which has a bearing on the colleague's competence, performance, reliability and conduct.

Maintaining trust

Professional relationships with patients

12. Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:

- listen to patients and respect their views;
- treat patients politely and considerately;
- respect patients' privacy and dignity;
- treat information about patients as confidential. If in exceptional circumstances you feel you should pass on information without a patient's consent, or against a patient's wishes, you should follow our guidance on confidentiality and be prepared to justify your decision;
- give patients the information they ask for or need about their condition, its treatment and prognosis. You should provide this information to those with parental responsibility where patients are under 16 years old and lack the maturity to understand what their condition or its treatment may involve, provided you judge it to be in the child's best interests to do so;

- give information to patients in a way they can understand;
- be satisfied that, wherever possible, the patient has understood what is proposed, and consents to it, before you provide treatment or investigate a patient's condition[1];
- respect the right of patients to be fully involved in decisions about their care;
- respect the right of patients to decline treatment or decline to take part in teaching or research;
- respect the right of patients to a second opinion;
- be readily accessible to patients and colleagues when you are on duty.

13. The investigations or treatment you provide or arrange must be based on your clinical judgment of the patient's needs and the likely effectiveness of the treatment. You must not allow your views about a patient's lifestyle, culture, beliefs, race, colour, gender, sexuality, age, social status, or perceived economic worth to prejudice the treatment you provide or arrange.

14. If you feel that your beliefs might affect the treatment you provide, you must explain this to patients, and tell them of their right to see another doctor.

15. You must not refuse or delay treatment because you believe that patients' actions have contributed to their condition, or because you may be putting yourself at risk. If a patient poses a risk to your health or safety you may take reasonable steps to protect yourself before investigating their condition or providing treatment.

1 Guidance on consent is given in our booklet 'Serious Communicable Diseases'. We will publish further guidance on consent in 1999.

If things go wrong

16. Patients who complain about the care or treatment they have received have a right to expect a prompt and appropriate response. As a doctor you have a professional responsibility to deal with complaints constructively and honestly. You should co-operate with any complaints procedure which applies to your work. You must not allow a patient's complaint to prejudice the care or treatment you provide or arrange for that patient.

17. If a patient under your care has suffered serious harm, through misadventure or for any other reason, you should act immediately to put matters right, if that is possible. You should explain fully to the patient what has happened and the likely long- and short-term effects. When appropriate you should offer an apology. If the patient is under 16 and lacks the maturity to consent to treatment, you should explain the situation honestly to those with parental responsibility for the child.

18. If a patient under 16 has died you must explain, to the best of your knowledge, the reasons for, and the circumstances of, the death to those with parental responsibility. Similarly, if an adult patient has died, you should provide this information to the patient's partner or next of kin, unless you know that the patient would have objected.

19. Subject to your right not to provide evidence which may lead to criminal proceedings being taken against you, you must co-operate fully with any formal inquiry into the treatment of a patient. You should not withhold relevant information. Similarly, you must assist the coroner or procurator fiscal when an inquest or inquiry is held into a patient's death.

20. In your own interests and those of your patients, you must obtain adequate insurance or professional indemnity cover for any part of your work not covered by your employer's indemnity scheme.

21. You must do your best to establish and maintain a relationship of trust with your patients. Rarely, there may be circumstances in which you find it necessary to end a professional relationship with a patient. You must be satisfied your decision is fair and does not contravene the guidance in paragraph 13; you must be prepared to justify your decision if called on to do so. In such cases you should usually tell the patient why you have made this decision. You must also take steps to ensure that arrangements are made quickly for the continuing care of the patient. You should hand over records or other information to the patient's new doctor as soon as possible.

Abuse of your professional position

22. You must not abuse your patients' trust. You must not, for example:

- use your position to establish improper personal relationships with patients or their close relatives;
- put pressure on your patients to give or lend money or other benefits to you or other people;
- improperly disclose or misuse confidential information about patients;
- give patients, or recommend to them, an investigation or treatment which you know is not in their best interests;

- deliberately withhold appropriate investigation, treatment or referral;
- put pressure on patients to accept private treatment;
- enable anyone who is not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor.

Your duty to protect all patients

23. You must protect patients when you believe that a doctor's or other colleague's health, conduct or performance is a threat to them.

24. Before taking action, you should do your best to find out the facts. Then, if necessary, you must follow your employer's procedures or tell an appropriate person from the employing authority, such as the director of public health, medical director, nursing director or chief executive, or an officer of your local medical committee, or a regulatory body. Your comments about colleagues must be honest. If you are not sure what to do, ask an experienced colleague or contact the GMC for advice. The safety of patients must come first at all times.

If your health may put patients at risk

25. If you have a serious condition which you could pass on to patients, or if your judgment or performance could be significantly affected by a condition or illness, you must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, you should modify your practice. Do not rely on your own assessment of the risk to patients.

26. If you think you have a serious condition which you could pass on to patients, you must have all the necessary tests and act on the advice given to you by a suitably qualified colleague about necessary treatment and/or modifications to your clinical practice.

If in doubt ...

27. You will find more advice on what to do when you believe that you or a colleague (including a health care worker for whom you are providing medical care) may be placing patients at risk in our booklets 'Maintaining Good Medical Practice' and 'Serious Communicable Diseases'.

Working with colleagues

28. You must always treat your colleagues fairly. In accordance with the law, you must not discriminate against colleagues, including doctors applying for posts, on grounds of their sex, race or disability. And you must not allow your views of colleagues' lifestyle, culture, beliefs, race, colour, gender, sexuality, or age to prejudice your professional relationship with them.

29. You must not make any patient doubt a colleague's knowledge or skills by making unnecessary or unsustainable comments about them.

Working in teams

30. Health care is increasingly provided by multi-disciplinary teams. You are expected to work constructively within teams and to respect the skills and contributions of colleagues. Make sure that your patients and colleagues understand your role and responsibilities in the team, your professional status and specialty.

31. If you lead the team you must:

- take responsibility for ensuring that the team provides care which is safe, effective and efficient.
- do your best to make sure that the whole team understands the need to provide a polite, responsive and accessible service and to treat patient information as confidential.
- if necessary, work to improve your skills as a team leader.

32. When you work in a team you remain accountable for your professional conduct and the care you provide.

33. If you disagree with your team's decision, you may be able to persuade other team members to change their minds. If not, and you believe that the decision would harm the patient, tell someone who can take action. As a last resort, take action yourself to protect the patient's safety or health.

Arranging cover

34. You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors.

35. If you are a general practitioner you must satisfy yourself that doctors who stand in for you have the qualifications, experience, knowledge and skills to perform the duties for which they will be responsible. A deputising doctor is accountable to the GMC for the care of patients while on duty.

Accepting posts

36. If you have formally accepted any post, including a locum post, you must not then withdraw unless the employer will have time to make other arrangements.

Decisions about access to medical care

37. You should seek to give priority to the investigation and treatment of patients on the basis of clinical need.

The central role of the general practitioner

38. It is in patients' best interests for one doctor, usually a general practitioner, to be fully informed about, and responsible for maintaining continuity of, a patient's medical care. If you are a general practitioner and refer patients to specialists, you should know the range of specialist services available to your patients.

Delegation and referral

39. Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient.

40. Referral involves transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment, which falls outside your competence. Usually you will refer patients to another registered medical practitioner. If this is not

the case, you must be satisfied that such health care workers are accountable to a statutory regulatory body, and that a registered medical practitioner, usually a general practitioner, retains overall responsibility for the management of the patient.

41. When you refer a patient, you should provide all relevant information about the patient's history and current condition. Specialists who have seen or treated a patient should, unless the patient objects, tell the general practitioner the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient.

42. Doctors practising in most specialties should usually accept patients only with a referral from a general practitioner or other appropriate health care professional. However, in some areas of practice, for example, accident and emergency, genito-urinary medicine, contraception and abortion services and refraction, there may be good reasons for specialists to accept patients without a referral. Similarly, occupational health physicians, police surgeons and other doctors with dual responsibilities may accept patients for assessment or screening without a referral.

43. If you accept a patient without a referral from the patient's general practitioner, you must keep the general practitioner informed, provided you have the patient's consent. If sensitive information is involved, you should encourage patients to allow information to be passed to their general practitioners, but you must not disclose information to a general practitioner unless the patient agrees. Except in emergencies or when it is impracticable, you should inform the general practitioner before starting treatment. If you do not tell the patient's general practitioner, before or after providing treatment, you will be responsible for providing or arranging all after care which is necessary until another doctor agrees to take over.

Providing information about your services

44. If you publish or broadcast information about services you provide, the information must be factual and verifiable. It must be published in a way that conforms with the law and with the guidance issued by the Advertising Standards Authority. If you publish information about specialist services, you must still follow the guidance in paragraphs 42 and 43 above.

45. The information you publish must not make claims about the quality of your services nor compare your services with those your colleagues provide. It must not, in any way, offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge.

46. Information published about specialist services should include advice that patients cannot usually be seen or treated by specialists, either in the NHS or private practice, without a referral, usually from a general practitioner. If you are a specialist you should do all that you can to see that a similar statement is included in any advertisement for specialist services issued by an organisation which you are associated with.

47. Information you publish about your services must not put pressure on people to use a service, for example by arousing ill-founded fear for their future health. Similarly, you must not advertise your services by visiting or telephoning prospective patients, either in person or through a deputy.

Probity in professional practice

Financial and commercial dealings

48. You must be honest in financial and commercial matters relating to your work. In particular:

- if you charge fees, you must tell patients if any part of the fee goes to another doctor;
- if you manage finances, you must make sure that the funds are used for the purpose they were intended for and are kept in a separate account from your personal finances;
- you must not defraud patients or the service or organisation you work for;
- before taking part in discussions about buying goods or services, you must declare any relevant financial or commercial interest which you or your family might have in the purchase.

Conflicts of interest

49. You must act in your patients' best interests when making referrals and providing or arranging treatment or care. So you must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect your judgment. You should not offer such inducements to colleagues.

Financial interests in hospitals, nursing homes and other medical organisations

50. If you have financial or commercial interests in organisations providing health care or in pharmaceutical or other biomedical companies, these must not affect the way you prescribe for, treat or refer patients.

51. If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the health care purchaser.

52. Treating patients in an institution in which you have a financial or commercial interest may lead to serious conflicts of interest. If you do so, your patients and anyone funding their treatment must be made aware of your financial interest. In addition, if you offer specialist services, you must not accept patients unless they have been referred by another doctor who will have overall responsibility for managing the patient's care. If you are a general practitioner with a financial interest in a residential or nursing home, it is inadvisable to provide primary care services for patients in that home, unless the patient asks you to do so or there are no alternatives. If you do this, you must be prepared to justify your decision.

Accepting gifts or other inducements

53. You should not ask for or accept any material gifts or loans, except those of insignificant value, from companies that sell or market drugs or appliances. You must not ask for or accept fees for agreeing to meet sales representatives.

Hospitality

54. You may accept personal travel grants and hospitality from companies for conferences or educational meetings, as long as the main purpose of the event is educational. The amount you receive must not be more than you would normally spend if you were paying for yourself.

Signing certificates and other documents

55. Registered medical practitioners have the authority to sign a variety of documents, such as death certificates, on the assumption that they will only sign statements they believe to be true. This means that you must take reasonable steps to verify any statement before you sign a document. You must not sign documents which you believe to be false or misleading.

Research

56. If you take part in clinical drug trials or other research involving patients or volunteers, you must make sure that the individual has given written consent to take part in the trial and that the research is not contrary to the individual's interests. You should always seek further advice where your research involves adults who are not able to make decisions for themselves. You may also benefit from additional advice where your research involves children. You must check that the research protocol has been approved by a properly constituted research ethics committee.

57. You have an absolute duty to conduct all research with honesty and integrity:

- you must follow all aspects of the research protocol; you may accept only those payments approved by a research ethics committee;
- your conduct must not be influenced by payments or gifts;
- you must always record your research results truthfully and maintain adequate records;
- when publishing results you must not make unjustified claims for authorship;
- you have a duty to report evidence of fraud or misconduct in research to an appropriate person or authority.

