FFW|104|02

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER

CONFIDENTIAL

SECRET

HELENA SERVICE

Volume 2

Witness list
Witness statements

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MG 9

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

URN:

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: ALEXANDER WILLIAM TUFFEY Address (HOME): Code A Occupation: RETIRED Date of Birth: Telephone: HOME Code A E-mail address:			
2	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A 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:			

MG 9

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

URN:

WITNESS LIST

Date of completion:

* Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	*	◆
5	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
6	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
7	Name: Code A Address (HOME): Code A Occupation: RETIRED RESIDENTIAL CARE HOME PROPRIETOR Date of Birth: Code A Telephone: HOME MOBILE Code A E-mail address:			
8	Name: Code A Address (WORK): Code A Occupation: GENERAL PRACTITIONER Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			

MG 9

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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	*	◆
9	Name: Code A Address (HOME): Code A Occupation: CONSULTANT Date of Birth: Code A Telephone: HOME Code A E-mail address:			
10	Name: Code A Address (HOME): Code A Occupation: CONSULTANT CARDIOLOGIST Date of Birth: Code A Telephone: HOME Code A WORK Code A MOBILE E-mail address:			
11	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK Code A MOBILE E-mail address:			
12	Name: Code A Address (HOME): Code A Occupation: NHS NURSE ADVISOR Date of Birth: Code A Telephone: HOME Code A MOBILE 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	*	◆
13	Name: Code A Address (HOME): Code A Occupation: DOCTOR Date of Birth: Code A Telephone: HOME / MOBILE Code A E-mail address:			
14	Name: Code A Address (HOME): Code A Occupation: HEALTH VISITOR Date of Birth: Code A Telephone: HOME Code A WORK Code A MOBILE E-mail address:			
15	Name: Code A Address (HOME): Code A Occupation: MATRON / MANAGER Date of Birth: Code A Telephone: HOME Code A WORK Code A MOBILE E-mail address:			
16	Name: Code A Address (HOME): Code A Occupation: TEAM LEADER SOCIAL SERVICES Date of Birth: Code A Telephone: HOME Code A WORK Code A MOBILE E-mail address:			

MG 9

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◆ 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	*	◆
17	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
18	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE E GRADE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
19	Name: Code A Address (HOME): Code A Occupation: CARE MANAGER Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
20	Name: Code A Address (HOME): Code A Occupation: LOCUM GP Date of Birth: Code A Telephone: HOME Code A E-mail address:			

MG 9

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

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◆ 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: CONSULTANT PHYSICIAN Date of Birth: Code A Telephone: WORK Code A E-mail address:			
22	Name: Code A Address (): Occupation: LOCUM GP Date of Birth: Telephone: HOME MOBILE Code A E-mail address:			
23	Name: POLICE Code A Address (): Occupation: POLICE OFFICER DC Code A Date of Birth: Telephone: E-mail address:			
24	Name: POLICE Code A Address (): Occupation: POLICE OFFICER DC Code A Date of Birth: Code A Telephone: E-mail address:			

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: TUFFEY, ALEXANDER WILLIAM

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

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

Signed: A W TUFFEY Date: 19/10/2004

I live at the address known to the Police.

I am the nephew of Helena SERVICE nee Code A b. Code A Code A

Code A

My Aunty Helena was known as Nellie by everyone. She was born Code A

Code A

I have been asked if I know any of Aunty Nellie's medical history.

She went deaf at an early age. She was always physically fit and very alert. She was a very intelligent woman.

Code A

Code A Nellie was left on her own. She continued to live alone and was perfectly able to care for herself. She would visit us regularly.

Signed: A W TUFFEY Signature Witnessed by: Code A

2004(1)

RESTRICTED

In the early 1990's Aunt Nellie had a stroke and though she regained all of her mental faculties she lost some use in her left hand.

She continued to live alone but was supported by various home helps and meals on wheels.

In 1993 the GP recommended that Aunt Nellie needed more care than she was getting and she moved into Willow Cottage Nursing Home .

Aunt Nellie after she settled in, liked living at the home. She was able to get about with the aid of walking stick and she was mentally alert and active. She would do the Telegraph crossword every day and was a voracious reader.

In the early part of 1997 Aunty Nellie became ill. She got a bad cough and was taken into the Queen Alexandra Hospital at Cosham. She was there for a few days. We visited her here and as did Jeff and Elaine WHITE who ran Willow Cottage.

They told Nellie that they were unable to take her back to Willow Cottage as she would need a greater level of care.

Aunty Nellie was deeply distressed by this. Her cough had left her very frail and very weak.

We spoke about where Nellie could go and Geoff WHITE informed us that he had a friend who ran a nursing home which could accommodate Nellie and that she would be happy there.

I cannot recall who suggested it but someone within the hospital suggested that Aunt Nellie could go to a new unit for old people. The unit was marvellous and it wouldn't cost anything.

This unit was at the Gosport War Memorial Hospital . I didn't know where this unit was, nor did I ever visit it.

RESTRICTED

A few days later I received a telephone call to say that Aunt Nellie had been moved to the hospital and that she had died in the early hours of the morning. My aunt died on 5th June 1997 (05/06/1997).

I received a telephone call from the hospital asking why I hadn't been to the hospital to collect the documents relating to Aunt Helena.

My aunt's death was unexpected, she hadn't complained of being in any pain, she was just frail. She had desperately wanted to live until she was 100 years old.

Her cause of death is given as 1a Congestive cardiac failure and was signed by Dr J BARTON .

In accordance with her wishes she was cremated.

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: O.18 (if over 18 insert 'over 18') Occupation: RETIRED

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: 21/07/2005

I am the above named person and I live at the address shown overleaf. I make this statement with regard to Helena SERVICE . Code A over the years I got to know her quite well. She was a lovely lady and was always very happy. She enjoyed the company of friends and family and was an avid letter writer.

Helena was born on the Code A and died on the 5th June 1997. Her cause of death was shown as Congestive Cardiac Failure and the death certificate was signed by Dr J BARTON.

Code A

Helena had a very sharp mind but as she got older she became more frail. In about 1990 Helena had a stroke and lost the use of one arm and would drag her leg.

As she got older she couldn't manage to live alone. In 1994 she moved into a residential home, Willow Cottage. She had friends there and family would visit so she was happy.

I can't be sure but at some stage in 1997 Helena was sent to the Queen Alexandra Hospital in Cosham . I went down and saw her. She was, was very frail and upset because she would not be going back to Willow Cottage. She was going to be moved to a nursing home. Her mind was still very sharp and even though she was 99 we all expected her to get better.

Signed Code A Signature Witnessed by:

RESTRICTED

After leaving Helena at the QA sadly I did not see her alive again. We got a call from the Gosport War Memorial Hospital to say she had died.

As we didn't see Helena at the GWMH I am unable to comment on the care that she got.

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 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: 29/06/2004

I live at the address known to the police. I am the widow of Code A who was the son of Code A (nee Code A.

Code A was the sister of Code A (nee Code A and the family knew Helena as Nelly.

Aunty Code A used to live in Code A After her husband Code A died, she lived there on her own.

I used to visit her everyday. She had been a very fit and active lady. She enjoyed having company and was very bright and alert.

I cannot remember when, but Nelly went to live in Willow Cottage Rest Home in Hill Head, Stubbington and her house was sold.

Again I cannot remember when but Code A, Nelly's old neighbour from Harold Rd, rang me to tell me that Aunty Nelly had been taken into the Queen Alexandra Hospital, Cosham .

I went to visit Aunty Nelly there and she seemed to be alright. I remember that she had a lot of visitors.

I believe that I visited Aunty Nelly about four times whilst she was at the Queen Alexandra Hospital. I remember that she appeared to be getting better. She was chatty and cheerful.

Signed: Code A Signature Witnessed by:

2004(1)

RESTRICTED

I then got another phone call from Code A telling me that Aunty Nelly had been moved to the Gosport War Memorial Hospital , Gosport.

I don't think that Aunty Nelly was at the Gosport War Memorial Hospital for very long before she died.

I went to visit her there and at first she appeared to be alright but each time I visited her I thought she seemed 'dopey'. She didn't speak and she hardly opened her eyes. I don't think that she knew I was there.

Later she was put in a ward on her own and I remember the last time I visited her. I went in the afternoon and Code A was there as well, Aunty Nelly was asleep the whole time.

I left to go home and hadn't been indoors for very long when Code A rang me to tell me that Aunty Nelly had just died.

I was very surprised when Aunty Nelly died because I thought that she was getting better when she was at the QA (Queen Alexandra Hospital).

Taken by:DC Code A ROBINSON

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 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: 15/07/2004

I live at the address known to the police. Code A of Helena SERVICE for some thirty years.

Helena moved next door with her husband Code A when he retired. They didn't have any children but Helena's sister and brother in law lived close by and she had relatives who lived in Essex.

Not long after they moved in, Code A died but Helena kept herself busy with the Women's Institute and her gardening club.

She was a fit and active lady but was extremely deaf.

She was very funny and very happy. She had many talents and over the years I grew very close to her, she was like a mum to me.

As she grew older she became more frail but was always mentally active and alert. She would do the Daily Telegraph crossword everyday.

Sometime during her 80's, Helena suffered from a series of small strokes. As a result of this she was paralysed in her left arm.

Helena continued to live in her own home with the support of home helps. However she had problems with her eyes and I would go in and put drops in them three times a day.

RESTRICTED

She began suffering from dizzy spells and had a series of falls. Her GP, Dr REES from the Stubbington Surgery thought that she required more supervision and suggested that she might consider going to live in a residential home.

Helena didn't want to go but her nephew, Alec TUFFEY Code A and although they visited her, they were such a long way away in case of emergency that a decision was made and Helena went to live in Willow Cottage Rest Home. I visited Helena regularly at Willow Cottage as did Code A , Helena's Code A Code A

Helena enjoyed living in Willow Cottage, everyone loved her there and she was happy.

In 1997 Helena was looking forward to reaching her 100 birthday. She was determined to get her telegram from the Queen and everyone thought that she would do it.

I remember that Helena had a cough and was taken into hospital. She went into the Queen Alexandra Hospital at Cosham.

I visited her there with Code A. Code A used to take me in her car.

Helena was her usual self in the QA hospital. We would sit and chat to her. To the best of my recollection she was not in any pain nor did she complain of being in any pain.

She appeared to be getting better but it was decided that she couldn't go back to Willow Cottage as it wasn't a nursing home and she needed to more care than a residential home.

Helena was going to go into the Gosport War Memorial Hospital in Gosport whilst a nursing home was found for her. She didn't need the medical bed at the QA Hospital. I thought that she was going in for rehabilitation and would eventually go back to Willow Cottage when she had fully recovered.

RESTRICTED

Continuation of Statement of: Code A

I remember visiting her on the afternoon before she was moved to the Gosport War Memorial Hospital. I have looked in an old diary and I have an entry for 4th June 1997 (04/06/1997) saying that I visited Helena at the Gosport War Memorial Hospital (DAK/1).

I remember that I visited her with Code A and that Helena seemed to be unconscious, I held her hand and stoked her hair. She didn't seem to be the Helena I knew, she was a fighter.

I don't know what type of treatment she was having I just thought she was 99 years old and that she was in the best place for her.

The following day I got a phone call from Code A elling me that Helena had died.

I was deeply sadden by the news, I had lost a great friend and I still miss her.

Taken by:DC Code A ROBINSON

Signed: Code A

Signature Witnessed by:

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 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: 01/07/2004

I live at the address known to the police. Code A Helena SERVICE who used to live at Code A . Code A

Code A

Code A

She was extremely intelligent and would do the Telegraph crossword. She never had children but had a close family.

Code A

Mrs SERVICE was very sound in mind but her body was frail, she had a problem with her side as a result of the stroke and her eye sight needed contact lenses. Code A

Code A

Some time around 1992/1993 it was decided by Mrs SERVICE's family that she was to vulnerable to live by herself. She kept falling out of bed and they were concerned for her as they lived so far away.

Mrs SERVICE went to live at Willow Cottage Rest Home in Crofton Lane, Stubbington . She was very happy there Code A

Signed: Code A Signature Witnessed by:

RESTRICTED

As she got older she had a problem with incontinence I believe that she got a urinary infection and this was why she was admitted to the Queen Alexandra to be treated.

I remember that the people who ran Willow Cottage Rest Home were concerned about Mrs SERVICE because they felt that being a Rest Home they were unable to provide the sort of care that Mrs SERVICE needed and that she would require the facilities of a nursing home.

Mrs SERVICE did not seem ill in the Queen Alexandra Hospital, she just needed treatment for her incontinence. She was alert, bright and witty.

I visited her the day before she was transferred to the Gosport War Memorial Hospital .

She knew that she was being moved but I think that she thought that when she had fully recovered she would be going back to Willow Cottage. I told her that I would visit her at the Gosport War Memorial Hospital.

The following day I visited Mrs SERVICE at the Gosport War Memorial Hospital and I was shocked at how I found her.

She was lying on her back with her mouth wide open. She was in a room on her own.

I asked a nurse who came into the room about the change in Mrs SERVICE.

The nurse told me "A lady of this age, we have to give her something to make the journey more comfortable for her, for the journey" she also said "Sometimes they can be like this for a few days". She told me to "Hold her hand and keep talking to her".

I sat with Mrs SERVICE and held her hand and chatted away. I asked her to squeeze my hand if she could hear me but I didn't get any response.

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Continuation of Statement of: Code A

Later that afternoon Code A , Code A Code A but Mrs SERVICE never woke up.

I assumed that she had been given a drug and when it wore off she would come through.

Code A

The next day I received a telephone call from Code A to tell me that Mrs SERVICE had died.

I was shocked that she had died, she was frail but she wasn't ill, I don't recall her ever being in pain.

I have seen the publicity about the Gosport War Memorial Hospital and I wondered about Mrs SERVICE. I wondered why she was drugged.

Mrs SERVICE was a lovely lady, she was kind, a funny and very independent. Her one wish was to live to be 100 years old.

Taken by:DC Code A ROBINSON

Signed: Code A

Signature Witnessed by:

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: WHITE, GEOFFREY MALCOLM

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

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

Signed: G M WHITE Date: 25/11/2004

I live at the address known to the Police.

From September 1987 until September 2002 I was the proprietor of Willow Cottage Rest Home, 33 Crofton Lane, Hill Head, Hampshire, PO143LP .

I ran the business with my wife Elaine and we employed a number of staff.

I have been asked if I recall a former resident of the rest home, Helena SERVICE . I remember Helena very well indeed. She was a witty, intelligent lady who spent her day reading books and completing the Telegraph crossword. She had an extremely good sense of humour and was a good conversationalist. She was extremely deaf and would use a 'humphry' amplifier to hear with. Although my wife and I have retired and the rest home is closed I have kept a number of records relating to past residents.

