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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: MURRAY, KEITH PAUL

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

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

Signed: K P MURRAY Date: 21/10/2002

I am the above named person and reside at an address known to the Hampshire Constabulary. I am employed as a fully qualified G grade charge nurse by the Portsmouth Hospitals NHS Trust and for the last two years I have been working in a full time basis as a convenor for the Royal College of Nursing . I undertook my nurse training in Portsmouth from 1967 to 1970 and after qualifying followed this by 18 months training in psychiatric nursing. After completion of this training I returned to general nursing where I have remained until my present role. I currently work from home as I do not have the provision of an office. While I am no longer actually practicing in the true sense of the word I remain an employee of the National Health Service and have to keep myself updated on nursing issues.

The Royal College of Nursing acts as a trade union and a professional organisation that formulates and writes policy on nursing issues. The RCN has people at each hospital known as Stewards who are a first contact point for the membership, a convenor is for want of a better way of putting it, one up from a steward and has a responsibility for a larger area encompassing several hospitals. The position is purely voluntary it is unpaid and persons filling this role are expected to do this in addition to their nursing duties. A convenor is expected to deal with a variety of concerns relating to nursing issues through to contractual/labour issues. In order to assist me in this role I underwent a five-day training course and then the training was an ongoing process where I attended study days and other courses. As a nurse I was expected to keep myself updated on new procedures and the like as well as identify courses that I wished to attend.

To assist me in the making of this statement I have referred to correspondence that I made with the staff and management of which I have copies, as did the police. All items given an identification reference of KPM/1-7 are items of correspondence that I still have copies of but

the police did not. All items given an identification reference beginning with JEP/GWMH/1/4 were already in the possession of DC Code A but I still have my own copies.

In 1991 I was employed as a G grade Charge Nurse on an orthopaedic ward at the Queen Alexandra Hospital in Cosham, Portsmouth . I was also a RCN convenor for Portsmouth and the surrounding areas. During the early part of 1991 I was contacted by a Staff Nurse Anita TUBBRITT who was working on an elderly care ward at Redcliffe Annexe, The Avenue, Gosport . Redcliffe was an annexe to the Gosport War Memorial Hospital and was an elderly care ward. As such it was not unusual for a large proportion of the patients to remain on the ward until they died. However if possible it would be preferred to care for the patients until they were able to return to care in the community. Staff Nurse TUBBRITT identified concerns that she and other members of the night staff at Redcliffe Annexe had over the use of Diamorphine and Syringe Drivers . I do not have a record of this telephone conversation but my pattern for dealing with such matters has always been the same. This occasion was not any different and I arranged a meeting for staff that wished to attend at the home address of Staff Nurse Sylvia GIFFIN . I cannot recall the date other than it would have been in February 1991 nor can I remember who was there but do remember that there were about five to six members of staff from the Redcliffe Annexe present.

During this meeting the staff expressed their concerns about patients being inappropriately prescribed Diamorphine either via a syringe driver or by other means. The nurses present expanded and explained that Diamorphine, which is an extremely powerful sedative used for pain relief was being prescribed without due consideration being given to the use of milder sedatives first. It was and still is normal practice to use a sliding scale when prescribing pain relief medication. If a patient is in pain then consideration should be given to the use of an analgesic first, at the bottom of the scale are such medication as Aspirin and the like. A doctor alone was responsible in 1991 for prescribing drugs to be used and common sense would dictate where, on the scale the patients needs would fall but it was not acceptable practice to start a patient immediately on Diamorphine. To use an anecdote, "you do not need a sledgehammer to crack a walnut".

Diamorphine would normally be used for patients that were terminally ill, suffering with coronary thrombosis or occasionally for postoperative care. This is by no means an exhaustive list for when this drug may be prescribed but gives an indication that it was the exception rather

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than the norm.

Examples were given by the staff of Diamorphine being used to insert a catheter into patients. This can be a particularly painful procedure especially for males but a local anaesthetic in the form of a jelly would normally be used.

Staff stated that not only was Diamorphine being prescribed but also the use of a syringe driver was being advocated. A syringe driver was quite a new piece of equipment as far as the nurses were concerned and it is a battery-powered device that administers a drug via a syringe at a steady rate over a 24 hour period. The benefit of this would be that a patient that was in considerable pain would not suffer the peaks and troughs suffered by a patient that was receiving pain control by another means. Without the use of a syringe driver a patient would suffer pain, pain relief would be administered as prescribed, the patient would have to wait for the drug to take effect before enjoying relief but as the effects of the drug wore off would again start to suffer before further pain control could be administered. A syringe driver is an excellent piece of equipment in the field of pain control but should be used very much as a last resort. If a patient has been tried on other forms of pain control and it has now been decided that Diamorphine should be the next step then other methods of administering it should be considered and have failed before resorting to the use of a syringe driver.