This booklet is not exhaustive. It cannot cover all forms of professional practice or misconduct which may bring your registration into question. **You must therefore always be prepared to explain and justify your actions and decisions.**

We publish further guidance on a number of issues raised in this booklet. You will find a list of our publications at the back of this booklet.

July 1998

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Note: Numbers refer to paragraphs

OPERATION ROCHESTER
GENERIC CASE SUMMARY

Further to the individual case summaries and files prepared for the individual patients. A further file of evidence has been prepared that should be read as an over view regarding events at the Gosport War Memorial Hospital from 1990 to 2002. Although this file alone does not pertain to any criminal charges it does corroborate all of the individual case files and should be read in conjunction with them.

The main points covered are as follows:-

1. Working Practices at the Gosport War Memorial Hospital

   Code A is an experienced retired Staff Nurse who joined Northcotte Annexe in 1972, she moved to Redcliffe Annexe and then to Dryad Ward in 1994, she details the general running of the hospital and the changing needs of the patients throughout the years.

2. Concerns raised by the nursing staff in 1991 regarding the excessive use of diamorphine via syringe drivers on Dryad Ward and the resultant management action.

   In 1991 a number of night nursing staff including Code A (Also spelt Code A) and Code A had serious concerns about the use of syringe drivers on the ward. These concerns included:-

   - Patients placed on syringe drivers when not in pain.
   - The blanket use of syringe drivers before any other analgesics were tried.
   - The blanket prescribing of diamorphine prior to the patient actually requiring a strong opiod, allowing the nursing staff to commence the use of the driver without the knowledge of the Doctor.
   - Used to calm patients who were aggressive or noisy rather than for pain management.
   - Patient deaths were sometimes hastened unnecessarily.
   - The use of the syringe driver or commencing diamorphine prohibits trained staff from adjusting dose to suit the patient needs.
   - That too high a degree of unresponsiveness from patients was sought at times.
   - That sedative drugs such as thioridazine would sometimes be more appropriate.
   - That diamorphine was prescribed prior to such procedures such as catheterisation where diazepam would be just as effective.

- That not all staff views were considered before a decision was made to start patients on diamorphine.
- That other similar units did not use diamorphine as extensively.

These concerns were aired in a meeting held at Redcliffe Annexe on 11th July 1991 that had been arranged in conjunction with the patient care manager Code A Code A who addressed the concerns. A number of meetings then took place between nursing, medical and management staff. This resulted in the training of staff in the use of syringe drivers and pain control and an agreement that a policy be written by management on the use of syringe drivers and controlled drugs.

Code A a Convenor for the Royal College of Nursing states that: Training was provided for staff by a Code A probably, but a policy was never written. Code A correspondences with regard to these meetings are available identification numbers KPM/1 to KPM/7.

The training did not allay the nursing staff fears and when Code A attended a course in Elderly care at the Queen Alexandra Hospital she chose to speak on 'The use and abuse of the syringe driver'. Her course tutor Code A visited Radcliffe Annexe and met nursing staff on 31st October 1991 after a request by Code A. The main conclusion of Code A visit was that:-

* The staff are concerned that non opiods or weak opiods were not being considered prior to the use of diamorphine.

* The staff have had some training arranged by the Hospital manager namely

  - the syringe driver and pain control
  - pain control

* Code A wrote to Code A the producers of diamorphine and reviewed literature and a video – Making Pain Management More Effective.

* Code A is undertaking a literature on Pain and Pain Control.

A copy of Code A report was sent to both Code A (deceased) the General Manager, Gosport War Memorial Hospital, Code A the Code A Code A and Code A, Solent School of Health Studies, Code A her CV is available SAF/VC/1).

As a result of this Code A circulated a memorandum on 7th November, asking for staff to identify any patient that they felt diamorphine (or any other drug) had been prescribed inappropriately. Due to the memo which mentioned 'allegations' and asking for individual responses to be put in writing Code A Code A sought the assistance of the Wessex Regional Office of the Royal

College of Nursing. This prompted a Code A to write to Code A outlining the nurses' position. In the main after the meeting in July it was decided that:-

1. The concerns would be addressed.

2. Clear guidance/policy would be promulgated.

It had now become a matter of serious concern that:-

1. The complaints were not acted upon.

2. The management were now seeking formal allegations.

At this time the RCN stated that the RCN would not be prepared to be drawn into what could emerge as a vindictive witch hunt that would divide nursing staff, medical staff and management. The complaints were adequately repeated to management and that if a policy was not formulated out then action would be taken by way of the grievance procedure.

A further meeting was then held at Radcliffe Annexe on 17th December 1991 with Medical, Nursing Staff and Code A This meeting is described as a 'them and us' meeting, medical staff on one side sat like a panel. During the meeting Code A highlighted the action management had taken:-

(i) The staff meeting on 11th July.
(ii) Code A lecture on drug control.
(iii) Staff being invited to detail individual cases, none were forthcoming.
(iv) The stressed placed on medical staff and the issue being detrimental to patient care.

She also presented the staff concerns and a Code A spoke regarding symptom control.

It was agreed that if any of the nursing staff had concerns in the future they would approach Code A or Code A in the first instance and if not resolved they could speak to Code A

The medical staff then left the meeting and Code A asked if there was still a need for a policy relating to nursing practice on the issue. No one at this meeting thought it was appropriate. Code A then addressed staff stating she was concerned over the manner in which these concerns had been raised, as it had made people feel very threatened and defensive. It is clear that the concerns had been turned around the result being that the syringe drivers were not an issue recognised by the management, but the nursing staff who had raised the concerns and the way the concerns were raised were. As such the nursing staff felt vulnerable and unsupported to such an extent that they stopped complaining.

Due to the fact that the RCN took its lead from the nursing staff and as they did not hear anything further from them they also took the matter no further.

3. The Recovery of Letters and Meeting Minutes regarding the Events in 1991.

On Monday 16th September 2002 in order to inform staff that Code A Code A had been tasked with reviewing the Gosport War Memorial Hospital and the prescribing procedures and policy's a meeting was called with the nursing staff. Prior to the meeting Code A and Code A approached Code A a nursing manager at GWMH and handed to her a file containing letters and the minutes of the meetings held in 1991, these were subsequently handed to Code A and are available (JEP/GWMH/1/). These papers detailed the nursing staff concerns and management action. When asked why they had brought the documents forward now Code A stated that she had seen an article in the Sunday newspaper about the GWMH which stated that no one had ever brought the concerns about syringe drivers to the attention of management before and that there had been no training in their use, but she had received training. When asked whether they felt the matter had been solved, as the documents seemed to stop abruptly, Code A said that things had changed for a short period of time as patients didn't appear to be automatically put on diamorphine and that Code A had been on a palliative care course and knew what she was talking about. The replies were recorded (TJS/1). A further meeting was held on the 18th September 2002 to investigate the events of 1991 with Code A Code A and Code A Code A being present. Notes from this meeting (TJS/2) reflect how Code A felt in 1991 throughout the different meetings and why they decided to speak to Code A now.

Code A also kept the minutes of the 1991 meetings and letters relating to the concerns (SG/GWMH/1). Code A identifies her letters from the bundle JEP/GWMH/1 and these are available JEP/GWMH/1/BAT/1.

Code A corroborates the meetings of the 16th and 18th September 2002 and provides continuity of the Exhibit JEP/GWMH/1. Code A and Code A also provide corroboration to the events of the 16th September 2002.

The concerns of Code A although not shared by all of the staff on Dryad Ward are corroborated by Code A and Code A is a Code A and represented Code A at the meeting on 18th September and she provides a note of the invitation to the meeting (BW/1), notes of the meeting (BW/2) (Typed BW/3). A list of the documents in JEP/GWMH/1 (BW/4).

4. Concerns held by training nursing staff at Gosport War Memorial Hospital relating to diamorphine, syringe drivers and general patient care that were never aired with the management.

A number of nursing staff have subsequently been interviewed and have highlighted concerns that had never been mentioned before these include:-

Code A – syringe drivers were used too often. Rather than being used to control pain they were used on patients who were approaching death and suffering anxiety and distress. Code A prescribed the diamorphine but it was up to a senior nurse when to use it. It was apparent that an awful lot of patients that died were on syringe drivers.

Code A – shared concerns of the nurses in 1991 and felt optimistic that the issues would be addressed. Left a couple of weeks after the meeting in July 1991 so didn't see how the issues were dealt with or what guidelines were put in place.

Code A – worked on Sultan Ward although covered other wards so is able to compare working practices between the different wards. In Daedalus ward the doses of diamorphine prescribed were set between large parameters leaving the dose administered to be decided by the attending nurse.

Code A – the needs and demands of the patients changed, by taking more acute patients. Medical cover was not reflected in the changes. Work load increased and patient contact was often less. By 2003 there was a lack of leadership and structure.

By charting a variable dose of medication the responsibility of the dose administered falls to the qualified nurse.

Code A would prescribe diamorphine by phone but not conduct a follow up visit. Inappropriate prescribing of diamorphine i.e when a patient was not in pain and/or other analgesics not used prior. 'It seemed that people were going onto syringe drivers for no reason at all. They were not ill or in pain and yet they were dying shortly after going on the drivers'.

Recalls a patient Marjorie that was prescribed diamorphine.

Code A – Corroborates the statement of Code A regarding Code A States that Code A would mention diamorphine and the patient would be dead within the week.

Code A – acknowledges that some staff had concerns with regard to the use of syringe drivers but did not have any herself. Attended the staff and management meetings, in 1991 regarding the staff concerns.

Code A – on a couple of occasions a patient was put onto a syringe driver with diamorphine when there was no indication that they needed it. Attended the 1991 meeting but nothing changed as a result of it.

Code A – syringe drivers were used too early before other methods of pain control had been tried, they were prescribed by Code A on the admission of the patient as, as and when

required prescription. Doses of diamorphine and midazolam were too high.

Code A actions were ill thought out and could have led to the premature death of a patient. Code A discussed her concerns with Code A Code A who recorded these concerns in her diary of 2001 (JMI/1) and 2002 (JMI/2)

Code A – had concerns over the high dosages of diamorphine given to patients. Drugs including diamorphine and midazolam were prescribed to patient on their arrival. It therefore became a decision for the nurses when to administer it. Patients went onto morphine without starting at the bottom of the analgesic ladder.

5. Concerns of Untrained Staff at Gosport War Memorial Hospital

Code A – holds concerns about the indiscriminate use of syringe driver. It appeared that euthanasia was practised. All patients upon their admission were written up by Code A who authorised the use of a syringe driver if appropriate, and that any person put onto a driver would die shortly afterwards.

Code A – believed that syringe drivers were used too soon on some patients. Patients were put on them because they just moaned and groaned. Patients put on a syringe driver would go into a coma and die a day or two week later.

Code A – untrained nurse would double check medication with a trained nurse if no other trained nurse was available and give patients medication that had been checked and left out by trained nurses when there wasn't any trained nurses on. Didn't understand why some stroke patients who didn't appear to be in pain were put on syringe drivers. When patients were put on syringe drivers they were not taken off of them until they died. In her opinion the use of a syringe driver shortened the patient's life. Diamorphine was used inappropriately, it made the patient quiet and shortened their life. It was given to patients who didn't require that level of pain relief. Diamorphine was used to keep the patients moving through the Annexe to keep waiting lists down. Code A didn't spend much time with the patients.

Code A – on occasions would leave work and a patient would appear to be well. On her return they would be receiving diamorphine through a syringe driver.

Code A – patients were placed on syringe drivers very early in their treatment. Other types of pain relief were not tried first.

Code A – syringe drivers used prematurely.

Code A – wondered why patients were on syringe

drivers.

Code A – concerns re the lack of labels on drugs, or what was in the syringe driver.

Code A – untrained nurse who would countersign a withdrawal of diamorphine as a witness and was asked to countersign a withdrawal when she hadn't witnessed it.

Code A – there was a practice of pre-prescribing syringe drivers and diamorphine. This was a practice that was not used on other wards.