I have in my possession records relating to Helena SERVICE. These include her Medication Records covering the periods from 1st January 1997 (01/01/1997) until 17th May 1997 (17/05/1997).

This is a record of each drug a resident was given, at what period of the day and is initialled by the member of staff who gave it (GMW/1).

I also have the 'Individual Care Plan' from 21/4/97 (21/04/1997) up to 5/6/97 (05/06/1997) when Helena died.(GMW/2)

This was a record kept by the management in relation to a resident. An entry was made when there was something out of the ordinary to note, i.e. any action taken with regards to them or if they are visited by their GP. Any changes or additions to a resident's medication is recorded here.

I also have the 'Daily Activity Report' relating to Helena from week commencing 7/4/97 (07/04/1997) until week commencing 2/6/97 (02/06/1997). (GMW/3)

This was a record kept on a daily basis by the member of staff who was dealing with a resident. It is divided into day and night, the night record being on the reverse of the page. This can be cross referenced to the Individual Care Plan.

From my records I can say that Helena came to live at Willow Cottage on 12/1/93 (12/01/1993). She was initially reluctant to stay and returned home on 9/2/93 (09/02/2003).

Once at home it became apparent that she would not be able to live alone. She returned to live with us on 12/2/93 (12/02/1993) and remained with us until she was admitted to the Queen Alexandra Hospital with heart failure on Saturday 17th May 1997 (17/05/1997).

From looking at the Individual Care Plan I can say that on 21st April 1997 (21/04/1997) Helena's GP, Dr REESE was called because she was not sleeping. Helena was prescribed 5ml of Melleril.

Helena's Daily Activity Report shows that from Sunday 27th April 1997 (27/04/1997), she was suffering from back pain which continued until Thursday 1st May 1997 (01/05/1997) when DC REESE again visited Helena and prescribed paracetamol to be taken 4 times a day.

The 'Daily Activity Report' for Monday 5th May 1997 (05/05/1997) shows that Helena was sick during breakfast with the pain in her back and then again during the night. She was bringing up phlegm and her feet were very swollen. It also notes that she was drinking plenty of fluids. The

RESTRICTED

entry for Tuesday 6th May 1997 (06/05/1997) states that Helena was up all night with back pain and that Dr REESE was again called. The entry in the Individual Care Plan shows that Helena was prescribed antibiotics for a chest infection and stronger painkillers for osteoporosis in her back and a urine sample was taken.

On Thursday 8th May 1997 (08/05/1997) the Daily Activity Report shows that Helena was still feeling unwell and that her legs were swollen. She slept all afternoon.

On Friday 9th May 1997 (09/05/1997) Helena was shown to be in a lot of pain and not well at all.

From the Individual Care Plan I can see that on Monday 12th May 1997 (12/05/1997) Dr REESE again visited Helena and diagnosed heart failure. She increased the dose of Zestril to be taken by Helena to 2 x 2 5mg.

At this point the rest home contacted Helena's next of kin.

On Saturday 17th May 1997 (17/05/199) Helena was described as being very poorly. Dr REESE was again called. It is noted in the Individual Care Plan that we were unable to provide the level of care Helena required. Our concern would have been that we would be operating beyond the terms of our Registration.

Dr REESE arranged for Helena to be admitted to F1 at the Queen Alexandra Hospital.

On Monday 19th May 1997 (19/05/1997), 20th May 1997 (20/05/1997) and Wednesday 21st May 1997 (21/05/1997) a member of staff had rung the Queen Alexandra Hospital to enquire after Helena and updated her daily activity report sheet accordingly.

From the individual care plan dated Friday 30th May 1997 (30/05/1997) I can say that I and my wife Elaine visited Helena at the Queen Alexandra Hospital. We met with Alec , Helena's nephew and his wife, Code A

RESTRICTED

We spoke with a Staff Nurse HART who, after speaking with a doctor, informed us that Helena was to be moved to the Gosport War Memorial Hospital for assessment of needs. It was thought at this stage that Helena would not be able to return to Willow Cottage because the level of care that she would require fell outside of our remit as a rest home.

At some stage around this time I sent Mr H. TENGNAH , the senior homes inspector, a Notification of Death, Illness or Accident report outlining the events in relation to Helena, in accordance with the Residential Care Homes Regulations 1984 (GMW/4).

The Individual Care Plan has an entry dated 3/6/97 (03/06/1997) noting that we received a telephone call informing us that Helena had been moved to the Gosport War Memorial Hospital.

The last entry relating to Helena on the Individual Care Plan is dated 5th June 1997 (05/06/1997). It states that we received a telephone call from Helena's nephew Alec TUFFEY informing us that Helena died at 4am (0400) that day.

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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: WHITE, ELAINE MARIA

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

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

Signed: E.M White Date: 27/06/2005

I am Elaine Maria WHITE and I live at an address known to the Police.

Between September 1987 and September 2002 I was the co proprietor of Willow Cottage Residential Care Home, 33 Crofton Lane Hill Head Hampshire . I ran the business together with my husband Geoff, and we employed a number of staff.

I have been asked if I recall a former resident of the Residential Rest Home, Helena SERVICE. I do recall her very well; she was a local lady who after a couple of strokes was unable to manage at home by herself. She was a very independent person who did not want to move into a care home. She had a trial period with us in January 1993 then returned home for a short time but was unable to cope on her own and returned to Willow Cottage permanently in February 1993.

I believe her home was sold by her nephew, but she did not want any of her own furniture to come with her saying "It was a load of old rubbish".

At Willow Cottage she had her own room which she stayed until she left.

As a person I would describe her as a very intelligent knowledgeable person. She was a great conversationalist who spoke often of her role in the last war. She had a great interest in difficult crosswords.

As I have said she suffered from strokes which caused her problems, and coupled with the fact

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that she was elderly made rehabilitation difficult.

Helena was also profoundly deaf and would use a Humphrey amplifier and microphone to both hear and speak. The fact that she was so deaf caused her to shout on occasions, in order to attract the attention of staff. She was unaware of this of course, because she couldn't hear. I recall that in our care plan notes previously provided to the police, it was often noted that Helena had shouted a great deal.

When Helena first came to us she was as good a resident as a person in her 90's could be, but latterly she became increasingly frail and used a wheelchair inside the home. She needed help with both washing and dressing. She really wanted to do these tasks herself and tried very hard to accomplish them.

She had one or two chest infections, and suffered from great pain in her back as she had osteoporosis. She was also incontinent and had a urine infection, and Dr REESE visited her at Willow Cottage several times and prescribed various medication

In May 1997 Helena was diagnosed with heart failure and she became breathless and quite poorly. We felt that we were unable to provide the level of care required, we were concerned that we were operating beyond the terms of our registration, as we were not permitted by regulations, to nurse.

On or around the 17th May 1997 Dr REESE arranged for Helena to be admitted to the Queen Alexandra Hospital at Cosham . She however did not want to go and made quite a fuss about it.

We did through telephone calls, visits and speaking to her many friends, maintain contact with her whilst she was in hospital. Her washing was still coming back to us. She did appear to making some improvement however and we were able to talk to her, she appeared to be OK, there was no dementia but she still was in pain as I recall. However on an assessment visit between my husband and I and a staff nurse at QAH at the end of May 1997 it was decided that it was inappropriate for her to return to us because of the level of care that she would require,

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and arrangements made for her to be transferred to Gosport War Memorial Hospital . She was transferred there in early June 1997 and I believe that it was two days later that we were informed that she had died on that day.

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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: REES, JUDITH ELIZABETH

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

This statement (consisting of 6 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: J.E. Rees Date: 15/11/2005

I am a General Practitioner Partner at Stubbington Medical Centre . My GMC number is Code A

My qualifications are as follows:

1971 B. Sc Upper Second Honours Biochemistry London University

1974 MB. BS (Lond) The London Hospital

1977 DCH (Eng)

1996 MRCGP

2004 Diploma in Medical Education Dundee University.

I have held the following positions:

February 1975 - July 1975	House Physician Torbay Hospital
August 1975 - January 1976	House Surgeon Torbay Hospital
February 1976 - July 1976	SHO Paediatrics Torbay Hospital
Sept 1976 - Sept 1977	SHO Paediatric Rotation Freedom Fields Hospital Plymouth
January 1978 - July 1979	Partner in General Practice Crownhill Surgery Plymouth
April 1981 - December 1981	Clinical Assistant in Paediatrics King George Hospital Ilford
January 1982 - September 1983	Partner in General Practice Buckhurst Hill Essex
October 1983 - October 1984	GP Retainer Dr Code A and Partners Gosport
October 1984 - July 1990	Partner in General Practice Dr Code A Portsmouth.

Signature Witnessed by:

RESTRICTED

I have been in my current employment as GP Partner in Stubbington Medical Practice since 1990.

I have been asked if I remember a patient named Helena SERVICE , I can say that I do remember her but not the details of her medical history. I have been asked to go through the entries in her medical notes.

I have been shown her GP notes labelled TAS/9 . From these notes I can comment on the sequence of events as follows:

Helena SERVICE had heart problems from 1984.

I first saw her in 1990 when she had fallen at home. I recall that she lived alone, had nice neighbours who were also patients of mine.

In February of 1991 she had symptoms of heart failure with shortness of breath. She refused to go to hospital and so I treated her at home and her neighbours offered to look after her. She was given Digoxin and Frusemide, which were drugs used conventionally for the treatment of heart failure. I saw her the next day when she was a lot better and her breathing had improved.

In June of the same year I was able to cut down her Frusemide (one of the drugs used to treat her heart failure) dose.

I saw her several times that year mostly on routine visits.

In March 1992 I saw her on a routine visit and noted "Marvellous old lady managing alone with help from neighbours".

In November of the same year I saw her after she had fallen. No treatment was required.

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In December 1992 she was seen by one of my partners having collapsed onto the floor at home. Mrs SERVICE was admitted to A&E at Queen Alexandra Hospital and following a short stay in hospital she was discharged to Willow Cottage Rest home as she was felt unable to cope on her own at home, where she remained.

In May 1993 I treated her for an eye infection.

She was seen by a GP colleague in October 1993 and treated for a chest infection.

In March of 1994 I treated her again for another chest infection. I saw her twice in May firstly for back pain and then when she had a small stroke.

In December 1993 I saw her on a home visit with increasing shortness of breath and treated her with Frusemide for heart failure.

I saw her once again the following month, January 1994, by then she was a little worse, I would have preferred her to go to hospital but she declined to be admitted. I prescribed an additional heart failure drug Lisinopril (Zestril). I was concerned about her and I decided to discuss her case with a consultant geriatrician colleague. I spoke with Dr LORD who suggested increasing her Lisinopril and substituting her Frusemide for Bumetanide - a stronger diuretic.

I saw her in May 1996 when she had a skin infection followed in June by an itchy rash.

In December of 1995 Helena SERVICE was treated by a colleague for a respiratory tract infection.

In January 1996 I referred her to the orthopaedic department at Queen Alexandra Hospital with a swollen hot right wrist, as I was concerned she may have a joint infection. That diagnosis of septic arthritis was confirmed and she was treated in hospital.

In September of 1996 she was treated by a colleague for a chest infection.

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In March of 1997 she was seen by me as she was shouting at night apparently keeping the other residents awake. I prescribed a small dose of a sedative, Melleril, to be administered by care staff in the Rest Home for night time agitation.

Early in May of 1997 she complained of low back pain treated with paracetamol.

A few days later she developed a fever and a chest infection and was treated with antibiotics.

On the 12th May 1997 (12/05/1997) her drowsiness increased, she had ankle swelling and her chest infection appeared to have exacerbated her heart failure symptoms. She was very unwell and in my judgement was dying and I did not think that hospital admission was appropriate. After discussion with the staff at Willow Cottage I decided to recommend nursing care and monitoring at home. On the 17th May 1997 (17/05/1997) I again visited her at the home. She was hot, drowsy and dehydrated. The rest home were unable to provide the level of nursing care she now required so I admitted her to Queen Alexandra Hospital.

I have been shown a copy of a letter contained on pages 51 and 52 of Helena SERVICE's hospital notes labelled BJC/72 . This is the letter sent with Mrs SERVICE when she was admitted. The letter is written and signed by myself and is dated 17/05/97, it reads as follows;

Dear Dr LISTER ,

Thank you for admitting this elderly lady who has a history of gout, non insulin diabetes, CCF. She has been seen by Dr TANDY in the past.

She recently developed a UTI & responded initially to antibiotics. She has now been increasingly short of breath, confused, disorientated and the rest home is unable to cope with nursing her.

Her current medication is.

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Zestril 2.5mg bd

Bumetanide 1mg daily

Aspirin 75mg daily

Melleril Syrup 25mg at night if required.

Allopurinol 100mg once daily.

Thank you for your help.

Yours sincerely

Judith REES

Signed: J.E. Rees

Signature Witnessed by:

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: MILLAR, JAMES GAVIN BURNETT

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

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

Signed: J G B MILLAR Date: 12/07/2005

I am a retired physician having given up my clinical duties in 1999. Prior to this I was employed as a general physician working at Queen Alexander Hospital at that time.

I qualified as a doctor in 1964 obtaining a MBChB, a bachelor of medicine and a bachelor of Surgery at Cambridge University and St Mary's Hospital, London. I obtained MRCP, Membership of the Royal College of Physicians in 1968 and was elected Fellow in 1980. After working under the direction of Sir John NABARRO at The Middlesex Hospital, London I was appointed Senior Lecturer in Medicine (Endocrinology) by the University of Southampton with an honorary consultant contract with the Wessex Regional Health Authority in 1975. Endocrinology is the speciality concerns with hormones and the glands that produce them.

My training posts, ie, pre registration house officer was in St Mary's Hospital, London and Hillingdon Hospital, with further training posts at West Middlesex Hospital, Isleworth, The Middlesex Hospital, St Mary's Hospital, London, The Middlesex Hospital and the Central Middlesex Hospital, Acton. During the period when I was in training posts my duties always included General Medicine as well as the practise of my speciality, ie, from 1964 to 1975.

In 1975 I took a consultant post at the Queen Alexandra Hospital and St Mary's Hospital, Portsmouth with responsibility for general medical patients, ie, heart attacks, strokes, infection and other acute non surgical condition.

From 1979 to 1994 all of my in patients were at St Mary's Hospital. From 1994 until my retirement they were all in Queen Alexandra Hospital. As a consultant I led a team of doctors

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that would include junior house officers, senior house officers and a senior registrar. The doctors reported to me, patients admitted as an emergency would be assessed and treated by members of my team. They would normally be seen by me within 24 hours. The diagnosis and treatment plan reviewed and discussed with nursing staff and recorded in the patient notes. Continuing management of the patients would be the responsibility of my team except when off duty at which time the duty team would take over.