Diamorphine is an extremely strong sedative as previously stated but does have some side effects one of which is the reduction of the respiratory rate. A patient that is elderly and lying in bed will not breathe deeply so could therefore suffer with congestion in the lungs leading to Hypostatic Pneumonia and to combat this often another drug such as Hyoscine was prescribed. Although I am not an expert in this field this was one of the common side effects that we were taught could accompany the administration of diamorphine.

I do not know what the staff to patient ratio was at the Redcliffe Annexe and also do not know what the care regime was in the way of attempting to return patients to care in the community. There were obviously Doctors that attended the annexe on a daily basis and one such Doctor that was named by the staff at the meeting was Doctor Jane BARTON . There was also a consultant geriatrician that would visit on certain days by the name of Doctor LOGAN .

As a result of this meeting I felt that their concerns were justified and suggested that they sent a letter to Isobel EVANS who was the Patient Services Manager. I drafted this letter myself and posted the draft to Staff Nurse Sylvia GIFFIN with an accompanying letter dated the 15th

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February 1991, (15/02/1991) I also enclosed a copy of the UKCC (code of professional conduct). I still have a copy of these documents, which are available with an identification reference of KPM/1 .

Staff Nurse GIFFIN obviously sent this letter as I later received a copy of a letter to Staff Nurse GIFIN from Isobel EVANS dated 28th February 1991, (28/02/1991) this letter contained a suggestion that they met to identify specific areas of concern so that a plan of action could be determined if necessary. This document is available with an identification reference of KPM/2 .

On the 4th March that year I sent a letter to Isobel EVANS stating that Staff Nurse GIFFIN had expressed a wish that she be represented at any meeting that should be convened on the receipt of her letter and that I wished to be informed of any such meeting so that this could be arranged. A copy of this letter is available with an identification reference of KPM/3 . I sent a copy of this letter to staff Nurse GIFFIN.

I was then sent a copy of a handwritten letter dated 5th March 1991 (05/03/1991) from Staff Nurse GIFFIN to Isobel EVANS stating that she was willing to attend any meeting but wished to be represented by me. The copy of this letter is available with an identification reference of KPM/4 .

On 26th April 1991 (26/04/1991) I represented Sylvia GIFFIN during a meeting with Isobel EVANS. I cannot recall anything about the meeting from memory but from other paperwork can say that it was decided that a notice should be displayed at the Redcliffe Annexe informing staff that the RCN were now aware of concerns regarding the use of syringe drivers on their ward and having discussed the matter with Mrs EVANS that a meeting would be arranged where staff could attend and voice any concerns without fear of reprisals by disciplinary action. Also a written policy be agreed on the use of syringe drivers and controlled drugs. I have a copy of this notice along with a letter that I sent to Sylvia GIFFIN accompanying the notice dated 30th April 1991 (30/04/1991). These documents are available with an identification reference of KPM/5 .

On the same day I sent a copy of the above notice to Isobel EVANS thanking her for the meeting held on 26th April 1991 (26/04/1991) and also conveying my apologies to Dr. BARTON as she had apparently felt that her clinical judgement was being questioned. A copy of this letter is available with an identification reference of KPM/6 .

I was later sent a copy of the minutes of a meeting held at the Redcliffe Annexe on 11th July

1991 (11/07/1991) where the staff reiterated their concerns. I had not been informed of this meeting so did not attend. A copy of these minutes is available with an identification reference of JEP/GWMH/1/4/B .

I was sent and still have a copy of a report regarding the visit of Geraldine WHITNEY to the Redcliffe Annexe dated 31st October 1991 (31/10/1991). Geraldine was the community tutor for continuing education and the purpose of the visit was recorded as in response to a request by Staff Nurse Anita TUBBRITT to discuss the issue of anomalies in the administration of drugs. The conclusion of the report was that the staff were concerned that Diamorphine was being used indiscriminately even though they reported concerns to their manager on 11th July 1991 (11/07/1991). The staff were also concerned that non-opoids, or weak opoids are not being considered prior to the use of Diamorphine. The staff had received some training arranged by the hospital manager, namely 'the syringe driver and pain control' and 'pain control'. Staff Nurse TUBBRITT was in undertaking literature on pain and pain control. A copy of this report is held by DC Code A and bears an identification reference of JEP/GWMH/1/4/C . I can remember receiving a telephone call from Geraldine WHITNEY prior to this meeting stating that she had had a member of staff from Redcliffe Annexe on a training day, this member of staff had got herself in to such a state over the matter that she poured her heart out to Geraldine which is what prompted the above meeting.

