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: HUMPHREY, LESLEY FORBES

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

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: L HUMPHREY Date: 27/01/2000

I am employed by the Portsmouth Health Care NHS Trust and my role is that of Quality Manager. I have a professional nursing background.

I have been requested, by Detective Chief Inspector BURT of the Hampshire Constabulary, to make available a particular Portsmouth Health Care NHS Trust Health Record which relates to a former patient named Gladys RICHARDS who died on the 21st August 1998 (21/08/1998) at the Gosport War Memorial Hospital .

Gosport War Memorial Hospital is a Community Hospital where the day to day care is provided by a team of nurses, therapists and managers. Clinical Assistants, who are usually local general practitioners, provide the routine medical cover by making daily visits to the wards and can be asked to make additional visits as necessary. Each consultant visits weekly to conduct a ward round. There is no residential medical cover.

The nursing care is provided is non acute, for instance intravenous fluids would rarely be given. Subcutaneous fluids can be given, as can fluids and liquid feeds via a naso-gastric tube.

Daedalus Ward has twenty four beds; eight are for people needing slow stream stroke rehabilitation and sixteen are for people who meet the criteria for NHS continuing care. Mrs RICHARDS was a continuing care patient.

I have traced the Health Record which relates to Gladys RICHARDS and I will retain it, in my possession, in its original state.

I will produce the original Health Record for inspection or such other purpose as may be required in connection with the police investigation.

The original Health Record now has attached to it a Hampshire Constabulary exhibit label, which I have signed, marked LH/1 .

Signed: L HUMPHREY Signature Witnessed by: R J BURT DCI7410

2004(1)

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I have produced a complete, photocopied, facsimile of this health record and I have handed it to Detective Chief Inspector BURT. Attached to this copy Health Record is a Hampshire Constabulary exhibit label, which I have signed, marked LH/1/C .

In order to assist with the police investigation process I will introduce and comment upon where it might be helpful to do so, each page of the copy Health Record (LH/1/C). In order to achieve clarification each page of the copy Health Record (LH/1/C) has been marked with an individual pencilled reference eg, File Cover Sheet (LH/1/C/1).

In an attempt to further assist I will, where it is possible to do so, given an indication of who the author of certain entries, among the file notes, may have been. However, whilst I may so comment in good faith, I cannot guarantee the accuracy of these particular observations on my part.

File Cover Sheet - Front (LH/1/C/1)

This is the File Cover Sheet and it has, recorded upon it, information relating to the patient and subject of the Health Record namely Gladys RICHARDS. This Health Record bears the reference number Code A The information includes the subject's name and date of birth - Code A The subject's address is recorded as being 'Glen Heathers' Nursing Home, Milvil Road, Lee-on-Solent, PO139LU . The subject's doctor (GP) is recorded as being Dr JH BASSETT . The File Cover Sheet has been stamped with an endorsement indicating that the subject, Gladys RICHARDS, died on the 21st August 1998 (21/08/1998).

Supply of Address Labels (LH/1/C/2)

This is a page with a number of adhesive pre-prepared address labels relating to the patient and designed to facilitate efficient administration.

File Divider - Correspondence (LH/1/C/3).

This represents an aid to efficient filing.

Provider Spell Summaries (LH/1/C/4 and 5)

A Provider Spell Summary is a computer generated form which is completed when a patient is either discharged from a hospital or dies. The form is completed by staff who add appropriate handwritten notes. There are two Provider Spell Summaries on the Health Record in question. Both forms, which are self carbonating, appear to have been inadvertently overwritten in places - more so in the case of LH/1/C/5.

The first form (LH/1/C/4) is hand dated the 21st August 1998 (21/08/1998). It was completed

on the occasion of the death of Gladys RICHARDS. I believe that the handwritten entries were made by Doctor J BARTON who is a visiting GP and Clinical Assistant at the Gosport War Memorial Hospital. I believe that the dates (21.8.98) (21/08/1998) and signature, lower down, were written by Staff Nurse GIFFIN.

The second (LH/1/C/5) is hand dated the 14th August 1998 (14/08/1998). It was completed on the occasion of the discharge and transfer of Gladys RICHARDS to the Royal Hospital Haslar. I believe that the date (14.8.98) (14/08/1998) and signature were written by Philip BEED who is a Clinical Manager. It is possible that the other handwritten entries were made by Philip BEED but I cannot be certain.

Letter from Royal Hospital Haslar (LH/1/C/6)

This letter, dated the 17th August 1998 (17/08/1998) is a discharge letter addressed to the Nurse in Charge, Daedalus Ward, Gosport War Memorial Hospital. It provides information as regards the condition of Gladys RICHARDS on the occasion of her being discharged and transferred from the Royal Hospital Haslar back to the Gosport War Memorial Hospital. I am unable to comment on the authorship of this letter.