Code A – worked on Daedalus ward in 1999 – 2000. States that the nursing care provided was very poor due to the poor management of the ward. Pain management was inadequate. No consideration was given to opiod tolerance. Correspondence outlining her concerns are available MRP/1 to MRP/3.

Code A – there was a culture within Gosport that would not change, there was little support from Doctors and Management. Had to request his own training for syringe drivers.

Code A – describes how and why it was decided by Code A and Code A and herself to prescribe medication prior to it being required.

6. Technical Matters, Production of Medical Records and Exhibit Continuity

Code A – provides details as to what Nozinam is used for, its properties, recommended dosages, when caution should be exercised prior to prescribing, and side effects.

Code A – produces the medical records of:-

Code A

- BJC/16
- BJC/30
- BJC/15
- BJC/21
- BJC/55
- BJC/45
- BJC/72
- BJC/67
- BJC/71

showing the deceased's treatment at Gosport War Memorial Hospital and Queen Alexandra Hospital and the admission books relating to Gosport War Memorial Hospital.

Dryad Ward 93/96 BJC/88
Dryad Ward 79/03 BJC/89
Daedalus Ward 01/03 BJC/90
Code A provides continuity for these exhibits and also produces cremation certificates for Code A (PJR/CREM/2) that show that both patients were in a coma prior to death.

Seven of the deceased were treated in Halslar Hospital (Military Hospital) prior to their admission to GWMH and their medical records are produced by Code A

Code A

- JR/11A (Chest X-rays JR/XR/1)
- JR/12
- JR/13
- JR/14
- JR/15
- JR/16
- JR/19A

The GP medical records for each of the patients are produced by Code A Code A as follows:-

Code A

- TAS/1
- TAS/2
- TAS/3
- TAS/4
- TAS/5
- TAS/7
- TAS/8
- TAS/9
- TAS/10

The controlled drugs record books for Gosport War Memorial Hospital, Sultan Ward, Dryad Ward, Daedalus Ward, Redcliffe Annexe, the female ward are produced by Code A and run from JP/CDRB/1 to JP/CDRB/48. Dryad Ward controlled drugs record books are available and cover the following periods,

25/06/95 to 24/05/96 – JP/CDRB/20
06/03/05 to 08/12/96 – JP/CDRB/21
22/11/96 to 23/06/97 – JP/CDRB/22
08/12/96 to 22/12/97 – JP/CDRB/23
02/09/98 to 18/06/99 - JP/CDRB/47
18/06/99 to 04/07/01 - JP/CDRB/48
12/07/97 to 05/03/02 – JP/CDRB/24

The bed numbers register from November 1992 t January 1997; JP/BNR/1 is also produced and covers Sultan, Dryad and Daedalus wards.

Code A the Pharmacy Services Manager for Portsmouth Hospitals NHS Trust explains how medicines are ordered, supplied and recorded and produces a hand book covering Palliative Care which gives guidance on Clinical management of patients who are dying (JJW/7). This includes, pain, diagnosis, strong opiods and syringe drivers.
Code A produces a fax copy headed 'Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion' ID/F & GPCT/1 that was sent to her by Code A (Medical Director PHCT) Secretary. This would appear to be the earliest protocol or policy regarding the prescribing of diamorphine by syringe drivers issued by PHCT and can be dated around the end of 1999. Even at this time it can be seen by this draft protocol the confusion surrounding the prescribing of diamorphine as it states:-

Dosage

Guidance from the palliative care service indicates that if pain has not been controlled in the previous 24 hours by 'X mg' of diamorphine then up to double the dose should be administered the following day, ie up to 2x 'X mg' should be given.

Prescription

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days,

Although these entries have been corrected to show the correct prescribing regime it clearly demonstrates the lack of knowledge and understanding by the hospital staff.

This is further highlighted by the patient care manager Code A who was responsible for all nursing care within the hospital who states incorrectly that if a patient was getting 10mgs of diamorphine orally every four hours amounting to 60 mgs over a 24 hour period then they would receive 60 mgs sub cut via the syringe driver over a 24 hour period.
The dose should be reduced by 1:3 or 1:2

Code A a GP in Petersfield describes the procedure for certifying cause of death within the PHCT and Code A explains the procedure at Gosport War Memorial Hospital producing an administrative form JAS/1 showing the administrative procedure followed in the hospital. Guidance of notice for the completion of cause of death certificates and a certificate JAS/2. Once the certificate is completed by the Doctor certifying death the certificate is placed in an envelope (JAS/3) which is sealed and taken by the deceased's relative or representative to the registrar. If the deceased is to be cremated further forms BC & F (JAS/4) are also completed. She also

produces the Cause of Death Certificate book with the relevant stub for each of the deceased:-

Code A

JAS/CODC/1
JAS/CODC/2
JAS/CODC/4
JAS/CODC/6
JAS/CODC/9
JAS/CODC/10
JAS/CODC/11
JAS/CODC/13
JAS/CODC/14

A certified copy of the deceased's death certificate is available produced by Code A

Code A

DB/2001
DB/2002
DB/2005
DB/2007
DB/2010
DB/2011
DB/2012
DB/2014
DB/2015

Code A a personnel assistant employed by Fareham and Gosport Primary Care Trust produces the job description for the Clinical Assistant at Gosport War Memorial Hospital that would have been applicable to Code A Code A (WJ/CA/1). This outlines the job summary as,

This is a new post of 5 Sessions a week worked flexibly to provide a 24hour Medical Cover to the Long Stay patients in Gosport. The patients are slow stream or slow stream rehabilitation, but holiday relief and shared care patients are admitted. An important aspect of this role is for the postholder to be seen not only as a medical advisor but as a friend and counsellor to patient's, relatives and staff.

Duties include, (This is not the entire list)

1. To visit the units on a regular basis and to be available "On Call" as necessary.
2. To ensure that all new patients are seen promptly after admission.
3. To be responsible for the day to day Medical Management of the patients.
4. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date and reviewed regularly.
5. To complete upon discharge the Discharge summary and HRM60.
6. To take part in the weekly consultant rounds.

7. Other Witnesses

On 4th April 2000 a Code A, 76 years of age was admitted to Haslar Hospital due to pain from arthritis and gout. As his condition was not acute he was discharged to Sultan Ward at The Gosport War Memorial Hospital for rehabilitation. Once there he was prescribed morphine sulphate tablets, a strong opiod for his pain. He became dozy suffering hallucinations and eventually slipped into unconsciousness. He was transferred back to the Haslar Hospital and diagnosed as having been given an analgesic over dose. Code A has a very poor memory of the whole episode. Code A Code A recalls the events. (Further work will be required around this part of evidence).

In 2002 the Chief Medical Officer commissioned Code A to conduct a statistical analysis of the mortality rates at the Gosport War Memorial Hospital, including an audit and review of the use of opiate drugs. His CV (RHB/CV/1) outlines his qualifications and experience. The report itself RHB/GWMH/1 concludes that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport hospital, and the attitude underlying this approach may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this practice, since evidence of it is found from as early as 1988. The practice almost certainly had shortened the lives of some patients, and it cannot be ruled out that small number of these would otherwise have been eventually discharged from hospital alive.

The practice was disclosed in several key findings.

Opiates had been administered to virtually all patients who died under the care of the Department of Medicine for Elderly People at Gosport, and most had received diamorphine by syringe driver.

Opiates were administered to patients with all types of conditions, including cancer, bronchopneumonia, dementia and strokes.

Opiates were often prescribed before they were needed – in many cases on the day of admission, although they were not administered until several days or weeks later.

In many records, evidence of a careful assessment before use of opiates was absent, and the stepped approach to management of pain in palliative care had not been followed.

In addition to these findings, two other matters also gave rise to concern. The amount of information recorded in the clinical notes was often poor, and recent fractures that had contributed to deaths, most commonly fractured hips, had not been reported on MCCDs.

MG 9

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WITNESS LIST

Date of completion:

✱ Tick if statement attached

R v

◆ Previous convictions? Enter Y or N

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: STAFF NURSE E GRADE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
2	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE E GRADE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
3	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
4	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
5	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE E GRADE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			

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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: STAFF NURSE F GRADE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
7	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: HOME Code A E-mail address:			
8	Name: Code A Address (HOME): Code A Occupation: RCN CONVENOR Date of Birth: Code A Telephone: WORK E-mail address:			
9	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: HOME Code A E-mail address:			
10	Name: Code A Address (HOME): Code A Occupation: FULL TIME RCN OFFICER Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			

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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: DEAN OF SCHOOL OF HUMAN AND HEALTH SCIENCES Date of Birth: Telephone: HOME Code A E-mail address:			
12	Name: Code A Address (HOME): Code A Occupation: RCN OFFICER Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
13	Name: Code A Address (HOME): Code A Occupation: SENIOR NURSE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
14	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
15	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			

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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	✱	◆
16	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
17	Name: Code A Address (HOME): Code A Occupation: COMMUNICATIONS MANAGER Date of Birth: Code A Telephone: WORK E-mail address:			
18	Name: Code A Address (HOME): Code A Occupation: RISK ADVISER AND FACILITATOR Date of Birth: Code A Telephone: HOME Code A E-mail address:			
19	Name: Code A Address (HOME): Code A Occupation: STATE ENROLLED NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
20	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			

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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	✸	◆
21	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
22	Name: Code A Address (HOME): Code A Occupation: COMMUNITY STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
23	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
24	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: E-mail address:			
25	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE F GRADE Date of Birth: Code A Telephone: E-mail address:			

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* Tick if statement attached

R v

◆ Previous convictions? Enter Y or N

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	*	◆
26	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
27	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
28	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
29	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
30	Name: Code A Address (HOME): Code A Occupation: PROVIDENT AGENT Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			

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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	✱	◆
31	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Telephone: HOME Code A E-mail address:			
32	Name: Code A Address (HOME): Code A Occupation: LEARNING SUPPORT ASSISTANT Date of Birth: Telephone: HOME Code A E-mail address:			
33	Name: Code A Address (HOME): Code A Occupation: WARD CLERK Date of Birth: 05/09/1960 Telephone: HOME Code A E-mail address:			
34	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Telephone: HOME Code A E-mail address:			
35	Name: Code A Address (HOME): Code A Occupation: EX NURSING AUXILIARY Date of Birth: Code A Telephone: HOME Code A E-mail address:			

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Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
36	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
37	Name: Code A Address (HOME): Code A Occupation: REGISTERED GENERAL NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
38	Name: Code A Address (HOME): Code A Occupation: PHYSIO TECHNICIAN Date of Birth: Code A Telephone: HOME Code A E-mail address:			
39	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: E-mail address:			
40	Name: Code A Address (HOME): Code A Occupation: MEDICALLY RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			

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R v

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Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✱	◆
41	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
42	Name: Code A Address (HOME): Code A Occupation: RETIRED RGN Date of Birth: Code A Telephone: HOME Code A E-mail address:			
43	Name: Code A Address (HOME): Code A Occupation: MEDICINES / PHARMASIST INFORMATION MANAGER Date of Birth: Code A Telephone: MOBILE Code A WORK E-mail address:			
44	Name: Code A Address (HOME): Code A Occupation: OUTPATIENT SERVICES MANAGER Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
45	Name: Code A Address (HOME): Code A Occupation: CIVIL SERVANT Date of Birth: Telephone: HOME Code A WORK Code A E-mail address:			

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Date of completion:

* Tick if statement attached

R v

◆ Previous convictions? Enter Y or N

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	*	◆
46	Name: Code A Address (): Occupation: Detective Constable Code A Date of Birth: Telephone: WORK Code A E-mail address:			
47	Name: Code A Address (): Occupation: Detective Constable Code A Date of Birth: Telephone: WORK Code A E-mail address:			
48	Name: Code A Address (WORK): Code A Occupation: Code A Date of Birth: Code A Telephone: WORK E-mail address:			
49	Name: Code A Address (HOME): Code A Occupation: PHARMACY SERVICES MANAGER Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
50	Name: Code A Address (HOME): Code A Occupation: PERSONNEL ASSISTANT Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			

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R v

◆ Previous convictions? Enter Y or N

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	*	◆
51	Name: Code A Address (HOME): Code A Occupation: SECRETARY Date of Birth: Code A Telephone: HOME Code A E-mail address:			
52	Name: Code A Address (HOME): Code A Occupation: GENERAL PRACTITIONER SELF EMPLOYED Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
53	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
54	Name: Code A Address (WORK): OFFICE FOR NATIONAL STATISTICS 1 DRUMMOND GATE LONDON LONDON SW1V2QQ Occupation: CIVIL SERVANT Date of Birth: Telephone: E-mail address:			
55	Name: Code A Address (): Occupation: Code A Date of Birth: Code A Telephone: WORK Code A E-mail address:			

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R v _____ ◆ Previous convictions? Enter Y or N

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
56	Name: Code A Address (HOME): Code A Occupation: RETIRED ELECTRICAL MANAGER Date of Birth: Code A Telephone: HOME Code A E-mail address:			
57	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
58	Name: Code A Address (WORK): LEICESTER GENERAL HOSPITAL CLINICAL GOVERNANCE RESEARCH AND DEVELOPMENT UNIT GWENDOLEN ROAD LEICESTER LEICESTERSHIRE LE54PW Occupation: Code A OF Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
59	Name: Code A Address (): Occupation: Detective Constable Code A Date of Birth: Code A Telephone: E-mail address:			

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Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✱	◆
60	Name: Code A Address (): Occupation: Date of Birth: Telephone: E-mail address:			

OPERATION ROCHESTER

ADDITIONAL GENERIC CASE SUMMARY

Further to the individual case summaries, files prepared for the individual patients and the original generic case file. Additional statements, evidence has been obtained regarding events at the Gosport War Memorial Hospital. Again this file should be read in conjunction with the above mentioned submissions.