Routine ward round took place twice weekly by myself together with my medical team and the nursing staff. I would also perform ward rounds to ensure that all patients were seen by me within 24 hours on admission. Junior and senior house staff would monitor the progress of patients from day to day adjusting treatment and reporting to their seniors as necessary.

When patients conditions permitted plans would be made for their discharge or transfer for the purposes of further treatment.

My GMC number is Code A

I have been asked to detail my involvement in the care and treatment of Helena SERVICE (BJC/72) . I have no clear recollection of this patient but by referral to her medical notes I can say that Mrs SERVICE was under the care of my team. I am unable to say who made the initial assessment of Mrs SERVICE on 17.5.97.

On the 18th May 1997 I conducted a ward round again with a members of my staff, one of whom, I am unable to say whom, made a clinical note that reads (page 158).

18/5/97 SB JGBM
Apyrexial
Mildly dehydrated
More alert than o/a
P-80 JVP↓ BP 125/80
Chest clear

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(P) continue iv fluids & regular digoxin

i/v Cefuroxine

JGBM are my initials and indicate to me that this was my ward round. Apyrexial means that the patient had a normal temperature. Mrs SERVICE was mildly dehydrated, this could be seen by looking at her tongue and skin. More alert than o/a (on admission). This would have been an observation by a member of my staff and nursing staff. The pulse rate was normal, P-80. Her jugular veinous pulse was not elevated and the clear chest sounds suggested an improvement in the function of her heart.

The plan was to continue intravenous fluids, for her dehydration and regular doses of digoxin to control her heart rate and cefuroxine to maintain her lungs free from infection. Cefuroxine is an antibiotic.

During my review of Mrs SERVICE I would have examined Mrs SERVICE's chest x-ray and read her clinical notes. The senior registrar had already noted on her chest x-ray on 17.5.97 at 1900 hrs bilateral + effusions, upper lobe blood diversion and fluffy shadowing of the lung fields. These are classic indications of left heart failure.

Subsequent entries in the notes show that Mrs SERVICE's cardio vascular (heart) and respiratory (breathing) problems continued to improve but attempts to mobilise her proved difficult. On the 28th May 1997 she was therefore referred to the elderly care medical team. This was recorded in the medical notes (page 162) asking for consideration of the measures for continuing care. She was seen by Dr ASHBAL who recorded his observations in the medical records Page 162 and subsequently wrote to me about his plan to transfer Mrs SERVICE to Gosport War Memorial Hospital for assessment with a view to considering continuing care (page 39). This letter is addressed to me as I was the consultant in charge of Mrs SERVICE's care during her admission at Queen Alexandra Hospital.

My final assessment of Mrs SERVICE was on 3rd June when it was recorded page 163

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3/6/97 WR Dr MILLAR

Well

Gosport today.

This is then signed by a person whose signature I am unable to recognise.

This was a ward round conducted by myself. I found that Mrs SERVICE was well and to be transferred to Gosport War Memorial Hospital later that day. I was satisfied with the advisability of this plan.

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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: MILLAR, JAMES GAVIN BURNETT

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

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: J.G.B. Millar Date: 23/09/2005

Further to my statement dated 12th July 2005 (12/07/2005). I have been further shown Page 25 of Mrs Helena SERVICE's medical record (BJC/72) and page 24. Page 24 refers to Mrs SERVICE's Bartel ADL (Activities of Daily Living) Index. It is dated 3rd June 1997 (03/06/1997) and shows a score 0 for all categories.

Although there is no entry in relation to the patient's bladder this form is an assessment of the patient's capabilities of daily living and it therefore reflects there independence, or lack there of. The scores of zero represent a need for a high degree of care, i.e. caring in a nursing home or a hospital. This form is completed by the nursing staff and is used by them and they will base their advice on the basis of there assessment to other medical staff, nursing staff, healthcare staff. Page 25 is Mrs SERVICE's water low pressure score prevention, Treatment Policy. Again this form is completed by the nursing staff and is used by them to assess the damage and helping the prevention of pressure sores. The responsibility for managing pressure sores lies with the nursing staff and I would not have expected a direct report from the nursing staff on the contents of that document.

Gosport War Memorial Hospital was a hospital that had the facilities to cope with the problems identified by the Bartel Index and the water low score. It therefore would not have been a factor in deciding if Mrs SERVICE was fit to be treated there.

I have also been shown page 269 of BJC/72. This is a regular prescription chart for Mrs SERVICE that covers 29th May through to 3rd June 1997 (03/06/1997). Page 270 is a regular prescription chart from the 17th May to 28th May 1997 (17-28/05/1997) for Mrs SERVICE.

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Page 272 is again a regular prescription sheet covering 19th May to 22nd May 1997 (19-22/05/1997). This page shows that CEFACLOR SR was prescribed on 19th May 1997 (19/05/1997) and administered twice daily at 6am (0600) and 6pm (1800) at a dose of 300 mgs by mouth. CEFACLOR is an antibiotic. It had been prescribed as treatment for a chest infection.

Page 273 is a prescription sheet for Mrs SERVICE that covers once only prescriptions and as required prescriptions. As required prescriptions could be given by nursing staff at there discretion, these were: -

MELLERIL (Thioridazine) 25 mgs, by mouth. This was administered at night (nocte pm rn) as necessary. This is a sedative commonly used to aid sleeping. It appears that this drug has been administered nightly for the duration of her admission, although one entry is not clear.

PARACETAMOL 1 gram by mouth as necessary. It is given for pain relief and one dose was administered on 25-5-97 (25/05/1997) at 0825 hrs.

OXYGEN was prescribed at a concentration of 35% to be given by mask. It is shown on page 157 that it was to be used after the patient's initial assessment, the date and time when it was discontinued do not appear to have been recorded. The oxygen was prescribed to improve her breathing that had been affected by her heart failure, and chest infection.

DIGOXIN 250 micrograms, (on admission) 17th May 1997 (17/05/1997) at 1630 hrs by mouth and this was repeated 12 hours later on 18/05/1997 at 0430hrs. DIGOXIN is used for heart failure, particularly when a rapid and irregular heart has resulted from atrial fibrillation as in the case of Mrs SERVICE.

Page 270 shows regular prescriptions as follows: -

ZESTRIL (LISINOPRIL) was given at a dose of 2.5 mgs by mouth twice daily starting on 19th May 1997 (19/05/1997) until date discharge (Page 269). This drug is used to improve heart

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failure by reducing the pressure against which the heart has to pump.

BUMETANIDE was given at a dose of 1 mg by mouth daily from 19th May 1997 (19/05/1997) until the date of discharge (P. 269). Bumetanide is a drug used for heart failure. By its diuretic action, i.e. it increases the excretion of salt and water of the kidney and thereby reduces the volume of blood that the heart has to pump around the body.

ASPIRIN was given at a dose of 75 mgs by mouth from the 18th May 1997 (18/05/1997) until the date of discharge (P. 269). Aspirin at this dose is used to prevent thrombosis.

ALLOPURINOL was given at a dose of 100 mgs daily by mouth from the 17th May until the day of discharge, although it was omitted on 20th, 21st, 28th May . On the first of those dates it was noted that it was omitted, as the patient was too drowsy when the drug was due, page 271. Allopurinol is used to prevent gout, which is otherwise a common side effect of diuretic treatment.

CEFUROXIME was given at a dose of 750 mgs intravenously from the day of admission until the 19th May 1997 (19/05/1997) at which time the treatment was change to CEFACLOR, which is an oral antibiotic with the same effect.

The last drug on page 270 is DIGOXIN at a dose of 125 micrograms by mouth that was given from 19th May until the day of transfer. After the initial two doses detailed previously, it is normal practice to continue at a lower dose with occasional measurements of the level in the blood, such a measurement was made on 23rd May.

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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: HEATLIE, GRANT JAMES

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

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: G.J. Heatlie Date: 12/11/2005

I am a Consultant Cardiologist, with a special interest in cardiac imaging, at the University Hospital of North Staffordshire NHS Trust, Stoke-on-Trent, I have held this post since 2004.

My academic qualifications are:

1987	BSc Hons (First Class) in Mathematical Physics, Edinburgh University.
1990	PhD Southampton University
1995	MBBS Newcastle University.
1998	MRCP (UK).
2000	British Society of Echocardiography accreditation in transthoracic echocardiography.
2002	British Pacing and Electrophysiology Group certificate of competence examination.
2003	British Society of Echocardiography accreditation in transoesophageal echocardiography.
2004	Level 3 (Facility Director) credentialing of the Society of Cardiovascular Magnetic Resonance.

My previous appointments are:

1995	House Physician Newcastle General Hospital.
1996	House Surgeon Kings Mill Hospital, Mansfield.
1996-98	Senior House Officer Rotation in Medicine, Queen Alexandra Hospital,

Portsmouth.

1998-99 Specialist Registrar in Cardiology, Princess Royal Hospital, Haywards Heath.

2000-2005 Specialist Registrar in Cardiology, Queens Medical Centre and City Hospital, Nottingham.

2003-2004 Specialist Registrar in Cardiac Magnetic Resonance, Royal Brompton Hospital, London.

Between 1996 and 1998 I was employed as a Medical Senior House Officer at Queen Alexandra Hospital, Portsmouth. Between February and August 1997 I was working as part of the team headed by Gavin MILLAR (Consultant) and Darryl MEEKING (Senior Registrar).

Part of my role would be to see new admissions on the medical wards, I would generally be the first or second doctor to see such patients. If a patient was admitted as an emergency the patient would be seen in Accident and Emergency and if appropriate would then be transferred onto a medical ward. It would then be normal for the duty team to take that patient on, though if a consultant had some previous dealings or knowledge of a patient their treatment would be the responsibility of that consultant and his team from the next normal working day. I have been asked if I recall a patient named Helena SERVICE, I have no memory of the name, I have however been shown a copy of her medical notes (BJC/72) and do recollect a lady who had a 'hearing trumpet' of some kind. The notes show that she was admitted as an emergency via her GP and with an accompanying letter. Pages 155, 156 and 157 of the history sheets are the initial clerking notes dated 1400 17/05/1997. These were probably written by a house officer, I do not recognise the signature though the bleep number is 110.

On page 158 is an entry dated 1900 17/05/1997. This entry indicates to me that she was for our team, I have started the entry off by writing SHO, however I have then crossed this out and it is then followed by the writing of Darryl MEEKING. This also indicates that I probably started to examine Helena SERVICE and was joined by Darryl who then took over and wrote the entry. As I have said this is not my writing but I believe his note reads as follows (with explanations in brackets):

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SR Review. Thank you. I note Hx. (History) Ċ evidence LVF (With evidence of left ventricular failure)

ECG. Q waves inf. T waves inv Cxr bilateral effusion ULBD Fluffyfields.
Imp Dehydrated + LVF
Not a candidate for inotropes.
xx not for 555 xx
Plan Rehydrate as above antibiotic cover.

Darryl MEEKING has then signed it.

What this shows is that her electrocardiogram (ECG) and chest x-ray (cxr) showed findings of heart failure. She was not suitable for inotropes, these are drugs which make the heart work harder but as her heart condition was not reversible they were considered as being inappropriate. The Q waves and T waves are patterns on the ECG, which indicate previous damage to the heart muscle. ULBD is upper lobe blood diversion, this is another sign of heart failure.

555 is the code given for resuscitation should a patient's heart stop beating. This is a form of treatment and as in all forms of treatment careful consideration has to be given as to who receives it. In Helena SERVICE's case it was considered inappropriate due to her current and past medical history, her age, her poor outlook and that her heart condition was non reversible.

On page 159 I have written an entry timed at 1500 on 19/05/1997 which reads:

SHO. Improved mx as above. I have signed the entry. Mx means manage, so the entry shows that the patient was improving, she seemed to be getting better and that the treatment should be the same as previously written up.

There are three further entries on that page, one is dated 20/05/1997 and another dated 22/05/1997, in between these is an undated entry, which is written by myself. I assume that this was probably written on the 21/05/1997, I say this as patients would normally be seen at least once a day during the normal working week and there is no other entry relating to the

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21/05/1997. The entry reads as follows:

SHO.
ISQ
Apyrexial
90 AF
Ct as above.

I have signed the entry

Again this shows that she was improving, ISQ means "In Status Quo" (unchanged).
Apyrexial shows that her temperature was normal.
90 AF shows that her irregular heart rate had improved.
Ct means continue as above.

My next entry is dated 28/05/1997 and reads as follows:

SHO.
Barthel 4
will need ct care.

Dear Geriatrician,

Thanks for seeing this delightful 99 year old lady who presented to us in some LVF. She is better but with a Barthel of 4 can't go back to NH or RH (she was in a RH).

Thanks for considering continuing care.

Don't forget to use 'Humphrey' when talking to her!!

Thanks

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Grant HEATLIE
(HEATLIE, SHO to Dr MILLAR)

The entry is signed by me.

Regarding this entry I can explain that the Barthel score is a means of determining the independence of a patient, it gives an indication of the patient's ability to cope with various aspects of daily living. It is normally recorded on a simple form and although this can be carried out by doctors, it is usually completed by the nursing staff. In this case I see that on page 267 of the notes, which is a page of the nursing continuation sheets, somebody has recorded the low score (4) and that they contacted myself with regards to referring Helena SERVICE to Elderly Services. The entry is dated 27/05/1997. Page 267 of the notes shows the Barthel ADL Index form dated 27/05/1997 and that the score was 4.

The score was very low and in these circumstances the patient is clearly not in a position to return to a nursing home or rest home therefore we should see if she was suitable for continuing care. Consequently I wrote the entry effectively asking the geriatrician from Elderly Medicine to assess her.

The next entry in the notes is dated 29/05/1997 and is signed Dr ASHBAL, he agrees to transfer her to Gosport war Memorial Hospital for assessment regarding continuing care.

The same day, 29//05/1997 I wrote a further note which reads:

Thank you Dr ASHBAL, plan as above. I signed the entry.

My next entry is dated 30/05/1997 and starts off with a note regarding a different patient by mistake:

SHO

Looks a little better only eating and drinking with bullying. Temp 37.1. Wrong patient. I have then crossed this out and written the following:

SHO.
Well
ISQ
Ct.

I have signed the entry.

In this case well is a relevant comment rather than absolute, i.e. it relates to how she was then compared to how she was on admittance. Again nothing had changed and the plan was to continue as previously.

I note that she was transferred to Gosport War Memorial Hospital on 03/05/1997.

I have been shown Helena SERVICE's GP medical records with an exhibit number of TAS/9. Within these notes is a Discharge Summary dated 18/06/1997 after the headings the summary reads as follows:

Diagnoses: Left ventricular failure
Ischaemic heart disease
Atrial fibrillation

HISTORY: This delightful 99 year old lady was admitted with increasing shortness of breath and confusion.