I was extremely concerned about the issues being raised by members of staff at the Redcliffe Annexe so I ensured that Steve BARNS the RCN Regional Officer responsible for my area was constantly updated. At this stage I did not feel as though anything was being accomplished through the correspondence and meetings with Isobel EVANS so I contacted Steve BARNS in writing. As a result of this Steve BARNS wrote a letter dated 22nd November 1991 (22/11/1991) to Isobel EVANS stating that it was now a matter of serious concern that these complaints were not acted upon in the way that had been anticipated and that management were, some months after the discussions seeking formal allegations. It also stated that if a clear policy on the use of diamorphine and syringe drivers was not forthcoming then the RCN would need to seek further instructions from it's membership to pursue this matter through the grievance procedure on the basis that the management had failed to manage the situation properly. DC Code A holds a copy of this report bearing the identification reference of JEP/GWMH/1/4/H .

On the 2nd December 1991 (02/12/1991) I wrote to Chris WEST , who was the then District

General Manager asking advice on how best to resolve this matter, a copy of which is held by DC Code A bearing the identification reference of JEP/GWMH/1/4/I .

I also informed Staff Nurse TUBBRITT that I had corresponded with Chris WEST and a copy of this letter was shown to me by DC Code A bearing an identification reference of JEP/GWMH/1/4/J . The same letter was sent to Staff Nurse Code A and the copy held by DC Code A bears the identification reference of JEP/GWMH/1/4/K .

I can remember getting a reply from Chris WEST but no longer have a copy. Chris WEST stated that he had passed the matter down to the management at the Gosport War Memorial to act upon. I felt that this action was totally inappropriate and we were in fact back to square one.

I again wrote to Staff Nurse TUBBRITT on the 10th December 1991 (10/12/1991) enclosing a copy of a letter that I had sent to Isobel EVANS which related the serious concern I had in the lack of response to what was considered a reasonable request from staff and that 7 months had now passed since the issue was first brought to her attention. Copies of these letters are held by DC Code A bearing the respective identification references of JEP/GWMH/1/4/M and JEP/GWMH/1/4/N .

On 11th January 1992 (11/01/1992) I wrote to Staff Nurse TUBBRITT explaining what action Chris WEST had taken. A copy of this letter is available with an identification reference of JEP/GW/MH/1/4/R

I also have a copy of a handwritten note from Isobel EVANS to Staff Nurse TUBBRITT, which is not dated but refers to a letter dated 31st October 1991 (31/10/1991) informing her of a meeting with Geraldine WHITNEY. Isobel EVANS stated that she welcomed open discussion regarding any areas of concern. A copy of this is held by DC Code A with an identification reference of JEP/GWMH/1/4/F .

A copy of a typed memo from Isobel EVANS dated 7th November 1991 (07/11/1991) stating that it had come to her attention that members of staff still had concerns over the appropriateness of prescribing Diamorphine to certain patients at the Redcliffe Annexe. This was addressed to all trained members of staff at the redcliffe Annexe and Dr.'s LOGAN and BARTON and the Night Sister. A copy of this report is held by DC Code A with an identification reference of JEP/GWMH/1/4/G .

A letter from me addressed to Isobel EVANS dated 14th November 1991 (14/11/1991) stating that it would appear that the only manner in resolving this matter would be through the

grievance procedure. This letter is available with an identification reference of KPM/7

I felt that the concerns raised by the staff at the time were serious enough to request that a policy should be decided for ALL staff on the use of Diamorphine and that ALL staff should receive training in the matters highlighted by the policy. To my knowledge such a policy was not made as a result of my request. I would say that the training within the National Health Service around the time of these events was somewhat lacks so I also asked that staff should receive training in the use of syringe drivers.

The Gosport War memorial was quite an isolated hospital in that it did not have other major hospitals in it's vicinity, the Redcliffe Annexe was even more isolated as it was situated about a mile from the Hospital.

I must add that although the onus is on hospital management to ensure that it's staff received adequate training it was also the responsibility of members of staff to ensure that they attend updating courses and any other courses that they feel relevant to their current work. The staff would however find themselves in a somewhat 'catch 22' situation as although they may identify courses that they wish to attend it would not always be possible for the management to release them to attend due to staffing commitments.

Around the middle of 1992 correspondence with the staff at the Redcliffe Annexe ceased so I assumed that the matter had been resolved to the satisfaction of both parties. I therefore had no further dealings with the staff at the Redcliffe Annexe about the subject of Diamorphine and syringe drivers.