The main points covered are as follows:-

1. **Working Practices at Gosport War Memorial Hospital**

Code A – has been involved in nursing since 1959. Worked nights at GWMH since 1973 as a Health Care Support Worker. Was aware of the introduction of syringe drivers and of the concerns of the other nurses, i.e. Code A

Code A – Retired SEN involved in nursing for over 30 years. Worked at Radclyffe annex. In 1990 a new management regime was put in place and morale plummeted. Syringe drivers were prescribed by Code A as required by the patient.

2. **Supervision of** Code A

Code A – Retired in 2000 was a Medical Consultant. From 1971 was employed as a Consultant Physician in Geriatric Medicine for Portsmouth Health District. Details Code A Code A application for the Code A post and training for the post. Covers ward round roles and responsibilities. Produces her application form and letter detailing her training as JAMG/1. Left GWMH in 1992.

Code A Consultant covering GWMH, covers ward rounds and details out of hours consultant cover and the responsibilities of the Code A Has a vague recollection of the nursing concerns in 1991 regarding the use of syringe drivers. Produces a copy of a letter sent to Code A requesting him to speak to nursing staff re the concerns raised, and of notes made in the December 1991 meeting.

Further comments on the job description of the Clinical Assistant.

3. **Recovery of Letters/Minutes Of Meetings Of Events In 1991**

Code A – Chairman of the Fareham and Gosport Primary Care Trust – co-oberates and Code A recovery of the documents (JEP/GWMH/1).

Code A – Has no recollection of informing Code A that 'the matter', i.e. syringe drivers, had been sorted out.

4. **Concerns Raised by** Code A

Code A – Junior staff nurse at GWMH explains the procedure adhered to at GWMH re the administration of drugs via a syringe driver and explains the terms 'ANC' – all nursing care,

'TLC - tender loving care and 'I am happy for nursing staff to verify death'. Has no recollection of Code A expressing her concerns regarding syringe driver's.

Code A – Staff Nurse – has no recollection of Code A expressing her concerns regarding syringe drivers.

Code A – Staff Nurse – has no recollection of Code A expressing her concerns regarding syringe drivers.

5. **Working Practices/Policies and Equipment Available at GWMH**

Code A - Senior Nurse, Code A - Staff Nurse and Code A Code A all detail equipment and working practices at GWMH in particular that an ECG machine was available for use along with oxygen. In the event of a medical emergency staff would administer first aid (resuscitation) and call 999 for transfer to Queen Alexandra Hospital. Blood test results would be forwarded by post by the lab, but if urgent they would be telephoned direct

Code A – Medical Personnel Manager with Portsmouth Health Care Trust, dealt with the administration of training with the trust. Defines training and career grade posts, states that a Clinical Assistant is a substantive hospital grade.

Code A – Senior Lecturer in Palliative Medicine. Provided a 24 hours advisory service for health care professionals regarding patients at GWMH (and other health care establishments) receiving palliative care. Attended GWMH conducting out reach educational programme for palliative care, including Dryad Ward. This training included the use of syringe drivers, the analgesic ladder.

Code A – Part time staff grade in the Department Of Medicine For Elderly People at QA involved in the planning and launch of the Wessex Palliative Care Guide. Amends the 'protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion' written by Code A (ID/FGDCT/1).

Code A – Drug Information Pharmacist within Portsmouth Hospitals NHS Trust. Produces a copy of the Compendium Of Drug Therapy Guidelines For 1998.(SW/CDG/1)

Code A – Medical Support Officer produces Royal Hospital Haslar patient administrative form (DLH/DW/1) stating that 'all civilian patients transferred to the elderly medical bed placements in Gosport community hospitals must take notes (F Med 9 and enclosures) with them. Failure to do so will result in the transfer being refused.

6. **Production Of Certificates**

Code A – Team Manager in Certificate Services at the office for National Certificates produces a certified copy of the Death Certificate for:-

Code A GL/112
GL/113

Code A

GL/114
GL/115
GL/116
GL/117
GL/118
GL/119
GL/120
GL/121

(Duplicates of previously submitted certificates)

Code A – Team Manager in Certificate Services at the office for National Certificates provides a certified copy of the Death Certificate for:-

Code A DB/2013

Code A – Patient Affairs Officer. Produces the cause of death certificate book with the relevant stubs for Code A as JAS/CODC/12.

Code A – Local Services Manager at the office for National Statistics. Produces medical certificates of cause of death (MEDA22) for:-

Code A

- DW/1
- DW/3
- DW/5
- DW/6
- DW/7
- DW/8
- DW/9
- DW/10
- DW/12
- DW/13

And forms 100A – Notification to the registrar by the coroner that he does not consider it necessary to hold an inquest for:-

Code A

- DW/2
- DW/4
- DW/11
- SW/14

7. Continuity of Exhibits

Code A Separates JEP/GWMH/1 and details each document.

Code A – Receives medical records from Code A

Code A – Receives medical records from Code A

Code A – Receives the ward controlled drugs' books from Code A admission books from Code A

Code A receives documentation relating to the meeting of 1991 (SG/GWMH/1) from

Annex 1 - Detailed Chronology

Background

1. Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed previously by the Fareham and Gosport Primary Care Trust. The hospital came under the control of the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002.

2. The hospital operates on a day-to-day basis with nursing and support staff employed by the PCT. At the relevant time clinical expertise was provided by way of visiting general practitioners and clinical assistants subject to the supervision of consultants.

3. Elderly patients were generally admitted to GWMH by referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

4. Code A is a registered Medical Practitioner who in 1988 took up a part-time position in GWMH as Code A in Elderly Medicine. During the period that she worked at GWMH, Code A also worked on a part-time basis as a partner in general practice.

Police Investigations

5. Hampshire Police conducted a number of investigations, referred to below, into the deaths of elderly patients at GWMH, following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at dosages or in circumstances that hastened or caused death. The investigations also looked at further concerns raised by families of the deceased which indicated that the general standard of care afforded to patients was below an acceptable standard and potentially negligent.

6. Most of the allegations involved Code A

7. Two allegations (in respect of patients, Code A referred to in more detail below) were investigated by the Police in respect of a consultant Code A Code A Part of Code A responsibilities involved the supervision of Code A Code A

8. Of 945 death certificates issues in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Code A

9. The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the

deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

10. The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Code A

The First Police Investigation

11. Hampshire Police investigations commenced in 1998 following the death of Code A aged 91.

12. Code A died at the GWMH on Friday Code A whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

13. Following the death of Code A Code A complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Code A contacted Gosport Police on 27 September 1998 and alleged that her mother had been unlawfully killed.

14. Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

15. The Reviewing CPS Lawyer determined that on the evidence available a criminal prosecution could not be justified.

16. Code A then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

17. The complaint made by Code A was upheld and a review of the police investigation was carried out.

Second Police Investigation

18. Hampshire Police commenced a re-investigation into the death of Code A Code A on Monday 17 April 2000.

19. Code A an elected member of the academy of experts provided a medical opinion in a report dated 9 November 2000 and came to the following conclusions:

- Code A prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Code A in a manner as to cause her death."

- Code A were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Code A was unlawfully killed."

20. A meeting took place on 19 June 2001 between senior police officers, the CPS caseworker Code A Treasury Counsel and Code A

21. Treasury Counsel took the view that Professor Code A report on the medical aspects of the case, and his assertions that Code A had been unlawfully killed were flawed with regard to his understanding of the law.

22. Code A provided a second report dated 10 July 2001 where he concluded, as follows:

- "It is my opinion that as a result of being given these drugs Code A death occurred earlier than it would have done from natural causes."

23. In August 2001 the Crown Prosecution Service nevertheless advised that there was insufficient evidence to sustain a realistic prospect of a conviction.

24. Local media coverage of the case of Code A resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH and as a result four more cases were randomly selected for review - Code A Code A

25. Expert opinions were sought from a further two medical experts, Code A Code A who were each provided with copies of the medical records of the four patients in addition to the medical records of Code A

26. The reports from Code A were reviewed by the Police and a decision was taken not to forward them to the CPS as the conclusions were similar to the Code A case and that there was insufficient evidence to provide a realistic prospect of conviction. The Police then decided that there would be no further investigations at that time.

27. Copies of the expert witness reports of Code A were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement, for appropriate action.

Intervening Developments between Second and Third Investigations

28. On 22 October 2001 the Commission for Health Improvement (CHI) launched an investigation into the quality of health care at GWMH, interviewing 59 staff in the process.

29. A report of the CHI investigation findings was published in May 2002, concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality of patient care.

30. The CHI further reported that the Trust, post investigation, had adequate policies and guidelines in place that were being adhered to, governing the prescription and administration of pain relieving medicines to older patients.

31. Following the CHI Report, the Code A commissioned Code A to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

32. On Monday 16 September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Code A Immediately following the meeting Code A (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

33. The documents were copies of memos, letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including:-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (as per the Wessex Protocol).
- Particular concerns regarding the conduct of Code A in respect of prescription and administration of Diamorphine.

34. Code A disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19 September 2002. The following decisions were made:-

- To examine the new documentation and investigate the events of 1991.
- To review existing evidence and new material in order to identify any additional viable lines of enquiry.

- To submit the new material to experts and subsequently to the CPS.

- To examine possible individual and corporate liability.

35. A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

36. On 23 September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients who had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns.

37. In addition, Code A during his statistical review of mortality rates at GWMH, identified 16 cases which were of concern to him in terms of pain management.

38. 14 further cases were identified for investigation through ongoing complaints by family members between 2002 and 2006.

39. A total of 92 cases were investigated by police during the third phase of the investigation.

40. A team of medical experts (the key clinical team) were appointed to review the 92 cases, and completed this work between September 2003 and August 2006.

41. The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

42. The terms of reference for the team were to examine patient notes (initially independently) and to assess the quality of care provided to each patient according to the expert's professional discipline.

43. The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine, but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1 - Optimal care.

Category 2 - Sub optimal care.

Category 3 - Negligent care.

44. The cases were screened in batches of twenty and following this process the experts met to discuss findings and reach a consensus.

45. Each expert was instructed to retain and preserve their notes and findings for possible disclosure to interested parties.

46. All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHM to confirm the key clinical Team's findings.

47. Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly these cases were referred by the police to the General Medical Council and Nursing and Midwifery Council for their information and attention.

48. The fourteen Category 3 cases were referred to the police for further investigation. These included two cases which the police considered as part of their second investigation - Code A Of the fourteen cases, four were potentially negligent in terms of standard of care, but the cause of death was assessed as entirely natural. In the circumstances, the essential element of causation in these four cases was not capable of being proved.