ON EXAMINATION: There were some signs of cardiac failure. (mild.)

MANAGEMENT: We admitted her and treated her with some antibiotics and diuretics. She

made a good improvement. Her hearing aid was rather temperamental at the start of her admission but soon settled down and provided much amusement to everyone who was talking to her. She certainly looked very well.

We asked Elderly Medicine Dept to review this lady and they kindly have taken her to Dryad Ward at Gosport War Memorial Hospital for some further assessment re continuing care.

DRUGS ON DISCHARGE: Lisinopril 2.5 mgs bd Bumetanide 1 mg mane Aspirin 75 mgs mane Allopurinol 100 mgs nocte Digoxin 125 mcgs mane.

FOLLOW UP: Nil.

I have then signed the letter.

"She certainly looked very well" - while I have no direct memory of this letter, I would have been commenting on the fact that she had improved generally during her admission. This of course does not mean that she was cured of her heart failure, rather that we may have improved her condition and got rid of some of the excess retained fluid with the diuretic treatment. I would stress that this is a very elderly lady who has just got over an episode of heart failure bad enough to necessitate her admission to hospital so again the description "well" is a relative one.

Lisinopril is a drug called an "ACE Inhibitor" - it is used in heart failure to try and improve the heart function. Bumetanide is a diuretic used to treat water retention, which is common in heart failure. Aspirin is widely used to try and reduce the chance of a heart attack or stroke. Digoxin is a treatment used to regulate the speed of an irregular heart beat. Allopurinol is a treatment used for gout.

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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: PRACTICE EDUCATOR

This statement (consisting of 6 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 09/08/2005

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

I am a Registered General Nurse (RGN) but at present my title is a Practice Educator at the Queen Alexandra Hospital, Cosham Portsmouth.

I qualified in 1985 as a State Enrolled Nurse (SEN) converting in 1992 and my Nursing and Midwifery Pin No is Code A

Between 1983 and 1985 I was a student nurse at the QAH

Between 1985 and 1992 I was an SEN on an acute medical ward at QAH

Between 1991 and 1992 as I have said I converted from an SEN to an RGN and I undertook work experience at the Countess Mountbatten Hospice Southampton, the Chest Clinic at St Mary's Hospital Portsmouth, C1 Children's ward St Mary's Hospital Portsmouth, Accident and Emergency QAH and Community Nursing in Portsmouth.

I have kept up to date with various courses, lecture and study days including the following topics;

Manual Handling

Discharge Planning

Advanced Life Support

Pressure Area Management

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Pain Control Workshop.

Between 1992 and 2001 I was an E Grade staff nurse on an acute medical ward then an F Grade staff nurse on an acute medical ward and medical assessment unit at QAH

Between June 2001 and April 2002 I was ward manager G grade on the medical assessment unit at QAH Hospital Cosham

Between February and May 2002 I was seconded to the Complaints Dept at St Mary's Hospital Portsmouth

Between May 2002 to present I am the Practice Educator for Healthcare Support Workers at QA Hospital Portsmouth.

At the time of this investigation I was Staff nurse on F1 ward at the QAH and my line manager was Code A. My responsibilities included the care of the patients and supervision of staff.

I have received training in the use of I/V drugs and syringe drivers . There was training offered to staff.

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

The term Named Nurse was temporarily tried out on F1 ward at QAH but didn't prove very successful. We worked in teams there.

With regard to the time and date of all entries in the notes varied, if there was an emergency then everything else would be put aside, until after the event. Otherwise they would be written up at the end of the shift.

At that time I was working 37 1/2 hours per week. I worked shifts with night duty on a rota; I

can't recall what the rota was. My day and late shifts were from 0730 to 1500 and from 1315 to 2115.

The term ANC short for all nursing care is something I am not familiar with. We were told never to abbreviate at the Queen Alexandra Hospital but unfortunately Nurses and Doctor do have a tendency to do this.

The term TLC was I term used and means tender loving care. It means simply that a patient would get a lot of attention at the end of their days and be made as comfortable as possible.

The term "I am happy for staff to verify death" is again something I am not familiar with. Training has to be completed to verify death, and in any event it would be duty sisters who would do this and not staff nurses. It wasn't standard practice

Ward rounds would be completed by the consultants usually once or twice a week. The patient's doctor would be around and be contactable via a bleep. The duty sister would usually be available to do a ward round or a Staff Nurse from each team.

I have been asked to detail my involvement in the care and treatment of Code A. I have no recollection of this patient even after seeing her photograph. But from referral to entries in her nursing notes, (Exhibit reference BJC/72) I can state that on page 295 of these notes which is a Patient Care Plan regarding confusion, on 17/5/97 I have written,"Pm very confused" I have signed that entry.

On the same page at 22/5/97 I have written, "Loud and very demanding this am, bowels opened ++ (see cardex re pending discharge" I have signed this entry.

On page 296 of the notes on 30/5/97, which is a continuation of the Care Plan for confusion, I have written," Not confused, but is quite agitated @ times"

On page 297 of the notes which is a Patient Care Plan for Dyspnoea (shortage of breath) on

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17/5/97 I have written," (Pm) O2 @ 35%. IVI commenced. Stat. Digoxin given" I have signed this entry.

02 means oxygen

IVI means infusion

Stat means straight through bag of fluid

Digoxin is drug used to regulate the heartbeat.

On the same page at 22/5/97 I have written," Need to push oral fluids and get IV ↓ ASAP" I have signed that entry

↓ means down.

On page 298 which is a continuation of the care plan dated 30/5/97, I have written, "Quite chesty, nursed upright" I have signed that entry.

On page 299 of the notes which is a Patient Care Plan regarding deafness dated 30/5/97, I have written, "Keeps taking H/Aid out!" I have signed this entry

H/Aid means Hearing Aid.

On page 302 which is a continuation of a Patient Care Plan for reduced ability to care for own hygiene, on 30/5/97 I have written, "Full wash, oral & nail care given "I have signed that entry.

On page 303 which is a Patient Care Plan regarding increased weakness on left side, dated 30/5/97 I have written," Transferred with 2. Needs help with food". I have signed that entry.

On page 304 which is a Patient Care Plan for Incontinence dated 30/5/97, I have written, "Incontinent of urine ++ even though commoded regularly. Drepolene to red unbroken bottom". I have signed that entry.

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++ means A lot.

Drepolene is a cream.

On page 269 of the notes which is a drug chart I note that I have administered the following AM on 30/5/97;

Lisinopril (Zestril) 2.5 Mgs. This is an ACE Inhibitor. This stops an enzyme in the body constricting and narrowing the blood vessels.

Bumetanide 1 Mg. This is a water tablet.

Aspirin 75Mgs. This is to keep blood thin.

Digoxin 1.25 Mcgs. This is to regulate the heartbeat. This patient had a pulse rate of 68. The drug can be administered to anyone with a pulse rate over 60.

On page 270 of the notes I see that I have administered the same drugs as described above, Lisinopril 2.5 Mgs, Bumetanide 1Mg, Aspirin 75Mgs and Digoxin 125Mcgs on both 21/5/97 and 22/5/97.

On page 271 of the notes which is an Exceptions to Prescribed Order form) dated 17/5/97 at 1900 hrs the Lisinoprol (Zestril) was prescribed but not given because there was none in stock.

On page 272 of the notes I note that I have administered 3.75 Mgs of Cefaclor, which is a slow release Anti Biotic to be taken with food, both AM and PM

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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: NHS NURSE ADVISOR

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: 16/09/2005

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

I am a Registered General Nurse with 14 years post registration experience in various role and my Nursing and Midwifery pin no is Code A

I am at present a Nurse Advisor for NHS Direct and employed in a Special Health Authority. I am a telephone triage and consultation/designated nurse.

I qualified as an RGN in 1991 at Bede College of Nursing and Midwifery, Sunderland, Tyne and Wear.

I then joined the Royal Navy and between January 1992 and July 1993 I served at the Royal Naval Hospital Haslar Gosport as an LNN (Leading Naval Nurse), Staff Nurse on the Male/Female Orthopaedics Ward.

Between December 1993 and March 1996 I served at the Royal Naval Hospital Gibraltar as an LNN on the Accident and Emergency Unit, Maternity, Medicine and Surgery Wards.

Between March and June 1996 I again served as an LNN at the Royal Naval Hospital Haslar on the Male/ Medical/CCU.

Between June and December 1996 I was employed by Portsmouth NHS Trust at St Mary's Hospital Portsmouth as a D Grade Staff Nurse in the Neonatal Unit.

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Between January 1997 and July 1998 I worked at the Queen Alexandra Hospital Cosham as an E Grade Staff Nurse on the Medical Assessment Unit/F1 Ward.

I have gained the following qualifications "NEBOSH" a certificate in Occupational Health and Safety and an ENB 928 in Diabetic Nursing.

Between July 1998 and June 2000 I was employed by Marsh Health Ltd at Health Works in Southampton as an F Grade Occupational Health Practice Nurse.

Between June 2000 and April 2002 I was employed as a G Grade Nurse Advisor at NHS Direct by Hampshire Ambulance Service. I was Telephone Triage and Consultation/Designated Nurse.

Between April 2002 and June 2005 I was employed by DDAT UK Ltd at DDAT Southampton where I was Centre Manager at a unit for persons with learning difficulties.

Between June 2005 and today, I am employed as an NHS Direct Nurse Advisor as I have mentioned earlier.

At the time of this investigation I was an E Grade Staff Nurse on F1 Ward at the QAH Hospital Cosham. At that time the nurses were split into two teams and the teams dealt with patients in so many beds and were required to deal with every facet of that patient's treatment from the ward. Part of my responsibility would be to complete the drug round and accompany the consultants on their ward rounds.

My line manager at this time was Sister Code A

I had been trained and certified in the use of IV Drugs.

I am not familiar with the term the Wessex Protocols, but I am familiar with the analgesic ladder in relation to pain control.

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I have received training in the setting up of Syringe Drivers . The person in charge of the team set them up and it was always two persons who would administer. It is unlikely that a patient who was on a syringe driver at the QAH would be transferred to another hospital as it may be deemed that they were too ill at that point.

The Named Nurse on ward F1 would usually be the nurse who admitted the patient and would be the person responsible for that patient whilst they were on duty. The named nurse's name would be on a board at the back of the patient bed.

The time and date of all entries would depend on the patient. Usually the documentation would be done at the end of the shift, but if there was time to do it at the time then it would be done then. However it could be manic on the ward at times.

At that time my tours of duty during a 371/2 hour week were 0730 to 1530, 1300 to 2100 and 2100 to 0800.

Ward rounds by consultants were done a few times a week, possibly every day, Monday to Friday with the different consultants at the hospital.

I have been asked if I recognise the term ANC - All nursing care. I do not recognise this term, although I understand what all nursing care is. We used the term ADL - Activities of Daily Living.

If I had heard the term all nursing care used after surgery I would assume the patient would get better and go home.(This was not a surgical ward and patients did not have surgery on F1.

I have been asked if I understand the term TLC. Of course I understand this term as tender loving care; I have never seen this written on nursing notes at the QAH to my knowledge.

I have also been asked if I am familiar with the term, "I am happy for staff to verify death" I am

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not familiar with this at all. A Doctor only can verify death in my opinion. If I was asked to do so then I would refuse. It is not acceptable in my opinion for a Dr, not to be contacted in the event of death.

I have been asked to detail my involvement in the care and treatment of a patient named Code A Code A. I have looked at a photograph of her but do not recall this patient at all. However from referral to entries in her medical notes (Exhibit reference BJC/72) I can state the following.

In 1997 I was known as Code A

On page 263 of the notes, which I identify as a hospital handover or transfer form written by myself relating to Code A I have written

That Code A of Willow Cottage Rest Home, 3 Crofton Lane, Hill Head, Stubbington, Hants was to be transferred from F1 Ward. She was aged 99 yrs and was C of E Religion.

Her diagnosis was Atrial Fibrillation and Confusion. Chest Infection and Deaf (very)
Her Diet was Non Insulin Dependant Diabetic
Requires Help with Eating and Drinking
Her Treatment was I/V Fluids, I/V Antibiotics, O2 Therapy, Digitalised.
Drugs Administered was Melleril 25Mg nocte,
Lisinopril 2.5Mg BD,
Bumetanide 1Mg OD,
Aspirin 75mg OD
Allopurinol 100Mg nocte,
Digoxin 125 Mcg OD
The condition of her Pressure areas were intact, although slightly red
She had no valuables
Her next of kin had been notified of her transfer
The name and address of her next of kin was Mr Code A Nephew on telephone number

RESTRICTED

Code A

In remarks it stated "Needs all care for hygiene, feeding and dressing. Transfers with two. Occasionally incontinent of urine. Wears hearing aid in right ear (Known as Humphrey)"

I have signed that entry Code A which is dated 3/6/97.

Lisinopril is an antipsychotic drug used for Hypertension

Bumetanide is a diuretic

Aspirin is a non opioid analgesic and used for helping to keep the blood thin

Allopurinol is used for gout

Digoxin is used for heart failure.

Nocte means at night

OD means once daily

BD means twice daily

Mg means Milligram's

Mcg means micrograms

Code A was admitted with increasing confusion, urinary tract infection, chest infection and atrial fibrillation and the drugs mentioned above are a reflection of treatment for the above ailments.

Code A was on the following care plans at the QAH.

Confusion

The objective being to reorientate and prevent her from causing herself injury.

The nursing action being to reorientate regularly, reassurance to be given and to prevent her from hurting herself whilst disoriented. This is detailed on pages 295 to 296.

Breathlessness (Dyspnoea)

The objective being to resolve Dyspnoea.

The nursing action being to nurse the patient sitting upright. To administer 35% 02 via mask as prescribed. To inform Dr's if patient becomes increasingly dyspnoeic or cyanosed, and to monitor 02 saturation levels.

This is detailed on pages 297 to 298.

Deafness

The objective being that the patient will be able to hear staff.

The nursing action is to ensure that patient's hearing aid is in and switched on. Speak clearly into the microphone. Speak slowly. Provide written questions if necessary.

This is detailed on pages 299 to 300.

Reduced ability to care for own hygiene

The objective is to maintain patient's personal standard of hygiene within reach of the patient's ability.

The nursing action is that hygiene facilities will be provided daily; offer hand wash after elimination; Assist with all hygiene requirements as deemed necessary by trained nurse this is to include eyes, mouth, hair, nail and shaving care. To provide clean bed linen and bed wear as necessary. Whilst administering this care note skin integrity and comment upon condition of pressure areas. Ensure privacy and dignity. Assist as necessary but encourage independence.

This is detailed on pages 301 and 302.

Increased weakness on left side

The objective being to treat cause and rehabilitate to patients norm

The nursing action is to refer to physio. Provide support for left side. To monitor weakness and report changes. To inform Dr's of any deterioration.