Letter from Royal Hospital Haslar (LH/1/C/7)

This letter, dated the 10th August 1998 (10/08/1998) is a discharge letter which was prepared on the occasion of the discharge and transfer of Gladys RICHARDS from the Royal Hospital Haslar to the Gosport War Memorial Hospital. It purports to have been signed by Sergeant NJ CURRAN a Staff Nurse.

Letter from Gosport War Memorial Hospital (LH/1/C/8)

This letter, dated the 14th August 1998 (14/08/1998) is a discharge letter which was written by Philip BEED on the occasion of the discharge and transfer of Gladys RICHARDS from the Gosport War Memorial Hospital to the Royal Hospital Haslar. This letter was written on the back of LH/1/C/7.

Letter from the Portsmouth Health Care NHS Trust (LH/1/C/9)

This letter, dated the 5th August 1998 (05/08/1998) was written by Doctor RI REID , a Consultant Physician in Geriatrics, to Surgeon Commander M SCOTT of the Royal Hospital Haslar. In this letter Doctor REID refers to the fact that he has seen Gladys RICHARDS, on Ward E6 at the Royal Hospital Haslar and undertakes to arrange for her transfer to the Gosport

War Memorial Hospital.

File Divider - Clinical Record (LH/1/C/10)

This represents an aid to efficient filing.

(Medical) History Sheet (LH/1/C/11)

This form facilitates the recording of the subject's medical history. In the case of LH/1/C/11 both sides of a single page have been completed. There are seven, dated, entries covering the period of the 11th - 21st August 1998 (21/08/1998) inclusive. The first six entries appear to have been written by Doctor BARTON while the seventh appears to have been written by Staff Nurse GIFFIN.

File Divider - Therapy and Nursing Notes (LH/1/C/12)

This represents an aid to efficient filing. All pages in this section (LH/1/C/13-22) make up the nursing records.

General Information Form (LH/1/C/13)

This form caters for the recording of various categories of general information. On the back of LH/1/C/13 there are some handwritten notes relating to the past medical history of, presumably, Gladys RICHARDS. I am unable to comment on the authorship of this form.

Summary Form (LH/1/C/14)

This form is designed for the recording of significant events. It has one entry written upon it. It is dated the 11th August 1998 (11/08/1998). I am unable to comment on the authorship.

Assessment Sheet (LH/1/C/15)

This form is designed to enable a comprehensive nursing assessment to be carried out in respect of a patient. I am unable to comment on the authorship of the entries which have been made upon it.

Abbreviated Mental Study (LH/1/C/16)

This form is designed to enable a basic assessment to be carried out of a patient's mental capabilities. It was not completed in this case.

The Barthel ADL Index (LH/1/C/17)

This form is designed to enable an assessment to be carried out of a patient's ability to undertake the activities of daily living (ADL). In the case of Gladys RICHARDS an assessment was made on the 11th August 1998 (11/08/1998). I am unable to comment on the authorship of this form.

Waterlow Pressure Sore Prevention/Treatment Policy (LH/1/C/18)

This form is designed to enable an assessment to be carried out of the degree of risk that a patient will develop pressure sores. In the case of Gladys RICHARDS an assessment was carried out on the 11th August 1998 (11/08/1998). I am unable to comment on the authorship of this form.

Lifting/Handling Risk Calculator (LH/1/C/19).

This form is designed to enable an assessment to be carried out of the degree of risk associated with lifting/handling a patient. It was not completed in this case.

Patient Medication Information (LH/1/C/20)

This form is used to record details of patient's medication. In this case there are two entries both dated the 11th August 1998 (11/08/1998). I am unable to comment on the authorship on these entries. This form is only a nursing record and in no way replaces the prescription sheet.

Contact Record (LH/1/C/21)

This form is used to record significant events in terms of patient/relative/doctor contact. In this case there are two sheets (four sides). There are seventeen entries and I am able to suggest that they may have been written by the following members of staff:

13/08/1998 Staff Nurse BREWER

14/08/1998 Clinical Manager Philip BEED

14/08/1998 CM Philip BEED

17/08/1998 Staff Nurse JOICE

17/08/1998 Staff Nurse COUCHMAN

17/08/1998 Staff Nurse JOICE

17/08/1998 Staff nurse COUCHMAN

17/08/1998 CM Philip BEED

18/08/1998 CM Philip BEED

18/08/1998 CM Philip BEED

18/08/1998 CM Philip BEED

18/08/1998 Staff Nurse JOICE

18/08/1998 Staff nurse FLORIO

19/08/1998 Staff Nurse FLORIO

19/08/1998 CM Philip BEED

21/08/1998 Staff Nurse JOICE

21/08/1998 Staff Nurse GIFFIN

Nursing Care Plan (LH/1/C/22/1-4)

A Nursing Care Plan form (LH/1/C/22) was, in this case, commenced on the 12th August 1998 (12/08/1998). There are six, subsequent, dated entries covering the period of the 12th August 1998 (12/08/1998) until the 19th August 1998 (19/08/1998) inclusive. The majority of these entries may have been made by Staff Nurse FLORIO. I am unable to comment on the authorship of the entry dated the 17th August 1998 (17/08/1998).