49. Accordingly the following four cases were released from police investigation in June 2006:-

- Code A

50. The final ten cases (referred to below) were subject to a full criminal investigation on the basis that they had been assessed by the key clinical team as being 'negligent care that is today outside the bounds of acceptable clinical practice and where the cause of death is unclear'.

51. The investigation included taking statements from all relevant healthcare staff involved in care of the patients and family members. Medical experts were engaged to provide opinions in terms of causation and standard of care. The police took statements from over 300 witnesses.

52. The expert witnesses, principally Code A (Palliative care) and Dr Code A (Geriatrics) were instructed with guidance from the Crown Prosecution Service to ensure that their reports addressed the relevant legal issues in the context of a criminal investigation.

53. The experts completed their reports following a review of each patient's medical records, all witness statements and transcripts of police interviews with Code A Code A They were also provided with the relevant documents required

to put the circumstances of care into 'time context'. The reviews were conducted by the experts independently.

54. Supplementary expert medical evidence was obtained where necessary to clarify particular medical conditions beyond the immediate sphere of knowledge of Code A Code A

55. A common denominator in respect of the ten cases was that the clinical assistant in each case was Code A She was responsible for the initial and continuing care of the patients, including the prescription and administration of opiates and other drugs using syringe drivers.

56. Code A was interviewed under caution in respect of the allegations.

57. The interviews were conducted in two phases. The initial phase was designed to obtain an account from Code A in respect of care delivered to individual patients. Code A responded during these interviews by submitting prepared statements and exercised her right of silence in respect of questions asked.

58. During a second interview phase (following provision of expert witness reports to the police investigation team) Code A again exercised her right of silence and refused to answer any questions.

59. Code A was interviewed in respect of 2 cases Code A following concerns raised by the expert witnesses. Code A answered all questions put to him.

60. Full files of evidence were submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.
- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

61. Additional evidence was forwarded to the CPS including general healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

62. The ten category three cases were:-

Privileged and Confidential

1. Code A Admitted to GWMH 21 October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died Code A days after admission. Cause of death recorded as Bronchopneumonia and Glomerulonephritis.

2. Code A Admitted to GWMH 22 February 1996 with head injury/ brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Code A days after admission. Cause of death recorded as Cerebrovascular accident (stroke).

3. Code A Admitted to GWMH 3 September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Code A Code A days after admission. Cause of death Bronchopnuemonia.

4. Code A Admitted to GWMH 14 October 1998 with fractured left humerus and alcoholic hepatitis. Code A days after admission. Cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Code A Admitted to GWMH 26 March 1999 with a fractured neck of the femur. Code A days after admission. Cause of death recorded as cerebrovascular accident.

6. Code A Admitted to GWMH 18 August 1998 with a fractured neck of the femur, atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Code A days after admission. Cause of death recorded as bronchopneumonia.

7. Code A Admitted to GWMH 5 January 1996 with Parkinsons disease. He was physically and mentally frail; immobile, suffering depression. Code A Code A days after admission cause of death recorded as bronchopneumonia.

8. Code A Admitted to GWMH 3 June 1997 with multiple medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Code A Code A days after admission. Cause of death recorded as congestive cardiac failure.

9. Code A Admitted to GWMH 23 August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Code A days after admission. Cause of death recorded as myocardial infarction.

10. Code A 79 yrs. Admitted to GWMH 21 September 1998 with Parkinson's disease and dementia. Code A days after admission. Cause of death recorded as bronchopneumonia.

63. Code A provided extensive evidence in respect of patient care and identified particular themes of concern in respect of the final 10 category ten cases including:-

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'.*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues including:-*

Code A *- orthopaedic surgeon, microbiologist*
Code A *- general physician, gastroenterologist*
Code A *- general physician, cardiologist*
- haematologist
- psychogeriatrician
general physician/palliative care physician
Code A *- palliative care physician*

64. Many of the concerns raised by Code A were reflected by expert Geriatrician Code A, and by other experts who were commissioned to review other aspects of the medical care. Full details are contained within their reports.

65. There was however little consensus between the two principal experts Code A and Code A as to whether the category 3 patients were in irreversible/terminal decline, and little consensus as to whether negligence more than minimally contributed towards the death of patients.

66. As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to the overall expert evidence it

could not be proved that Code A was negligent to the required criminal standard.

67. Whilst the medical evidence obtained by police was detailed and complex it did not prove that the medication contributed substantially towards death. There is some expert evidence which suggests that in the case of some patients the opiates prescribed and/or administered where excessive to the patient's needs and may have hastened the patient's death by a matter of hours or days.

68. In the view of the CPS there was not sufficient evidence to prove that the doctors were criminally culpable and the CPS concluded that there was no realistic prospect of conviction.

69. Family group members of the deceased and stakeholders were informed of the decision in December 2006. The police investigation was closed.

70. ***IOC Proceedings and Referrals***

71. The IOC considered Code A case on three occasions; on 21 June 2001 (during the second police investigation); on 21 March 2002 and on 19 September 2002 (a few days prior to the police starting the third investigation).

72. On each occasion the IOC made no Order. On 13 February 2002, approximately one month before the second IOC Hearing, it appears that Code A came to the following agreement with the Isle of Wight, Portsmouth and South East Hampshire Health Authority :

- To cease to provide medical care for adult patients at GWMH
- To stop prescribing opiates and benzodiazepines with immediate effect.

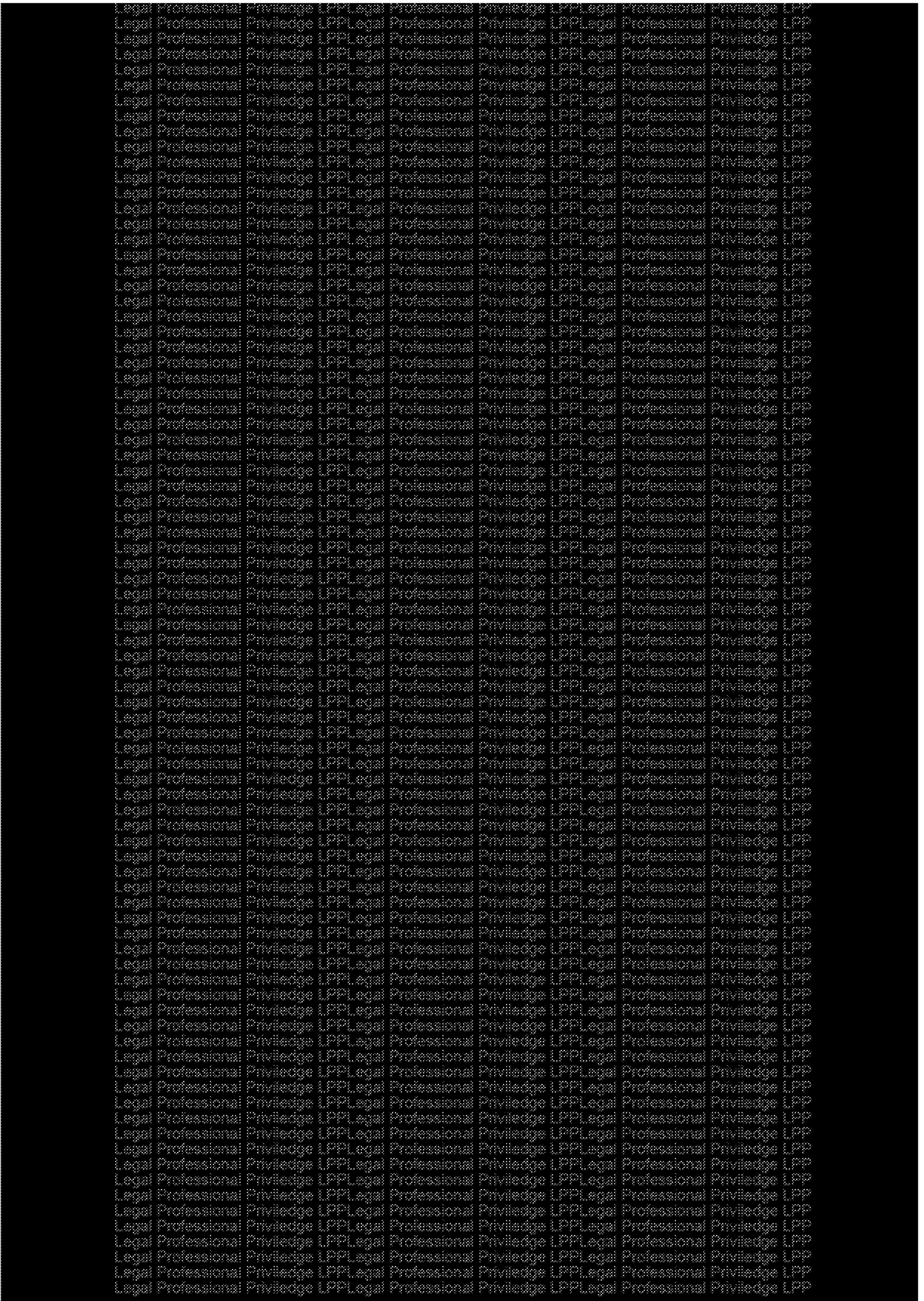
73. On 13 February 2002 it appears that Code A reached a separate agreement with the Portsmouth Health Care NHS Trust, which effectively meant that Code A Code A would no longer work at GWMH.

74. On 29 August 2002, shortly before the second IOC Hearing and one month before the police commenced their third investigation, the Preliminary Proceedings Committee decided to refer to the Professional Conduct Committee the cases referred to in paragraph 24 above, i.e. Code A Code A

75. The allegations which were referred relate to the period between February and October 1998 and include the following :-

> Inappropriate/unprofessional prescribing of opiate and sedative drugs; and prescribing in dosages and combinations which were excessive and potentially hazardous to the condition of the patients.