This is detailed on pages 303.

Incontinent

The objective being to promote continence and prevent breakdown of skin.

The nursing action is to offer regular commodes. To check bowels/record. To maintain privacy/dignity. Aperients as necessary. Good hygiene. Barrier cream to red skin.

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This is detailed on page 304 of the notes.

In my estimation the drugs she would require at the Gosport War Memorial Hospital were the drugs she was prescribed at the QAH and those which are listed on the transfer form; it is unlikely she would have been transferred if she was so ill that she required other medication e.g. syringe driver.

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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: LOCUM CONSULTANT PHYSICIAN

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: 14/09/2005

I am a Locum Consultant Physician in Geriatrics and have been since 1989. I qualified in 1970 at Baghdad Medical School where I gained my MBCHB.

I first came to Britain in 1976 as a Registrar at West Middlesex Hospital. Following that I was at Kings College, before going to Saudi Arabia, where I worked as a GP for two years from 1977 to 1979.

I returned to the NHS in 1979 when I worked as a SHO at Frenchay Hospital in Bristol.

From 1982 to 1984 I was a Registrar in Elderly Medicine at Exeter Hospital.

I became a Locum Consultant in 1989 and thus have worked in many hospitals across Britain.

I have worked at the Queen Alexandra Hospital, Cosham on two or three occasions. One such occasion was in 1997, I believe I was standing in for Dr Code A who may have been on maternity leave. My position was that of Locum Consultant Physician in Geriatrics. I was responsible for patients in the acute beds, out-patients clinic and the day hospital. These were all elderly patients with variable complaints and conditions but not surgical. My team would have consisted of a Senior Registrar, Senior House Officer and House Officer.

I have been asked if I recall a patient named Code A. I have no recollection of this patient. I have been shown a copy of her medical records marked BJC/72.

From these notes I can see that Code A was admitted onto F1 ward at Queen

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Alexandra Hospital on 17/05/97 under the care of Dr Code A who was the Consultant Endocrinologist in the Department of Medicine. F wards are general medical wards and therefore I would have little contact with patients within them. This was certainly the case with Code A

I have seen a note on page 162 of BJC/72 and I can confirm that this is in my handwriting and that it is signed by me. The note is on a page of the clinical notes. It is dated 29.5.97 and reads as follows;

'Thank you, further episode of LVF. Still congested but better. Immobile. Alert. I will transfer her to Gosport Hospital for assessment regarding continuing care.'

LVF stands for left ventricular failure. She had fluid on the lungs. She was unable to walk but she was alert.

Although I was not responsible for the care and treatment of the patient I had visited her at the request of one of Dr Code A SHO's, specifically to assess her for continuing care. The request would have been received by my secretary and a visit scheduled for me. Dr Code A team felt that she could not return to her rest home. If a patient needed to be assessed for continuing care it would be my responsibility as the Consultant in Geriatrics to do so.

I have also been shown Code A GP notes marked TAS/9 .Within these notes is a letter which was dictated on 29th May 1997 and typed on 2nd June 1997. I can confirm that the letter was signed by me. It reads as follows;

'Dear Dr Code A

WARD VISIT - WARD F1, QAH

Code A dob Code A

H/a: Willow Cottage R/H, 3 Crofton Lane, Stubbington

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Thank you very much for asking me to see this delightful lady, whom I saw on the ward today. She has long - standing cardiac failure and was admitted again because of breathlessness and general deterioration. She was found to be in heart failure. She is deaf and uses a deaf aid. Although clinically she is better, she is still in a degree of heart failure. She is normally in a rest home, but I doubt whether they can manage her.

I'll put her on the list for Gosport War Memorial Hospital for assessment, with a view to considering continuing care.

Yours sincerely

Dr Code A
Locum Consultant Physician in Geriatrics.'

I have signed the letter.

This letter was sent as a consequence of my visit to the ward on 29th May 1997, it is complimentary to my handwritten note on page 162 of BJC/72. The note was written to provide the SHO with my immediate decision. Clearly I concurred with the comments of the SHO and agreed to put her on the list for Gosport War Memorial in order that she could be properly assessed. In making my decision I would probably have referred to the medical notes, possibly the GP's letter and I may also have talked to the nursing staff. The latter almost certainly due to her immobility, in such cases I would always ask the nursing staff how the patient was managing in that respect.

I note that I saw Code A on the 29th May 1997 and that she was transferred to Gosport War Memorial Hospital on 3rd June 1997. I had no further involvement with Code A Code A following that visit of the 29th May.

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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: HEALTH VISITOR

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: 11/07/2005

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

I qualified as a State Registered Nurse in North Yorkshire in 1994 and my GMC number is Code A Code A I began work as a Staff Nurse on Dryad Ward at the Gosport War Memorial Hospital in 1997 until 1998 when I began work also as Staff Nurse on Ashling Ward at St Richards Hospital Chichester until February 1999.

Until 2000 I was at the Kings College London and the Bethlehem and Maudsley NHS Trust on sponsorship for mental health nursing. I then worked for two years at the Queens Hospital Worthing as a Staff Nurse.

I then worked as a bank nurse also in Worthing before beginning training as a Health visitor.

In September 2003 I was appointed as a Health visitor in Littlehampton.

In 1998 I was working on Dryad ward at Gosport War Memorial Hospital as a Staff Nurse as I have stated earlier. I was Junior Staff nurse at that time and my primary role was caring for the physical needs of the patients. Ward sister Code A was my line manager at that time.

I had not received training in the use of IV drugs in 1998. I have never heard the term "Wessex Protocols. I had on the job training in the use of syringe drivers from the ward sister. I did not attend any courses in this regard as there were none available to my knowledge.

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The Named Nurse is the person the family and patients can communicate with regarding patient care. Entries in the Nurses notes would be done at the time if it was an important entry, but generally they would be done at the conclusion of the shift.

My tour of duty would be based on a 30 hour week over 5 days. I always worked weekends and my duty was 0730 - 1330 on three days and 1430 - 2030 on two days.

I have been asked to detail my involvement in the care and treatment of Code A. I do not recollect this patient, even after being shown her photograph, but from referral to entries in her medical notes (Exhibit reference BJC/72) I can state the following:

On page 22 of the notes dated 3/6/97 I have written as the admitting nurse the following entry which is a patient summary," Admitted today from F1 ward QA. Code A is a very pleasant lady. She has a normal diet but needs assistance at mealtimes. She has faecal incontinence. Her buttocks are very red and sore and the skin is broken. Her skin is quite dry. She has two superficial grazes on her spine. Skin on lower arms is discoloured.

Code A uses a Code A hearing aid which has a microphone. She is able to respond to questions.

Code A is a Non Insulin Dependant Diabetic. Has Congestive Cardiac Failure. Suffers from confusion, has upper Respiratory Infection, also gout.

Code A has had bowels open and passed urine since admission.

Ist swabs of MRSA screening sent.

Helena has not eaten supper this evening but has had a drink of water"

I have signed this entry as Code A

Signed Code A

Signature Witnessed by: Code A

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Although I am shown as the named nurse for this patient I have made no further entries in the nursing notes, and appear to have had no further involvement with this patient. Most of the care plans appear to have been completed by Staff Nurse Code A

From looking at the other notes on the summary it appears that Code A was given Midazolam which is used to reduce anxiety and agitation and Diamorphine which is used to relieve pain.

My interpretation of a patient who is restless and agitated is someone who is unsettled, and maybe someone who is unable to be comforted.

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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: GROUP CLINICAL MANAGER

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

Signed: Code A Date: 04/08/2005

I am Code A and I live at an address known to Hampshire Police. I am a Registered General Nurse. I qualified in June 1980 and my Nursing and Midwifery Pin No is Code A

Between May 1977 and June 1980 I was a Student Nurse at the Royal Hampshire County Hospital, Winchester, Hampshire.

Between June 1980 and June 1981 I was a full time day duty Staff Nurse at the Royal County Hospital, Winchester, working on an acute medical ward.

Between June 1981 and January 1982 I was on maternity leave.

Between January 1982 and September 1983 I was night duty Staff Nurse at the Queen Alexandra Hospital, Cosham, Hampshire, as part of the multidisciplinary nursing team in the elderly care and medical unit.

Between September 1983 and May 1984 I was on maternity leave.

Between May 1984 and December 1985 I was day and Night Sister at Lonsdale Nursing Home Southsea.

Between December 1985 and September 1996 I was a Staff Nurse at both D and E grade at Gosport War Memorial Hospital.

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Between December 1993 and May 1994 I took maternity leave.

Between September 1996 and July 1998 I was Senior Staff Nurse at GWMH where I was responsible for the management of the hospital overnight and the assessment and overnight treatment of patients at the casualty unit. I was also responsible for overseeing night care development of patients and professional development of staff.

Between July 1998 and July 1999 I was Deputy Matron of Carleen Nursing Home Porchester, Hampshire.

Between July 1999 and December 2004 I was the Matron/Registered Manager of Fieldgate Nursing Home, Horndean, Hampshire.

Between January 2005 and the present I am the Group Clinical Manager/Head of Care, for Contemplation Homes Ltd. In this role I direct the staff in clinical issues and ensure current clinical best practice is sourced and introduced into homes within the group.

I also head the team of staff and set the standards to ensure that both the physical and physiological needs of the residents are met.

I am responsible for clinical matters, directly to Commission for Social Care Inspection and Nursing and Midwifery Council.

I have kept up to date with training courses such as Managing Performance Training, Introduction to/Advanced training - swallowing difficulties in the elderly, Palliative Care in Nursing Homes, pressure sore alleviation programme, care of patients requiring feeding training.

I have also completed training and supervision of all staff to meet CSCI and TOPPs England Standards.

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Designing and implementing Adaptation Training for Registered Nurse Accreditation.

I am a member of the Executive and Training Committees of the Hampshire Care Association.

In 1997 I was a Senior Staff Nurse at GWMH on Night Duty and my role responsibilities included the management of the hospital overnight and the assessment and treatment of patients both on the ward and from the casualty unit. My line manager at that time was Code A

.

I was trained in the use of IV drugs before I went to GWMH. I did not use those at that Hospital.

I received some training in the use of Syringe Drivers but I have not been certificated.

I am unfamiliar with the term the "Wessex Protocols" but understand the meaning of the analgesic ladder.

The Named Nurse is the trained nurse to which a group of patients would be allocated to and they would be responsible for planning their care.

At that time I worked 30 hours per week, which consisted of 3 nights per week at hours of 2000 to 0800.

The entries in the notes would be entered as contemporaneously as possible; the main object was to deliver the care first.

The term ANC, I understand is All Nursing Care. This was not used in 1997 but which means that everything necessary with regards to nursing care should be done, basic nursing.

The term TLC is Tender Loving Care, which means basic nursing needs, which includes the

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maintenance of comfort to patients who are nearing the end of their lives and would mean that we would not aggressively treat patients.

The term "I am happy for staff to verify death" I recognise as a term that Dr Code A used to write. It means that instead of calling out a GP after hours in the case of a death on the ward, she was comfortable with staff verifying death. Death could be verified in the following ways; the patient was not breathing, an absence of vital signs, no palpable pulse, and pupils fixed.

With regard to ward rounds, Dr Code A visited the ward at around 0830 hrs, I imagine before her surgery. She would check any problems at that time. She would also do a ward round with Dr Code A in the afternoon, once or twice a week. There were of course no ward rounds at night.

Dr Code A was always popping into the ward though. I recall her coming in on a Saturday morning when she was not supposed to be working.

I have been asked to detail my involvement in the care and treatment of a patient at the GWMH, Code A. I have no recollection of this patient and have looked at her photograph, but from referral to entries in her medical notes, (Exhibit reference BJC/72) I can state that on page 22 of the notes dated 03/06/97 I have written, Night - "Spenco mattress in situ, nursed on alternate sides overnight. Zinc and Caster oil to sore sacrum. HPU. Oral fluids encouraged & taken fairly well . Tongue dry & coated- mouth care given" I have signed that entry.

0200 "Failed to settle - very restless and agitated. Midazolam 20Mgs given via syringe driver over 24hrs"

Spenco mattress is a static mattress, one up from an ordinary kind but with pressure relieving properties.

HPU means Has Passed Urine

My involvement with this patient is that I looked after her overnight; I made her comfortable

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and provided all nursing care.

I gave her 20 Mgs of Midazolam which is a hypnotic relaxer used to calm a patient down. I presume that I set up the syringe driver although it doesn't mention this on the notes. Midazolam in not a controlled drug and 20mgs in a small dose and was prescribed as required.

On page 37 of the notes I have made an entry at 0215 on 04/06/97 where I have given the 20mgs of Midazolam subcutaneously through a syringe driver. The prescription is written up by Dr Code A

I could not find any Dr's records regarding this.

I would say that Code A was started on a syringe driver because she was in pain and agitated; the patient should be in the minimum of discomfort. 20mgs of Diamorphine is a small dose is an excellent method of pain relief, and Midazolam is ideal in a syringe driver combined with Diamorpine. The other drugs to be used in a syringe driver are Hyoscine , which is used to relieve secretions on the lungs.

On page 35 of the notes which is a Sleep Nursing Care Plan dated 03/06/97, I have written,

Problem

"REQUIRES MAXIMUM ASSISTANCE TO SETTLE AT NIGHT".

Desired Outcome

"TO ATTEMPT TO ENSURE AN ADEQUATE NIGHT'S REST".

Evaluation Date

"NIGHTLY".

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Nursing Action

"REQUIRES MAXIMUM ASSISTANCE TO PREPARE FOR BED

USE HEARING AID MICROPHONE WHEN ADDRESSING Code A

ATTEMPT TO NURSE ON ALTERNATE SIDES (SORE SACRUM) (SPENCO MATTRESS IN SITU FOR? TRANSFER TO PEGASUS)

WASH/CHANGE AFTER EACH EPISODE OF INCONTINENCE - REQUIRES PAD AND PANTS

APPLY BARRIER CREAM IE ZINC & CASTOR OIL

LIKES TO BE SAT UP - WELL SUPPORTED BY PILLOWS IN BED

ENCOURAGE/MONITOR ORAL FLUID INTAKE".

I have signed that entry.

Page 36 of the notes is a continuation of the Sleep Nursing Care Plan dated 3/6/97, I have written,

Evaluation

All care given overnight, washed and changed as required. Oral fluids encouraged and taken adequately. HPU."

0200 Hrs "restless and agitated Midazolam 20 Mgs given via syringe driver over 24 Hrs with some success"

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I have signed that entry.

The purpose of this care plan is to ensure that the patient has an adequate night's rest, and that all care is given as required.