The Nursing Care Plan document embraces four other pages which are designed to enable various aspects of nursing care to be monitored. The pages are headed - Nutrition (LH/1/C/22/1). Constipation (LH/1/C/22/2). Bowel Movement Calendar (LH/1/C/22/3 and Personal Hygiene (LH/1/C/22/4). Various entries have been made on these forms. I am unable to comment on authorship other than where the signature is legible.

File Divider - Prescription Sheets & Observation Charts (LH/1/C/23)

This represents an aid to efficient filing.

Prescription Sheet (LH/1/C/24)

This is a six sided, folding, form upon which details of drugs, prescribed and given to a patient, are recorded. Exceptions to prescribed orders are also given.

File Divider - Investigations (LH/1/C/25)

This represents an aid to efficient filing.

Biochemistry (LH/1/C/26)

No entries recorded.

Haematology, Blood Transfusions and Immunology Reports (LH/1/C/27)

No entries recorded.

Portsmouth Pathology Service Microbiology Report (LH/1/C/28)

This form indicates the results of microbiological tests conducted in respect of various MRSA screening swabs taken from Mrs Gladys RICHARDS on the 11th August 1998 (11/08/1998) and reported on, on the 14th August 1998 (14/08/1998).

Radiology Report (LH/1/C/29)

This form indicates the result of an 'x' ray examination of Gladys RICHARDS right hip conducted on the 17th August 1998 (17/08/1998).

Radiology Report (LH/1/C/30)

This form indicates the result of an 'x' ray examination of Gladys RICHARDS hips conducted on the 14th August 1998 (14/08/1998).

File Cover Sheet (Back) (LH/1/C/31)

This form has, printed upon it, an administrative index.

Moving on from the Health Record I am able to produce a photocopy of a Portsmouth Health Care NHS Trust 'Risk Event Record' form which has, attached to it, a Hampshire Constabulary exhibit label, which I have signed, marked LH/2.

This form, comprising of three sides, was commenced by Staff Nurse BREWER on the 13th August 1998 (13/08/1998) after Gladys RICHARDS suffered a fall at the Gosport War Memorial Hospital. Further entries on this form have been made by Philip BEED and Sue HUTCHINGS who is the Senior Nurse Co-ordinator.

On the 20th August 1998 (20/08/1998) I received a handwritten communication from Mrs LACK, the daughter of Mrs Gladys RICHARDS, in which she posed a series of questions concerning the care which had been provided for her mother. I am able to produce a photocopy of this document which has, attached to it, a Hampshire Constabulary exhibit label, which I have signed, marked LH/3 .

As a result I initiated an internal enquiry which was carried out by the then Acting Service Manager Mrs Sue HUTCHINS. Mrs HUTCHINS completed her enquiry on the 11th September 1998 (11/09/1998). I am able to produce a photocopy of the Enquiry Report which has, attached to it, a Hampshire Constabulary exhibit label, which I have signed, marked LH/4 .

Subsequently on the 22nd September 1998 (22/09/1998) a letter was sent, by the Trust, to Mrs LACK, in reply to her communication (LH/3). It was signed by Mr MILLETT , the Chief Executive and drew on the findings of Mrs HUTCHINS enquiry. I am able to produce a copy of this letter which has, attached to it, a Hampshire Constabulary exhibit label, which I have signed, marked LH/5 .

On the 11th December 1998 (11/12/1998) I received a telephone call from Code A e whose name, I believed w Code A As a result of the call I arranged for a report to be

prepared by Doctor A LORD , a Consultant Geriatrician, employed by the Trust.

Dr LORD was the Consultant to Daedalus Ward to which Mrs RICHARDS was admitted. The report set out to explain the care provided to Mrs RICHARDS prior to her death. A copy of the report, signed by Dr LORD and dated the 22nd December 1998 (22/12/1998), was forwarded to the Police on the 19th January 1999 (19/01/1999). I am able to produce a photocopy of Dr LORD's Report which has, attached to it, a Hampshire Constabulary exhibit label, signed by me, marked LH/6 .

Whilst Mrs RICHARDS was admitted to the Gosport War Memorial Hospital she was x-rayed on two occasions. The dates on which the diagnostic imaging took place were 17th August 1998 (17/08/1998) and 14th August 1998 (14/08/1998) (see LH/1/C/29-30 respectively). The x-rays are currently in my possession and I will retain them. I will make the x-rays available for examination, as required, for the purposes of the police investigation. The x-rays have attached to them Hampshire Constabulary exhibit labels, signed by me, marked LH/7 and LH8 respectively.