The cases have been "on hold" pending the conclusion of the Police investigations.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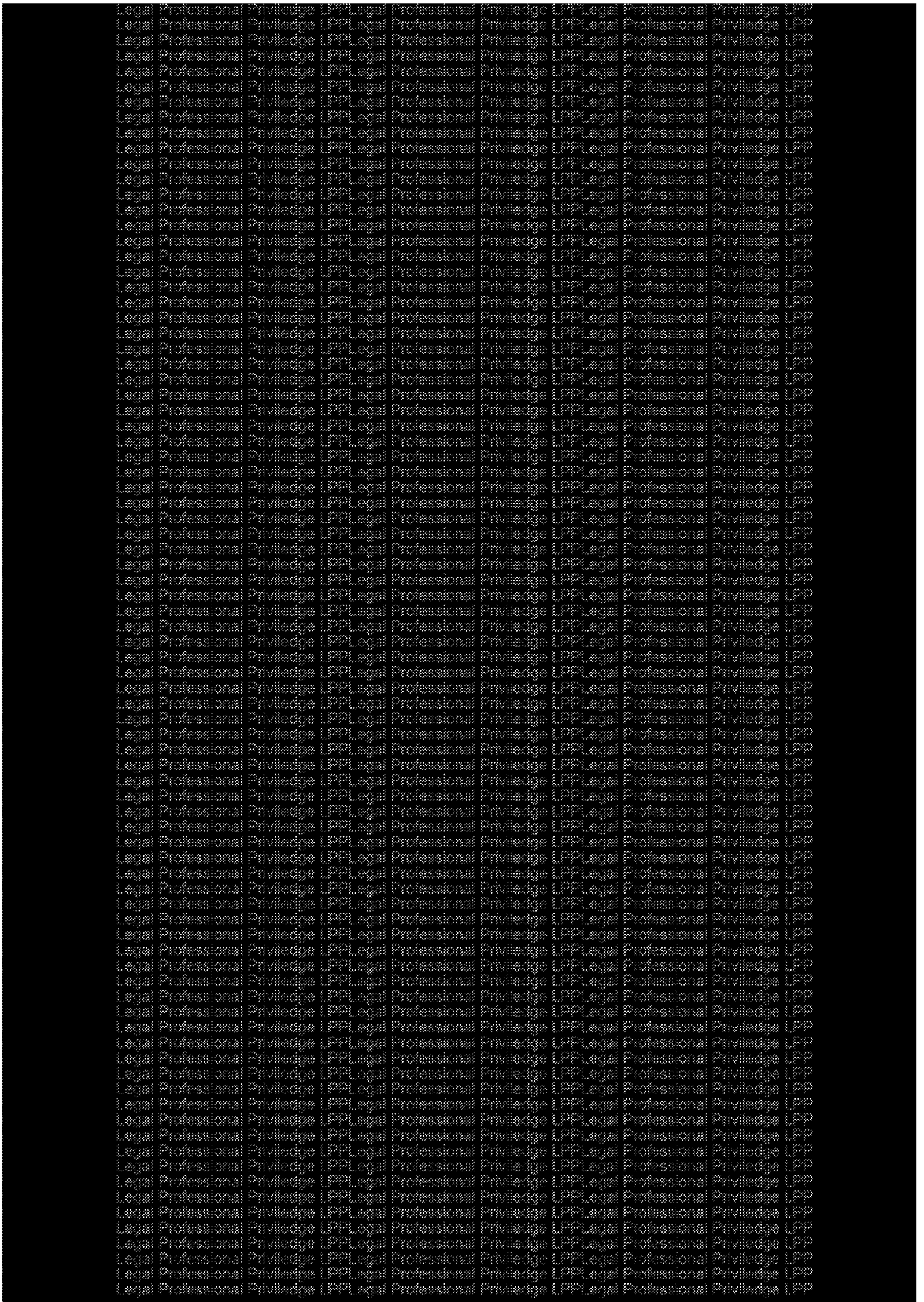
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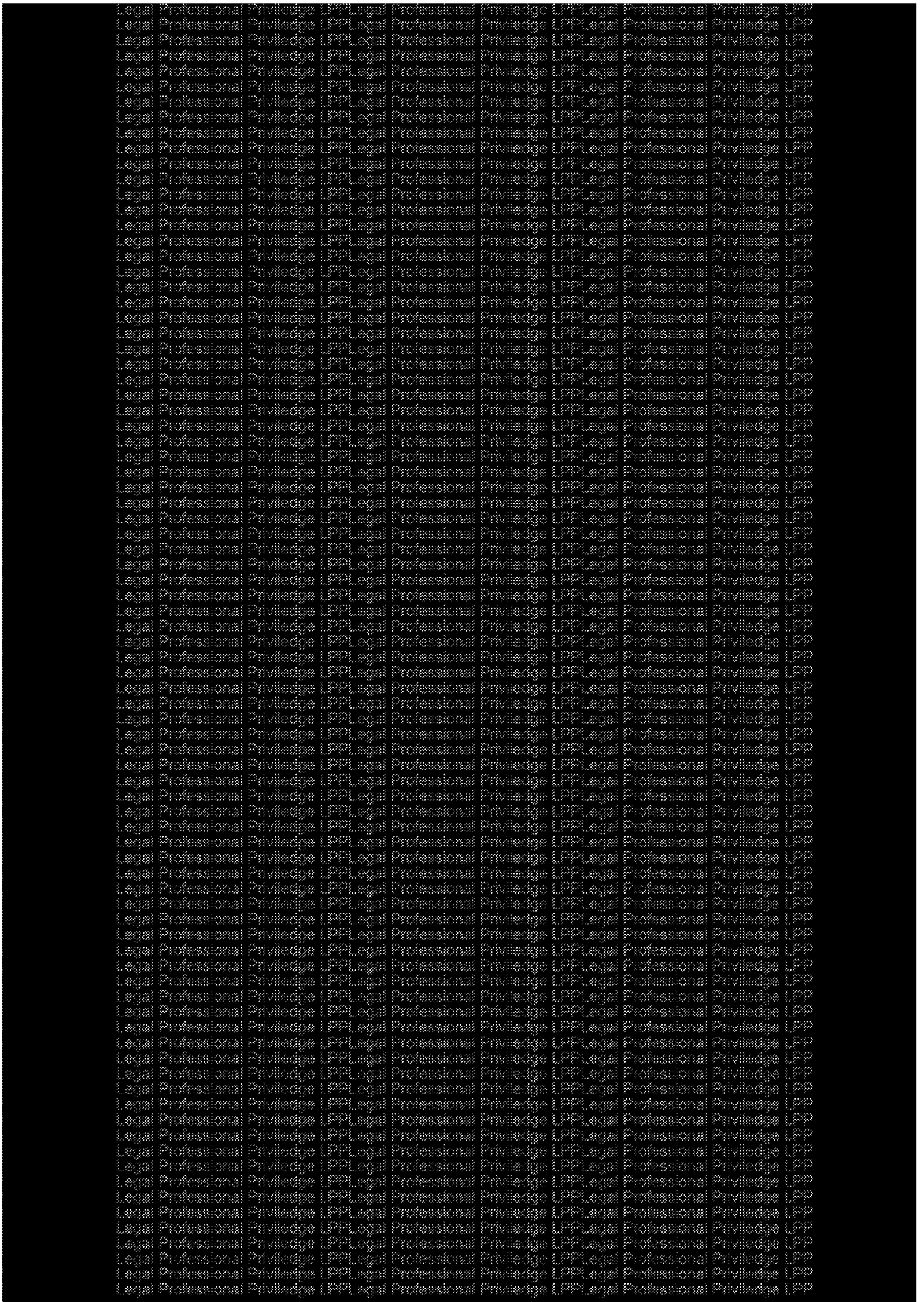
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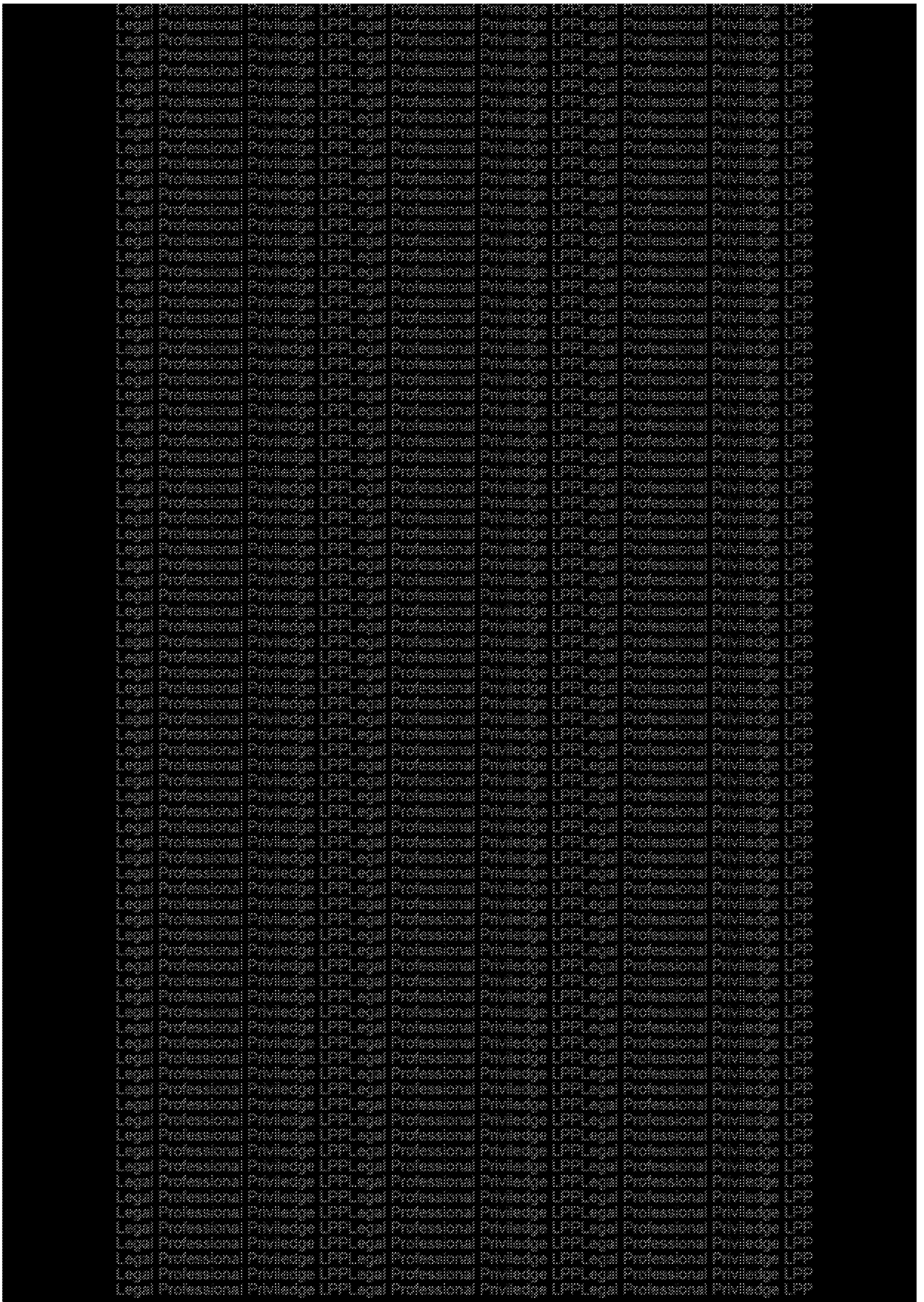