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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: GROUP CLINICAL MANAGER

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

Signed: Code A Date: 03/10/2005

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

Further to my previous statement dated 4th August 2005 (04/08/2005), I have been asked to clarify one or two points in that statement.

ANC which, as I have stated, I understand to be "All Nursing Care" is a term that is not used today and one that I did not use previously. I felt that the term was a bit "wishy washy" and I would have used the term "Appropriate Care". This would cover all hygiene matters and keeping the patient comfortable whilst maintaining dignity.

Diamorphine used in a syringe driver is a faster way of relieving pain than drugs taken orally. The syringe driver administers drugs subcutaneously (under the skin) and may be used if the patient is comatose, or absorption of oral drugs was impossible i.e. if the patient had difficulty swallowing, or if the patient had a slow metabolism.

I neither prescribed nor administered the syringe driver in this case, but in my experience, and with regard to recent research based evidence I have read, Diamorphine in a syringe driver is an excellent method of pain relief. 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: GROUP CLINICAL MANAGER

This statement (consisting of 3 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tended in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 09/12/2005

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

Further to my previous statements made to the Police, I have been asked to clarify some points in those statements.

I can confirm that I was the nurse that administered 20mgs of Midazolam via syringe driver at 0200 hrs on 4/6/97. I was on night duty and finished work at 0800 hrs that day. I therefore did not administer Diamorphine via the syringe driver at 0920 hrs the same day.

In my previous statement I have alluded that Code A was started on a syringe driver because she was in pain and agitated. On reflection and after reading the notes I can find no record of those indicating that the patient was in pain. As I have said I do not recall Code A Code A but in my vast experience as a Nurse I am able to recognise when a patient is in pain, perhaps because of body language, a grimace, if the patient is restless or they cry out when moved. This would have required an assessment of the patients needs at the time. I have written on page 22 of the medical notes, (Exhibit reference BJC/72) at 0200 on 4/6/97, "Failed to settle - very restless and agitated."

I would say that on perusing the notes that Code A was pretty poorly on admission.

These are good notes made on a busy ward in my estimation.

I have also written on page 22 of the notes, "Oral fluids encouraged & taken fairly well." These were given at sometime between 2000 3/6/97 and 0200 4/6/97 I can't recall exactly. I would

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assume that the syringe driver was used because it is the most effective method of administering medication to relieve agitation or pain, better in that context than oral medication. The medication for administration via the syringe driver was written up by Dr Code A who would have examined the patient. As nurses we would follow a Dr's instructions.

In practice 20 mgs of Diamorphine is the smallest dose I have known to be given via a syringe driver. I believe any smaller dose would be ineffective. The Diamorphine was written up as a variable dose of between 20-100mgs. Looking at the notes I see that 20mgs is the lowest dose prescribed and administered to the patient, and was therefore a small dose in the range of the prescription. The Midazolam dose however was doubled from 20mgs to 40 mgs on the 4/6/97.

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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: CARE MANAGER SOCIAL SERVICES

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

Signed: Code A Date: 27/07/2005

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

I am currently employed as a Care Manager in relation to social and home care for the elderly at Fareham Social Services.

I was an E grade staff nurse in the NHS and my Nursing Midwifery Council PIN number is Code A

Between May 1976 and May 1979 I trained as a student nurse. I worked at both St Mary's Hospital and the Royal Hospital in Portsmouth.

I qualified as a State Registered Nurse in May 1979. From then I worked on ward B3, the female geriatric ward as a Junior Staff Nurse.

In 1981 I commenced midwifery training (which should have been an 18 month course). Due to my own maternity leave I did not complete the course, leaving in November or December 1982.

During the period 1983 to 1986 I worked part time as a staff nurse on night duty at both Thalassa and Bury Lodge Nursing Homes for the Elderly in Gosport. I initially worked two night duties per week.

Between June 1986 and early 1990 having left the NHS I ran my own business named Bambino's in the precinct in Gosport, this was a shop selling baby clothes and related

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merchandise.

Between early 1990 until September 1991 I was employed by the Ministry of Defence as a clerical officer at HMS Centurian which was the pay and pensions dept.

In September 1991 I rejoined the NHS as a D grade Registered General Nurse (RGN), working part time at the Redcliffe Annexe in the Avenue, Gosport. This was a long stay unit for the elderly (patients over the age of 65 years) I had re registered with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

In my time at the Redcliffe Annexe I was working with Code A the Senior Staff Nurse, F Grade RGN. Code A an E Grade RGN, and Code A the G Grade RGN, who was the Ward Manager.

As a D Grade I was a Junior Staff Nurse, and as such I always worked with a Senior Staff Nurse.

I received no training in the use of IV drugs and I did not administer these.

I do not know the term the Wessex Protocols.

With regards to the use of a syringe driver , I am aware that it can only be used on the authority of a prescription written by a Doctor. The use of which is only authorised after discussions amongst the medical team and the nursing staff have reviewed the patient's pain relief/control and the analgesic ladder had been followed, i.e. beginning with simple paracetamol, distalgesics, co-dydramol, a codeine based analgesic and then morphiates would be the next consideration.

Once the authority for a syringe driver was given, ie, it was written on the prescription chart, and normally in the clinical notes, there should also be an entry in the nursing notes which would state what controlled drugs were to be administered to a patient and what quantity and

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dosage. The period of time the dosage was to be administered was usually over a 24 hour period.

These drugs would be taken from the secure drugs cupboard after the amount/dosage of the drug was checked against the prescription sheet. The appropriate amount withdrawn would be then recorded in the controlled drugs book which should be witnessed by the two nurses who had withdrawn the drugs.

The drug solution containing the prescribed drug(s) was made up in sterilised water.

In the case where it was a mixture of drugs, then the compatibility of the drugs would be checked in the British National Formulary (BNF). On occasions, the pharmacist would be contacted for advice.

Once satisfied that the drugs compatibility was correct then the driver would be taken to the patient, where a further check would be made to ensure it was the correct patient.

A small butterfly needle would have been inserted below skin level (sub cutaneous) and the syringe driver applied, which delivers a set quantity of drugs over a 24 hour period.

With regard to training it was purely on a one to one basis and on the job learning. We were given handouts and there may have been a course, I am unsure.

My understanding of the term the named nurse is that this person is responsible for the care of the patients allocated to them. The relatives of that patient would also speak to them if the named nurse was on duty.

The time and date of all entries would vary from patient to patient; they may be completed at the time, but normally completed at the end of the shift.

My shifts were from 0730 to 1330 and from 1230 to 2100.

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The Redcliffe Annexe closed and all patients and staff transferred to a new ward at Gosport War Memorial Hospital, known as Dryad Ward . At this time I was an E Grade Staff Nurse.

My responsibilities at this time were deputising in the absence of the senior staff nurse or ward manager, supervising staff and delegating work loads. Also assessing, implementing and evaluating individual patient's care. Further to this I would accompany doctors and consultants on their ward rounds. I would also order drugs and arrange for their safe storage and then dispense safely to the patients.

The ward rounds were completed before surgery by the GP's usually between 0730 and 0800. These would consist of a meeting between them and the staff and opinions from us sought and the GP would visit the patient if necessary.

The consultants rounds would usually be once a week and would take all morning, and all patients would be visited by them.

The following terms can be written in the nursing notes,
ANC means All Nursing Care and means all care that is required for the individual patient, in relation to care plans such as Hygiene, Nutrition etc.

TLC means Tender Loving Care, which indicates that the patient is in the terminal stages of life and should be treated with dignity and respect.

"I am happy for staff to verify death", would be written by a Doctor and means that the patient is expected to die in the near future. To verify death then two trained members of staff would check the patient for vital signs, and as such the eyes would be checked for pupil reaction, along with the pulse and the heart. The patient may also be pinched to see if pain registers.

I have been asked to detail my involvement in the care and treatment of Code A, I do not recall this patient at all, even after looking at her photograph, but from referral to her

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medical notes, (Exhibit reference BJC/72) I can confirm that on page 23 of the notes I have written in the patient Summary on 4/6/97, "Condition appears to have deteriorated over night - remains restless. Seen by Dr Code A Driver recharged with Diamorphine 20mgs, Midazolam 40mgs in 50 millimols hourly. Rang Mr Code A (Nephew) to inform him of poorly condition". I have signed that entry SR.

In relation to that entry I would think that Dr Code A probably saw the patient in my presence.

20 mgs of Diamorphine is not a large dose, administered over a 24 hr period.

40 mgs of Midazolam is again not a large dose, administered over a 24 hr period

Millimols are a breakdown of fluid measurement. 10 millimols is a slow flow and 50 millimols is a normal flow.

I have also made an entry in the prescription chart on page 37 of the notes, where I have made the following entries- Diamorphine on 4/6/97 at 0920 20mgs, administered and signed by me.

Midazolam on 4/6/97 at 0920 40mgs, administered and signed by me

These were the first doses of these drugs administered at the GWMH .

I have cross referenced this with page 164 of the notes dated 3/6/97 where there is an entry from Dr Code A

I am unable to read all of the entry, but what I can read, states;

3/6/97 Transfer to Dryad Ward

Recent admission 17/5/97

Confused

Off legs

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Gout

Came from a rest Home

O/E breathless

Needs palliative care if necessary.

I am happy for nursing staff to confirm death.

This entry is signed by Br Code A

On page 3 of the Dryad Ward Controlled drug record book (Exhibit reference JP/CDRB/23) dated 4/6/97 at 0920 hrs I see that I administered 20mgs of Diamorphine to Code A this was witnessed by Code A

Diamorphine is used to keep the patient pain free.

Midazolam is used to keep the patient more restful and peaceful, and help with agitation.

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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: CARE MANAGER SOCIAL SERVICES

This statement (consisting of 3 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 10/11/2005

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

Further to my statement made to the police regarding Code A I would like to add that Dr Code A authorised the commencement of the Diamorphine Syringe Driver for this patient. Page 37 of her nursing notes (Exhibit reference BJC/72) shows the issue of Diamorphine, Hyoscine and Midazolam in the following doses written up by Dr Code A on 03/06/97 subcutaneously, which means via syringe driver.

Diamorphine 20 - 100 mgs over 24 hrs

Hyoscine 200 - 800 mcgs over 24hrs

Midazolam 20 - 80 mgs over 24 hrs

The first Syringe Driver containing 20 mgs of Midazolam was given at 0215 on 04/06/97 by Code A This is shown on page 37 of the notes.

As I have previously stated I gave 20 mgs of Diamorphine and 40mgs of Midazolam via syringe driver at 0920 on 04/06/97. The desired outcome was to make the patient pain free and comfortable.

I t would appear that no other analgesics had been tried first.

I have looked at page 50 of the notes which is a discharge letter from the QAH which indicates the drugs the patient was prescribed up until transfer:

Signed: Code A Signature Witnessed by: Code A

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Lisinopril 2.5 mgs used for blood pressure

Bumetanide 1mg used as a diuretic

Aspirin 75mgs used for blood thinning and as an analgesic

Allopurinol 100mgs used in treatment of gout

Digoxin 125 mgs used for the heart

I have also stated that I believe 20mgs of Diamorphine to be a small dose. I quantify that by saying that in my experience this is a standard starting dose prescribed by a Dr over a 24 hr period. I would say that a smaller dose of Diamorphine say, 5 mgs I believe would be comparable to 2x Coproxamol. I would say that plenty of frail elderly patients are prescribed 20 mgs of Diamorphine. The syringe driver is used also in preference to multi intra muscular injection every 4 hours.

The patient would not be on a syringe driver for no reason. It was obviously deemed necessary. I would say that this was preferable to giving a patient 4 hourly intravenous injections. The driver was already there for the Midazolam, which had been prescribed because the patient was described as restless and agitated during the night.

I would suggest that this patient must have poorly when she was transferred from the QAH to the GWMH.

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

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

Signed: Code A Date: 26/07/2005

I am a Registered General Nurse and my nursing midwifery council number is Code A

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

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

I worked for a further year at Broadfield Hospital Port Glasgow, completing that in July 1978.

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

In March 1992 I began work as a D grade staff nurse at the Redcliffe Annexe which formed part of the Gosport war Memorial Hospital.

In 1995 I believe, this unit was closed down and all patients transferred to Dryad Ward at GWMH together with the staff.

I have worked at that Hospital since then and in 1995 I qualified as an E grade staff nurse

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

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training of student nurses who are ward placement.

I have not heard of the term, The Wessex Protocols.

Dryad Ward has 20 beds and the patients are primarily elderly, over the age of 65 years.

The majority of these are full dependant on nursing care and are usually in the ward for a 4-6 week period.

I have received on the job training in the use of syringe drivers . I believe I first used these in or around 1992.

I have also attended study days in connection with the manufacturer's requirements relating to their use.

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

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

This policy has since changed.

My understanding of the term the named nurse is that this is the person who is responsible for the nursing care of the patient. The Nurses were usually allocated a four bedded bay and split into teams A and B.

They were responsible for putting care plans in respect of those patients, in place and keeping

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them up to date. The named nurse would be the person whom the patient's family could speak to, if that nurse was actually on duty at the time. If they were not then another member of staff would speak to them.

On some occasions the care plans would be completed by another nurse, but show the named nurse on the heading.

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

My tour of duty has always been from 0730 to 1330 (days) and 1415 to 2030 (lates).

I have been asked to detail my involvement in the care and treatment of Code A I have no recollection of this patient but from referral to entries in her medical notes (Exhibit reference BJC/72) I can state the following,

Page 27 of the notes is a catheter nursing care plan which shows Staff Nurse Code A as the named nurse. Under problem, I have written the following on 4/6/97," Catheterised as skin vulnerable and skin deteriorating" I have signed that Code A

On the same date I have written, "Catheterised size 12 pre filled balloon"

Under Desired outcome, I have written, "To aim to keep catheter patent and prevent infection" I have signed that Code A

Under Evaluation Date I have written, "Daily"
Under Nursing Action I have written,
1. Twice daily catheter care
2. Empty draining bag as necessary
3. Change draining bag every 7 days

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4. Encourage adequate amount of fluid

5. Ensure privacy and dignity at all times. I have signed that entry Code A

On page 28 of the notes under evaluation, I have written on 4/6/97,"Catheterised with size 12 pre filled balloon. Draining well and clear" I have signed that entry Code A

Page 29 and 30 of the notes is pressure sore nursing care plan dated 4/6/97.

Under problem I have written, "Superficial grazing to buttocks" I have signed that entry.

Under Desired Outcome I have written, "To aim to promote healing and prevent further breakdown" I have signed that entry.

Under Evaluation I have written, "Daily"
Under Nursing Action I have written,"
1. "Wash and dry thoroughly"
2."Apply Zinc and Castor oil to act as barrier"
3."Assess if needs dressing when continent"
I have signed that entry.

On page 30 under evaluation I have written, "Zinc and Castor Oil applied as barrier as Code A leaking faeces". I have signed that entry.

Page 31 and 32 of the notes is a personal hygiene nursing care plan dated 4/6/97.

Under problem I have written, "Needs assistance with all aspects of personal hygiene" I have signed that entry.

Under desired outcome I have written," To aim to promote a standard of hygiene acceptable to Code A I have signed that entry.

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Under Evaluation I have written, "Daily"

Under Nursing Action I have written,"

1. "Give daily bed bath/bath"
2. "Wash hair, trim nails, clean ears as necessary"
3. "Check and report any skin changes"
4."Ensure privacy at all times"

I have signed that entry.

On page 32, under evaluation I have written,"Bed bath, ears cleaned"

I have signed that entry.

Page 33 and 34 of the notes which is a bowel care nursing care plan, dated 4/6/97.

Under problem I have written, Prone to constipation due to lack of mobility" I have signed that entry.

Under Desired Outcome I have written, "To aim to promote regular bowel action". I have signed that entry.

Under Evaluation I have written, "Daily"

Under Nursing Action I have written

1. "Encourage high fibre diet and adequate fluid intake"
2."Record all bowel actions observe for colour, amount, odour"
3." Give aperients as prescribed if necessary".
4."Ensure privacy and dignity at all times".

I have signed that entry.

On page 34, under evaluation and dated 3/6/97 which may be an error, I have written, "BO - faecal leakage soft" I have signed that entry.

Aperients are Laxatives

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BO means Bowels Opened.

The purpose of Nursing Care Plans is to ensure that everything possible is done for the patient to promote well being. The Care Plans are written for the nursing team to follow for patient care. It is basically things you do for the patient which follows the ADL index.

ADL means Activities of Daily Living.

Page 26 of the notes is a Mouth Assessment form dated 4/6/97, which is basically for mouth health and covers gums, dentures etc and whether mouth is dry, painful ulcerated etc. I have signed that entry.

Page 38 of the notes is a prescription chart and I have administered 2.5 mgs of Lisinopril at 1800 hrs on 3/6/97

Lisinopril is used for heart failure and blood pressure.

ANC means All Nursing Care and is a term which means giving all medical care necessary for the patient.

TLC means Tender Loving Care which indicates that the patient is very poorly and should be treated with dignity and respect.

"I am happy for staff to verify death" would be written by the Doctor for use of staff out of hours so that death can be verified by them. This would only be written if a patient was close to death.

GP ward rounds would be conducted week days. Patients usually would be greeted by the doctor but not examined by them unless there was a particular problem with them.

Consultant ward rounds were once a week where the patients would be seen individually.

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Continuation of Statement of: Code A

Signed: Code A

Signature Witnessed by: Code A

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 3 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 04/07/2005

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

I retired from the NHS in 1999, after 38 years nursing experience.

I retired as a Staff Nurse at Gosport War Memorial Hospita l; I cannot recall my RCN number.

In 1997 I was a Staff Nurse working night duty only on Dryad Ward at the Gosport War Memorial Hospital.

My responsibilities were in the main "patient care" and I was in charge of a team of two or three Auxiliary nurses. Our task on nights were to care for the patients, give medication, make up care plans and hand over to the day shift. My supervisor at that time was I believe to be Code A Code A

I don't believe I received any training in the use of I/V drugs. I may have received hand outs.

I have never heard the term the Wessex protocols.

I attended a day course at GWMH in the use and setting up of syringe drivers. I recall I was nervous regarding their use and along with others I requested more training.

Usually, by the time we came on to nights the syringe drivers for patients had already been set up for us by the day team.

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The title named nurse is something used on days, but not on nights. This was the nurse who was responsible for a particular patient and whose name was usually on a board in the nurse's station.

In relation to the time and date of all entries, I would complete these in the notes when I had finished all of my jobs, however if the patient was really poorly I would write in the notes at the time.

As I have said I only worked a night duty. I worked 20 hours per week which consisted of two nights. My hours were from 1930 until 0730 the following day.
I have been asked to detail my involvement in the care and treatment of a patient named Code A Code A I have no recollection of this patient but from referral to entries in her notes, (Exhibit reference BJC/72). I can say that on page 23 of the notes which are the general nursing notes I have written on 5/6/97 at 0400 hrs,"Condition continues to deteriorate and died very peacefully at 0345 hrs. Nephew informed". I have signed that entry Code A

On page 164 of the notes, following a lengthy note written and signed by Dr Code A I have written," Condition continued to deteriorated and died very peacefully at 0345 hrs 5/6/97, Death verified". I have signed that entry S/N Code A RGN.
This entry is written on the case notes.

From Dr Code A entry I am able to say that the patient was dying. I have no recollection of that patient's condition myself. Dr Code A has said that she was happy for nursing staff to confirm death.

Nursing staff are able to verify and confirm death but not to certify. That is a Dr's function only.

In general terms it is usually obvious that a patient has died, due to the pallor of the skin which shows a tinge of yellow. The eyes can be open and the mouth slack and open.

There are three main criteria to follow in this event. The first would be to shine a pencil torch or

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any light in the patient's eye for any pupil reaction. The second would be to feel for the carotid pulse in both sides of the neck. The third would be to use a stethoscope to listen to the heart.

If all three points were negative then death would be confirmed. It is not necessary for two persons to be present to confirm death, although it is likely that another person would be present. Of course, on nights there may only be two nurses on duty in the ward, another may be otherwise disposed.

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 3 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tended in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 17/10/2005

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

Further to my previous statement made in relation to a patient named Code A, I would like to add, that on page 164 of the notes (Exhibit reference BJC/72) Dr Code A has written a note on the clinical note sheet on 3/6/97. I am unable to read all of the entry but what I can read, states

Transfer to Dryad Ward
Recent admission 17/5/97
Confused
Off legs
Gout
NIDDM
CEF
Came from a Rest Home
O/E breathless
& gallop
&clear
Needs palliative care as necessary
I am happy for staff to confirm death

I was aware that Dr's including Dr Code A had indicated that they were happy for staff to confirm death, but this would only be if the patient was in terminal decline. It was with this in

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mind coupled with what else was written on the aforementioned note that I concluded that this patient was dying.

I am unsure if staff verifying death was policy at GWMH or indeed written down, it was just understood.

I am unable to say if this was common practice at other hospitals. However in larger hospitals Dr's are usually always In attendance. But in cottage hospitals such as GWMH Dr's are not present 24hours a day. If a patient died at any time when a Dr was not on site then one would need to be called out. When a death was expected, this was unnecessary when Nurses were capable of verifying death. I have verified death in this manner without a Dr present between ten and fifteen times in my career.

NIDDM means Non Insulin Dependant Diabetic Mellitus.
CEF means Cardiac Failure

Also re above, it would be obvious to any experienced nurse that someone is dying. The notes would indicate that a patient is in terminal decline.

Sometimes we would go to another ward to verify death when we would not know the patient. But we would verify an expected death only.

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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: O18 (if over 18 insert 'over 18') Occupation: TEAM 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: 04/11/2005

I am a Team Manager for Adult Services employed by Hampshire County Council.

In 1997 I was working at Haslar Hospital as part of the Social Worker Team.

I have been shown 2 pages of the hospital notes of a patient named Code A BJC/72. The pages shown to me are 274 and 275. I recognise these as a referral health summary, I do not recognise the handwriting on the form. The form would have been used at Gosport War Memorial Hospital in 1997. This form would have been used for patients who needed an assessment, typically this would be to determine the needs of a patient on discharge from hospital and whether they would need funding from Social Services.

Normally the form would have been completed by a Staff Nurse after a medical decision had been made regarding the patient.

This particular form is neither dated nor signed.

I have checked our computer records but can find no reference to Code A, this indicates that she was possibly privately funded at her previous address of Willow Cottage Rest Home. This also indicates that we did not receive a copy of this form in 1997, this would be for several reasons such as family members not wishing to pursue, patient's health improved or that the patient died.

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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: LOCUM GP

This statement (consisting of 10 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: 21/11/2005

I am a Locum GP and live at the address stated overleaf. My qualifications are as follows:

1996 BM University of Southampton

2000 DRCOG

2002 DFFP

2002 JCPTGP Certification

2002 MRCGP with distinction

2003 Approved for Obstetric, Minor Surgery and Child Health Surveillance lists.

My GMC Registration number is Code A

My career employment details are as follows:

1996 - 1997	House Surgeon in General Surgery and Urology, Salisbury District Hospital.
1997	House Physician In general Medicine, Queen Alexandra Hospital.
1997 - 1998	Senior House Officer In Accident and Emergency, Salisbury District Hospital.
1998	Resident Medical Officer, Bathurst Base Hospital, New South Wales, Australia.
1999	Senior House Officer In General Adult Psychiatry, St Ann's Hospital, Poole.
1999	Registrar In General Practice, Monksfield Surgery, Daventry.
1999 - 2000	Senior House Officer In Paediatrics, Northampton General Hospital.
2000	Senior House Officer in Obstetrics and Gynaecology, Northampton General Hospital.
2000 - 2001	Senior House Officer in General Medicine, Northampton General Hospital.

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2001 Registrar in General Practice, Monksfield Surgery, Daventry.

2001 Senior House Officer in Palliative Care, Cynthia Spencer Hospice, Northampton.

2001 - 2002 Registrar in General Practice, Trainer Dr Simon Thompson, Abington Medical Centre.

2002 - 2004 PMS Salaried GP, Abington Medical Centre.

2004 to date Locum GP, Somerset and East Devon area.

From February to August 1997 I was working as a House Physician in General Medicine (Respiratory Medicine, Diabetes and Endocrinology) at Queen Alexandra Hospital, Cosham. I was part of the team headed by the consultant Dr Code A , the Registrar was Dr Code A and the Senior House Officer was Dr Code A . I have been asked if I remember a patient named Code A . I have no recollection of this patient. I have been shown a copy of her hospital notes labelled BJC/72 . I note that Code A was admitted on 17/05/97. The Department of Medicine would accept patients from Accident and Emergency or via a GP referral, this was normally handled by the Admissions Bureau, however if it was out of hours I would take the calls as the Junior House Officer.

On page 51 of the notes is a copy of a letter dated 17/05/97, the letter is addressed to me and is signed by Dr Code A . The 17/05/97 was a Saturday and this indicates that I had possibly spoken to the patient's GP myself on the phone. The letter would have accompanied Code A Code A to the hospital, it explained that she was thought to have a urinary tract infection, she was short of breath, confused, disorientated and Wellow Cottage was unable to cope. She had several pre-existing medical conditions.

On our duty takes I would be the first Doctor to see a patient on admittance to a ward, I would examine the patient and carry out the initial clerking. Page 155 of the notes is the start of this process regarding Code A it continues on pages 156 and 157. All 3 pages are written by me and read as follows with explanations in brackets:

17/5/97 1400.

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EA via GP *HARD OF HEARING* *CONFUSED* *known to Dr Code A

PC (Presenting Complaint)

SOB (Short of breath)

Confused

? UTI (Looking to confirm cause of symptoms)

Rest Home unable to cope.

HPC (History of Presenting Complaint)

Hx from GP letter (Unable to communicate with patient so I took the history from the GP letter)

No Hx available from pt recent UTI.

V.deaf

Confused and disorientated.

Unable to do M.M.T.

(She was hard of hearing with confusion and was unable to do the mini mental test).

PMHx (Past Medical History)

Gout.

NIDDM. (Non-Insulin-Dependent Diabetes Mellitus).

CCF (Congestive Cardiac Failure)

DHx (Drug History)

Zestril 2.5mg bd (Twice daily)

Bumetanide 1mg od (once daily)

Aspirin 75mg od (once daily)

Allopurinol 100mg 1 tablet daily

? Melleril 25mg nocte prn (the question mark shows that I was unsure from the GP's handwriting).

Continues on page 156:

SHx (Social History)

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Lives in rest home.

O/E (On Examination)

Alert, disorientated & confused.

Vomit x 1 - bright yellow approx 50mls. (She was probably sick in mine or a nurse's presence)

Temp 36° ax

Dehydrated + + +.

CVS (Cardiovascular System)

P - 108 irreg at apex (Front of chest, this is faster than would be expected and there was a query re her heart rhythm)

88 irreg at radius (wrist)

BP - 140/100 Blood pressure)

JVP ↓ (Jugular venous pressure was down)

HS 1+11+0 (Heart sounds normal)

Mild SOA (Mild swelling of ankles)

Resp (Respiratory system)

On the note I have drawn a diagram of the lungs and wind pipe.

PN - res (Percussion note resonant, this is tapping on the chest and was normal)

Difficult to auscultate due to pt talking .

A few crackles in mid & lower zones. L→ R (Greater on the left than the right)

GI

On the notes I have drawn the abdomen.

Abdo soft

? tender to palpitation generally. (Nothing critical)

BS √ (Bowel sounds present)

MS (Musculo Skeletal)

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Moving all 4 limbs plantars downgoing (Examination of feet showing normal response)

Summary

98 year old lady confused and deaf admitted with increased confusion + ? UTI + ? chest infection + AF (Atrial fibrillation - irregular heartbeat).

Page 157 continues:

17/5/97 contd.

Impr (Impression)
? UTI
? chest infection / bronchopneumoia
+ AF.
Ix (Investigation)
FBC √ (Full Blood Count)
UEC √ (Urea Electrolytes Creatinine)
Glucose √
LFT √ (Liver Function Tests)
blood cultures √
ABG on air (Arterial blood gas)
CXR / AXR (Chest & Abdomen xrays)
Cxr- poor insp. Patchy consolidation (Did not take big breath and patchy infection)
Axr - loaded bowel (constipated)
ECG - rate 135 irg irg (Irregularly irregular, this was obviously written in after the Electrocardiogram had been received)
MSU (Midstream Urine)
Sputum.

P (Plan)

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1 iv access (intravenous)

2 iv fluids + oral fluids

3 Monitor urine output

4. iv cefuroxime (antibiotic)

5. MSU

6. BM's bd

7. 36% oxygen

8. 4° obs (4 hourly observations)

9. Sats monitor (placed on finger measures oxygen in blood)

10. SHO / Reg review

11. Start dig. (Digoxin) 2 x 250 mcg loading dose (This was for the irregular heartbeat)

12. For aperients. (Drugs for constipation)

In the left hand column of the page I have added the results from these tests, this was probably done later that day or the following morning.

Ur 14.4 (Urea)

NA 149 (Sodium)

K. 3.6 (Potassium)

Gluc 8.7 (Glucose)

Cr 151 (Creatinine)

Bili 13 (Bilirubin)

Prot 66 (Protein)

Alb 39 (Albumin)

Alk Phos 76 (Alkaline Phosphatase)

Ast 23 (Aspartate transaminase)

The results show a raised urea and creatinine level which might reflect an element of dehydration. Sodium is marginally raised (upper normal limit 145) but unlikely to be of clinical significance. Liver function tests are normal. The random glucose level is satisfactory.