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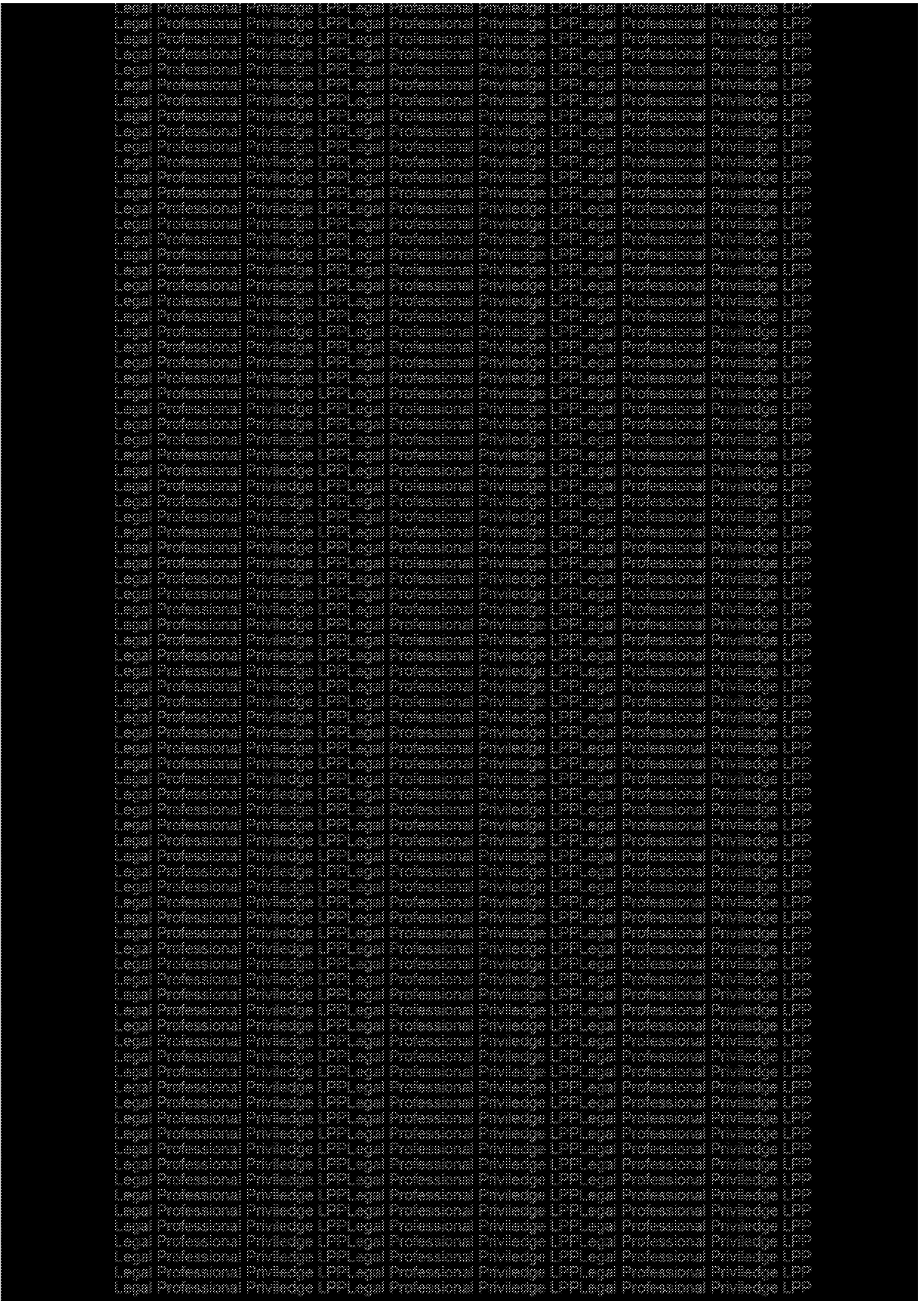
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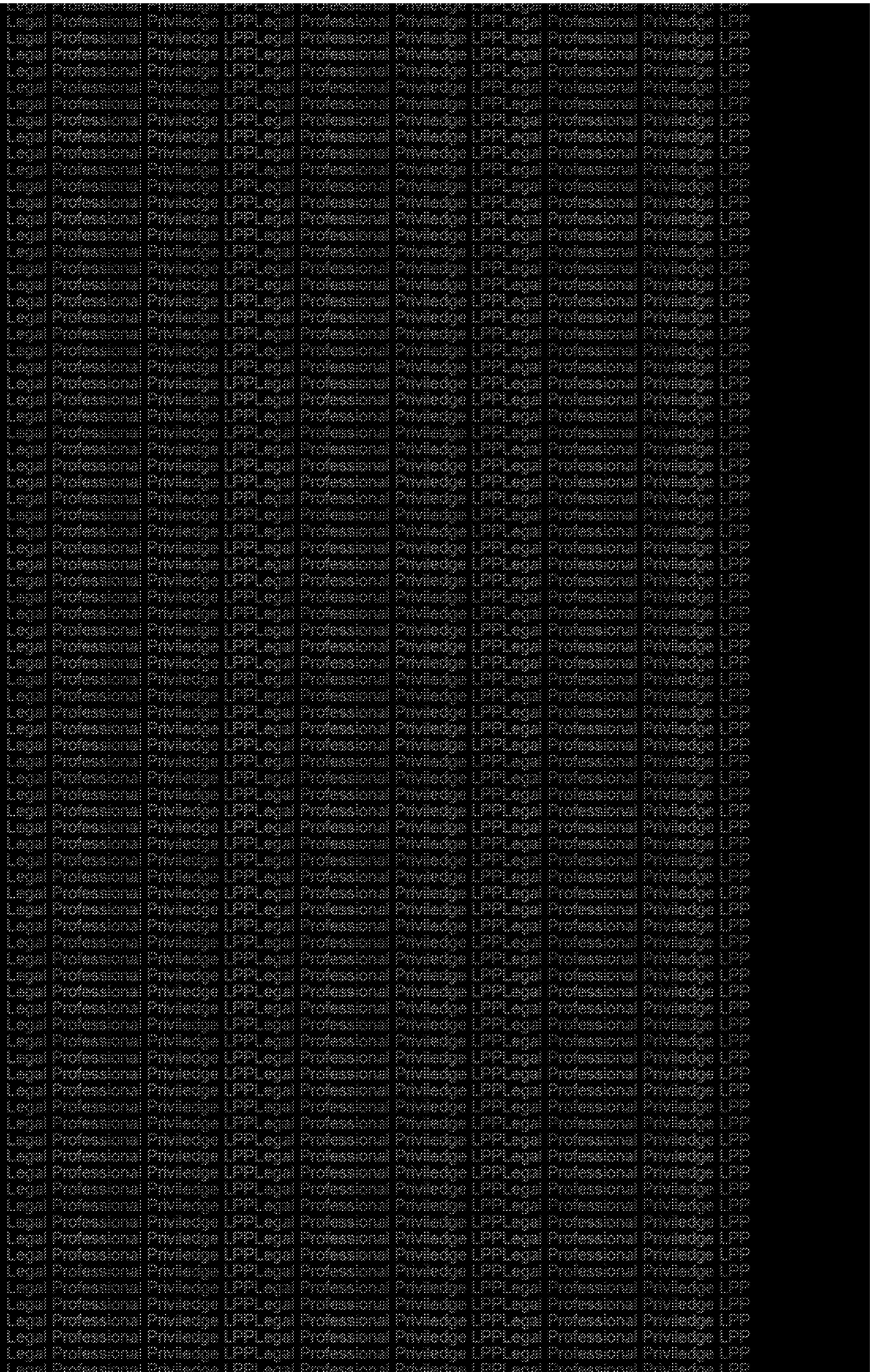
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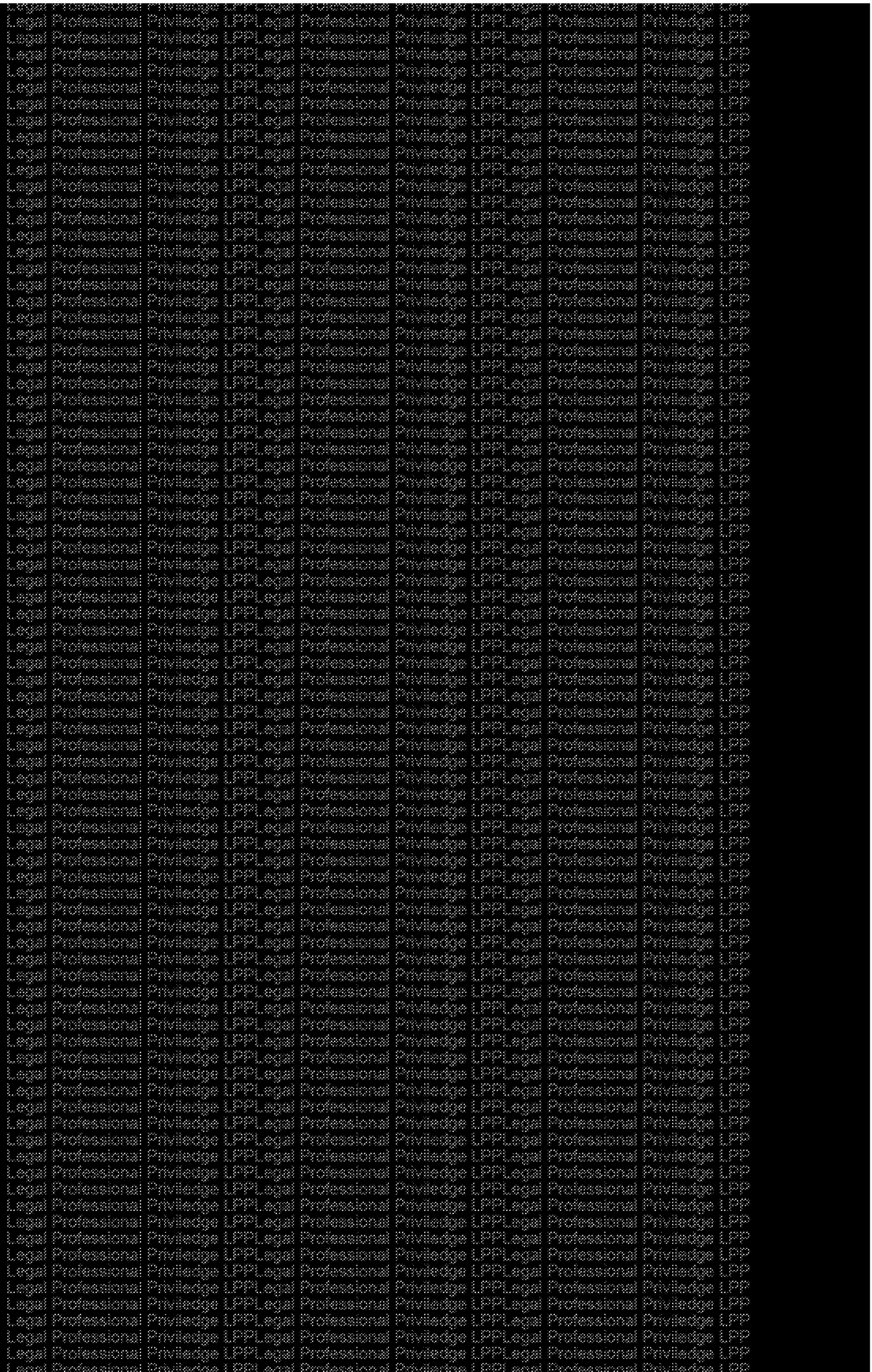
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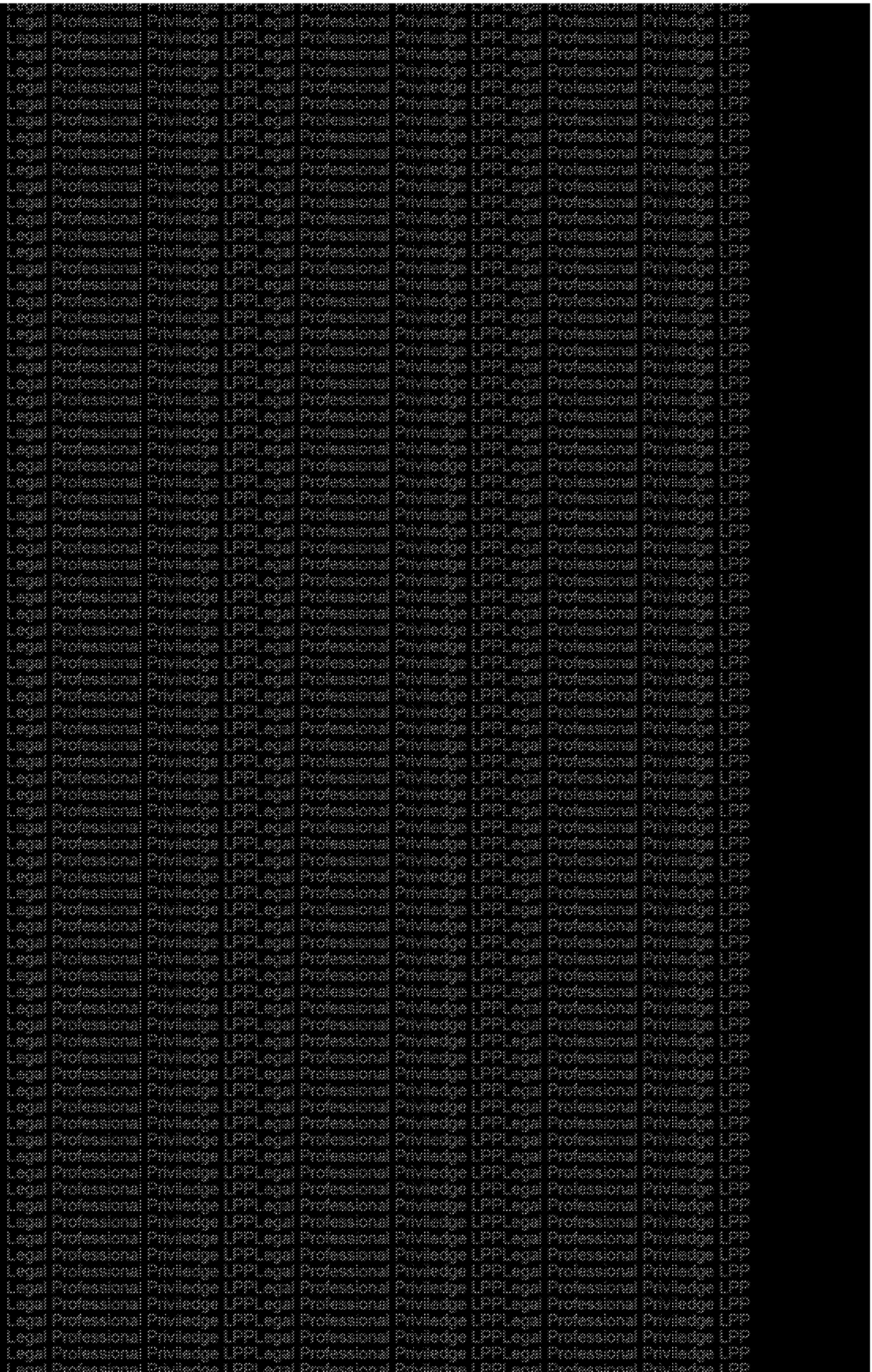