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ABG on air

H+ 35.

PCO 2 5.6

PO 2 6.7

HCO 3 28.4

BxS 4.6

O2 sqt 88.5%

The results show a reduced PO 2 and oxygen saturations which can be associated with infection and heart failure.

Hb 11.3

WBC 6.7

Plt 305

The full blood count results are satisfactory.

I next saw the patient on the following day and this was recorded by myself on page 158 of the notes. The entry reads as follows:

18/5/97 SB JGBM (Seen by Dr Code A

Apyrexial

Mildly dehydrated

More alert than o/a (On admission)

P - 80 JVP ↓

BP 125/80

Chest clear

P (Plan) Continue iv fluids + regular digoxin

Iv cefuroxime

I have signed the entry.

Signed: Code A

Signature Witnessed by:

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My notes record that the patient did not have a temperature, that she remained mildly dehydrated but that she was more alert than on admission. Her pulse was 80 (normal rate) and her jugular venous pressure (JVP) was down. This can be raised in heart failure. Blood pressure was normal and her chest sounded clear. The plan was to continue intravenous fluids, medication for her irregular heart beat and intravenous antibiotics.

On the same page (158) is another entry written and signed by myself, it reads as follows:

19/5/97 SB HO (Seen by House Officer)
Much better but v. deaf!
Sitting in chair but talking + + (talking a lot)
Temp 35.8 ax (normal)
BP 130/80 P - 90
Plan Discontinue iv fluids when oral intake adequate.
Change to oral antibiotics. Repeat bloods.
Mobilise before home

My next entry is on page 159 and relates to a visit by the Senior Registrar, I wrote and signed the entry up which reads as follows:
Sleeping in chair. Some SOB at rest (Shortness of breath)
Apyrexial
BP 120/80 P - 88

O/E (On examination) In AF (Atrial Fibrillation)
Slightly dry.

Restart slow I/V fluids.
Push oral fluids.
Continue dig (Digoxin)
Check TFT's. (Thyroid function tests)

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Check BM's (Blood sugars)

The results from the previous day's tests had been attached to this page and they showed that the creatinine and urea had improved, though the White Blood Count was slightly raised due to infection.

There is a further entry on page 159 which is also written and signed by me, it reads as follows:

22/5/97 SB Code A Seen by Dr Code A

Apyrexial
P - 80 irregular
BP 120/80
JVP ↓
A few basal crackles (bottom of lungs)
BO √ (Bowels open)

Plan Push fluids
Continue antibiotics till tomorrow, home soon.

My last recorded entry is on page 160 of the notes and reads as follows:
23/5/97 SB HO

Apyrexial comfortable at rest
BP 120/70 P - 88 irreg

T - T4 115 (Thyroxine)
TSH 1.6 (Thyroid Stimulating Hormone).

P 1. Continue iv fluids until oral intake improved.
2. Check dig levels.

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3. Plan for home next week.

As previously stated I have no recollection of this patient but the impression given by the notes is that clinically her condition was felt to be improving.

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

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

Signed: Code A Date: 29/11/2005

I am a Consultant Physician specialising in Diabetes and Endocrinology, I am an Honorary Senior Lecturer and Honorary Clinical Lecturer at The Universities of Portsmouth and Southampton respectively.

My qualifications are as follows;

MB.ChB. June 1989 University of Bristol

MRCP June 1994 London

FRCP July 2004 London

In 1997 I was working at Queen Alexandra Hospital, Cosham as a Senior Registrar under the consultant Dr Code A. Also in our team were Dr Code A Senior House Officer and Dr Code A House Officer. Although we specialised in Diabetes and Hormones we also had responsibility as the duty team for medical admissions. A patient admitted to the medical wards would be allocated to the duty team, that team would then take on responsibility for the care and treatment of the patient. If a patient had previously been seen by a consultant then that consultant might have been invited to take the case on after the duty team had completed the initial assessment etc.

I have been asked if I recall one of our patients named Code A, I have no recollection of her. I have been shown a copy of her hospital notes labelled BJC/72. From these notes I can say the following;

Code A was a 99 year old lady who was admitted to the ward as an emergency

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admission on 17/5/97 at 1400 hours. The initial entry was written by Dr Code A

On page 158 there is another entry in the clinical notes dated 17/5/97, it starts off SHO but this has been crossed out. The SHO was Code A so I assume that he was seeing the patient and that I joined him, I then continued by writing the following;

SR Review.

Thank you

I note Hx (Hx means history)
C evidence LVF (This means - with evidence of left ventricular failure)
ECG. Q waves inf. T waves inv Cxr bilateral effusion ULBD Fluffyfields.
Imp Dehydrated + LVF
Not a candidate for inotropes.
xx Not for 555 xx
Plan Rehydrate as above.
Antibiotic cover.

I have signed the entry.

These notes show that her electrocardiogram (ECG) and chest x-ray (Cxr) indicated findings of heart failure. Inotropes are intravenous drugs which are used to stimulate the heart, they make it pump more powerfully. However they were considered as unsuitable given her age, her fast irregular heart beat and her previous heart disease.

Not for 555 is a note to show that she should not be resuscitated if her heart was to stop beating, this decision was made as it was considered that the probability of a successful resuscitation was remote due to her age and her past history of ischemic heart disease. Not for 555 does not necessarily mean the patient was dying, in this case the plan was to rehydrate her and to give her antibiotic cover as there was a chance that she had a chest infection. This shows that we were

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managing her actively, we were trying to get her better.

On page 161 there is an entry dated 27/5 which reads as follows;

WR. SR.
C/O arm weakness
O/E L arm weak Plantars ↓

Plan Social services referral
RH ASAP

It is then signed by a junior doctor from my team

This entry relates to a ward round at which I would have been present as the Senior Registrar. Code A was complaining of weakness in her left arm. On examination her plantars were down, this is a simple test involving the feet and indicates that the weakness was not related to a stroke. There was no obvious condition. The plan was to get her referred to Social Services.

It is possible that I saw the patient on other occasions with Dr Code A but from the notes I am unable to confirm this.

Code A was a patient who was admitted as an emergency onto the medical wards, she was unwell, she had acute left ventricular failure, was dehydrated and possibly had a chest infection. During her treatment she was given Digoxin (for her heart), antibiotics(re her chest) and fluids for the dehydration. She continued to improve throughout her stay with us.

As the rest home from which she came were no longer able to look after her she was referred to social services. As it was no longer appropriate for the patient to remain at Queen Alexandra she was consequently seen by a Geriatrician named Dr Code A. His department looked after the beds at Gosport War Memorial Hospital. Dr Code A arranged for her to be further assessed at

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Continuation of Statement of: Code A

Gosport War Memorial Hospital. She was transferred on 3/6/97.

Signed: Code A

Signature Witnessed by:

2004(1)

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 6 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Date:

I am a qualified doctor currently taking a career break. I live at the address stated overleaf. My initial medical training was undertaken at Southampton University between 1990 - 1996, qualifying with a BM.

I have held the following positions;

Surgical House Officer Feb 1996 - Aug 1996 Princess Margaret Hospital, Swindon.
House Physician Aug 1996 - Feb 1997 Salisbury District Hospital.
Agency Locum appointments approximately May 1997 - Feb 1998.
Senior House Officer Feb 1998 - Aug 1998 Chelsea and Westminster Hospital.
Senior House Officer Medical Aug 1998 - Aug 1999 Chelsea and Westminster Hospital.
Agency Locum appointments Aug 1999 - Oct 1999 London area.
Staff Grade Accident and Emergency Oct 1999 to April 2001 Basingstoke General Hospital.
Senior House Officer Paediatrics May 2001 - July 2001 St Mary's Hospital, Portsmouth.
Senior House Officer Paediatrics Aug 2001 - Feb 2002 Wexham Hospital.

I then had a break from medicine .

Psychiatric Senior House Officer Oct 2004 - Aug 2005 Blackberry Hill Hospital.

I have been on a career break since then.

In May 1997 I was working as a Locum House Officer at The Queen Alexandra Hospital,

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Cosham.

I believe I was part of the following team;

Dr Code A Consultant, Dr Code A Senior Registrar, Dr Code A Senior House Officer and Dr Code A House Officer.

I have been asked if I remember a patient by the name of Code A. Having been given the opportunity to read the patient's hospital records (BJC/72) I do have some memory of the case, though this statement is made by referring to those notes.

I can see that she was admitted onto the Medical Wards at Queen Alexandra Hospital on 17/5/1997. I would imagine that Dr Code A's team were on call which would explain how we came to have responsibility for the patient. Code A was a patient who was admitted as an emergency onto the medical wards, she was unwell, she had acute left ventricular failure, was dehydrated and possibly had a chest infection.

As far as I am aware I did not see the patient personally until 26/05/1997, this is recorded on page 160 of the notes. The note is in my handwriting and reads as follows:

26/5/97 ATSP
Nurses complain;

1. Not weight bearing on transferring today.
2. Floppy L hand.

c/o Nil
Feels fine
Unaware of reduced use of left hand.

o/e Using L arm less Apyrexial
↑flaccid, but moving.

Power & tone ↓ L arm

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Biceps jerk + + also.

	LA	RA	LL	RR
Tone	↓	→	→	?↑
Power	4/5	4 ½ / 5	4/5	4/5
Co-ordination	↓↓	→	→	→

Reflexes Triceps jerks & biceps jerks ↑ on L

Legs L = R

See →

Imp CVA / TIA

Plan 1. Continue

2. Physio tomorrow.

I have then signed the entry. I will explain this entry in layman's terms.

The nurses asked me (ATSP) to see the patient, they had told me that Code A was not putting any weight down when they moved her and that her left hand was floppy. Code A Code A herself was not complaining of anything and was unaware that she had reduced use of her left hand. I examined her and found that her arm was weaker but she was still able to move it. Her power and tone (in the arm) were reduced. Her biceps and triceps reflex reactions had increased. Her legs were showing no abnormal reactions. Her temperature was normal.

My impression was that she may have suffered a cardiovascular accident (CVA) or a transient ischaemic attack (TIA). The plan was to continue her treatment as before and to have her seen by a physiotherapist the following day.

The following page (161) shows a continuation of this visit again in my handwriting and reads as follows:

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26/5/97 (Hx cont)

CNS II- X normal
XI ↓ on R
XII normal

CVS pulse 80 reg no carotid bruits.
HS 1 + 11 + 0 Normal

RVS Chest clear BS Vascular

I have signed this entry. These were basic tests on the Cranial Nerves, Cardiovascular System and Respiratory System they all showed normal results with no outstanding worries.

Also on page 161 I have written another entry as follows;

27/5 WR SR
c/o no weakness
o/e L arm weak
planters ↓

Plan Social service referral
RH ASAP.

I have signed the entry.

This entry shows that I was present during the Senior Registrars ward round, although it is not recorded the usual practice would have been for the SHO, HO and nursing staff to accompany the Registrar on his ward rounds. It was also normal practice for a junior doctor to write up the ward round on behalf of the Registrar. The entry shows that Code A was not complaining of any weakness though her left arm was still weak. She had had a small stroke affecting her left arm.

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I next saw her on 2/6/97 and this is recorded in my handwriting on page 163. The entry reads as follows;

WR HO

Well.
No change
Await Gosport War Memorial.
Plan Chase bed.

I have signed the entry. This shows that there were no changes in the patient's health and we were actively trying to get her transferred to Gosport War Memorial Hospital . I note that she had been seen by a geriatrician after my last entry and he obviously agreed that transfer to Gosport was appropriate for Code A

My last involvement with the patient was on 03/06/1997 and is recorded on page 163 of the notes. There is an entry dated 3/6/97 in my handwriting which reads as follows;

3/6/97 WR Code A
Well
Await angioplasty

This obviously related to the wrong patient which is why I crossed it out, the entry continues;

WR Code A

Well.
Gosport today.
I have then signed the entry.

This shows that Dr Code A the Consultant was of the opinion that the patient should be

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transferred that day as planned.

In summary I was not involved in the initial assessment and treatment plan for Code A she had been prescribed drugs for re-hydration, heart rate control and an antibiotic for her lungs. Code A presented to us in a confused state, the available evidence suggested that she had respiratory tract infection, atrial fibrillation and cardiac failure. She was treated and improved but during her stay she was noted to have problems with obvious loss of function to her left hand. She had deterioration with weight bearing. Examination confirmed a weak left arm suggesting a recent stroke or TIA.

Vailable evidence es in her condition on the occasions that I saw her and I did not prescribe any drugs, she continued to improve until she was able to transfer to Gosport War Memorial Hospital on 3/6/1997.

Statement taken by DC Code A

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 1 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 07/10/2005

I am Detective Constable Code A Christopher Code A of the Hampshire Constabulary currently attached to the Major Crime Department.

On Thursday, 6th October 2005 (06/10/2005) I attended the records office at the Portchester Crematorium, Upper Cornaway Lane, Portchester where I spoke to the Registrar Code A On the authority of a letter signed by the assistant Chief Constable Code A I seized the original cremation certificate for Code A

This cremation certificate is now available with an identification reference of 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: DETECTIVE CONSTABLE Code A

This statement (consisting of 1 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 07/11/2005

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

At 0911 hours on Thursday, 27th October, 2005 in company with Detective Constable Code A Code A I conducted a tape recorded interview of Doctor Code A. The interview took place within an office of the Fraud Squad at Netley Support Headquarters and in the presence of her solicitor Mr Code A. The interview was concluded at 0934 hours.

The interview was conducted in accordance with the codes of practice on tape recorded interviews and the sealed master tape is available with an identification reference of CSY/Code A1.

During this interview Doctor Code A produced a prepared statement which she then read and signed as being her statement. This prepared statement is available with an identification reference of 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: DETECTIVE CONSTABLE

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: 21/11/2005

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

In addition to the statement I made on the 7th November 2005 (07/11/2005) regarding the interview with Doctor Code A on the 27th October 2005 (27/10/2005), I have since caused a full transcript to be made of the interview tape bearing the identification reference Code A This transcript is now available bearing the identification reference of Code A

Signed: Code A Signature Witnessed by:

2004(1)

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

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

This statement (consisting of 1 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 09/01/2006

At 0911 hours on Thursday 27th October 2005 in company with Detective Constable Code A we conducted a tape recorded interview of Dr Code A in an office within the Fraud Squad at Support HQ, Netley. Also present was Doctor Code A solicitor Mr Code A

.

The interview was concluded at 0934 hours that morning. During the interview Doctor Code A made a prepared statement which she read out and then signed and dated. This prepared statement is available with an identification reference of Code A.

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

Signed Code A Signature Witnessed by:

2004(1)