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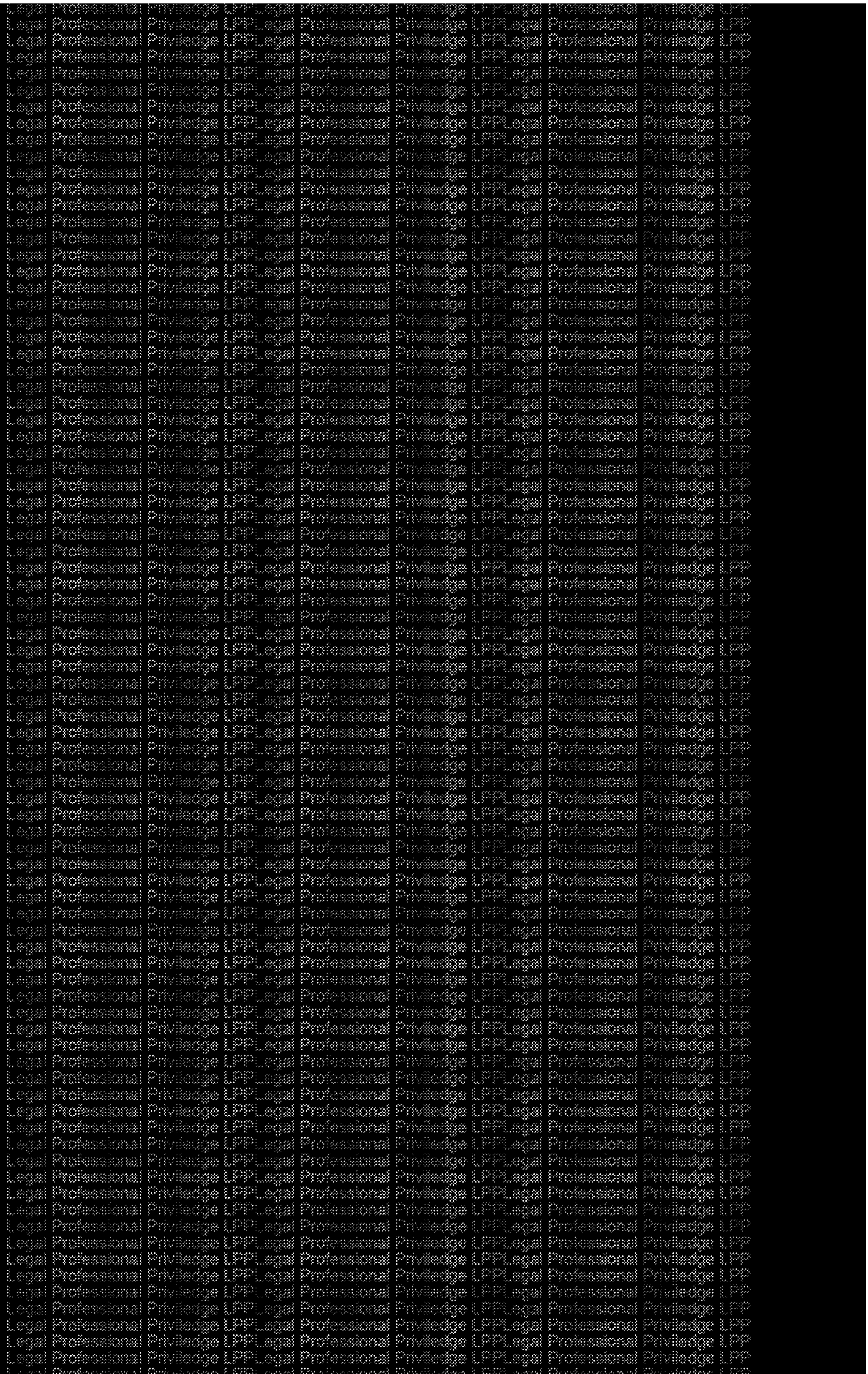
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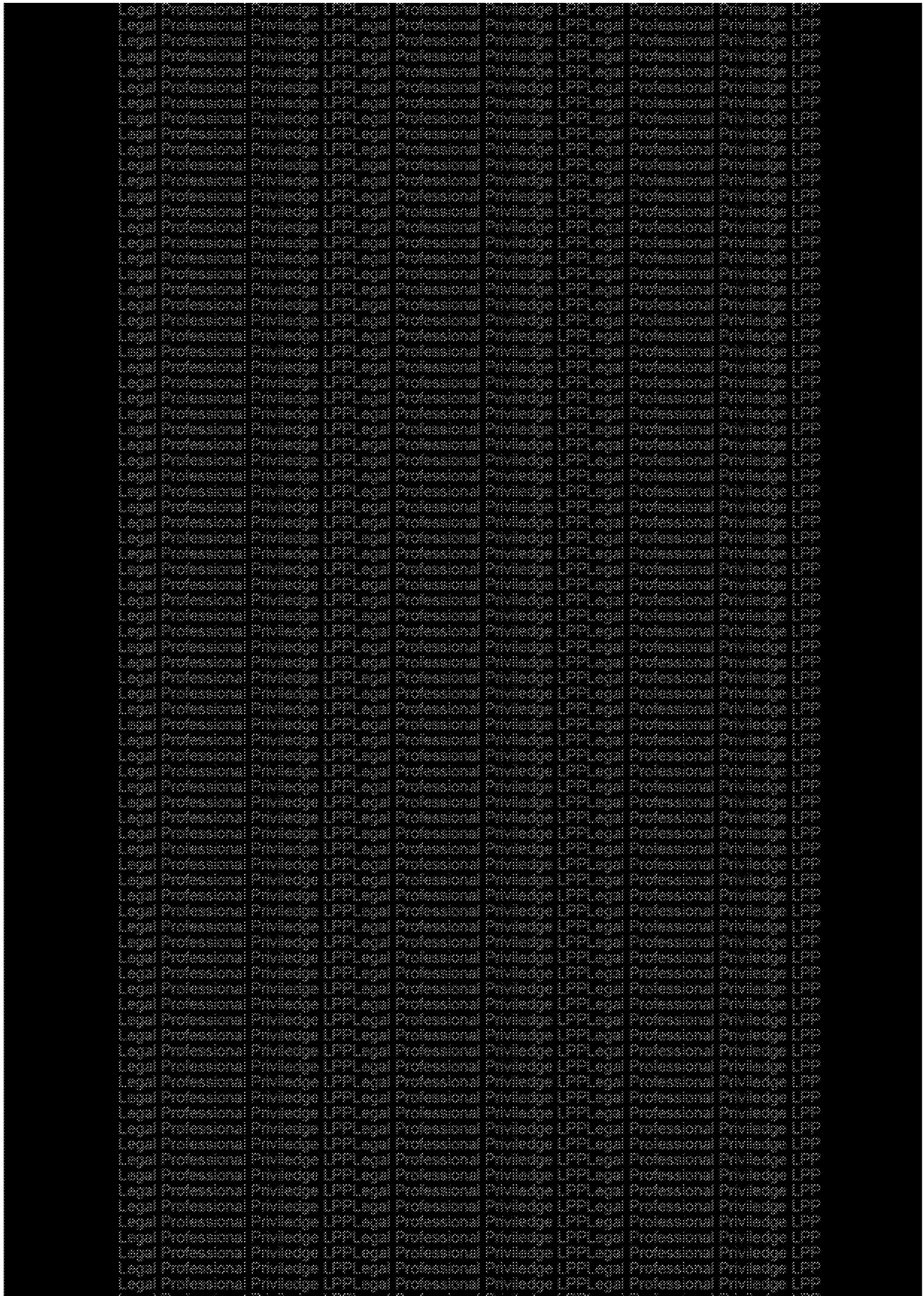
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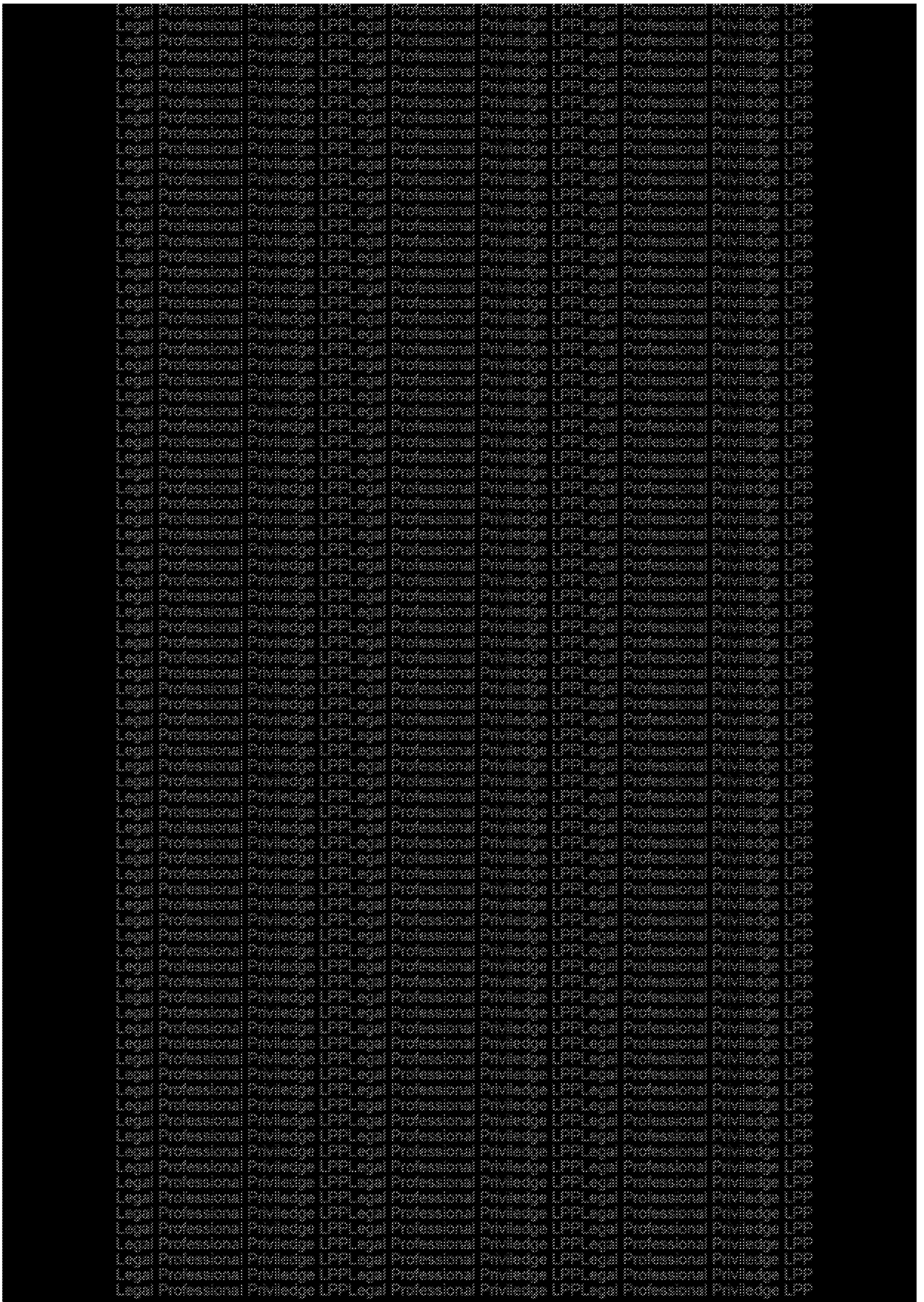
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