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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: PEACH, JANET

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: HOSPITAL SERVICE 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: J PEACH Date: 21/02/2003

I reside at the address shown overleaf. I am currently employed as the Service Manager for the Community Hospitals and Health Centres by the Fareham and Gosport Primary Care Trust (F&GPCT).

I am responsible for the efficient management of two community hospitals, six health centres and Coldeast Hospital, 'outpatients' department.

I am a State Registered Nurse, qualifying in December 1982 and I began my nursing career in General Medicine at St Mary's Hospital, Portsmouth .

In 1985 I became the Ward Sister on the elderly medicine ward at the Queen Alexandra Hospital, Cosham (QA).

In 1991 I became the Senior Sister and subsequently the Service Manager at St Mary's Hospital.

In 1994 I moved to the Queen Alexandra Hospital and became the Operational Manager for elderly medicine at the QA and St Mary's Hospital.

In March 2000 I moved to the Gosport War Memorial Hospital (GWMH) as Service Manager. My predecessor was Barbara ROBINSON .

As Service Manager my role is to ensure the efficient management of the entire hospital on a

daily basis and the service development within the community hospitals.
From the time that I was Service Manager at the QA part of my role was concerned with the bed management and the number of admissions to the wards. As such I was aware of the case mix and number of beds available in the continuing care facility at the GWMH.

I remember that all of the continuing care wards had waiting lists and that some patients were placed outside of the area, ie, Petersfield and Liss.

I was not aware of individual cases and I was never approached by anyone who had concerns over the bed spaces at the GWMH.

I have been asked when I first became aware of any complaints relating to the GWMH and concerns over the use of Diamorphine.

Shortly after I arrived at the GWMH in 2000 I became aware that there were a series of ongoing complaints from 1998. I was not aware of their content, and I took no part in them. Lesley HUMPHRIES , the Quality Manager, was dealing with them. There was then a second enquiry carried out by the police. A number of staff were interviewed during the investigation. I was involved by the fact that I assisted in the setting up of interviews by arranging for staff to be made available and providing rooms for people to be spoken to in.

I was aware that Mrs McKENZIE had involved the police, in relation to her mother. She had concerns regarding what she believed to be her untimely death and excessive doses of Diamorphine. I again had no knowledge or involvement in that.

Subsequently the Commission for Health Improvement carried out an enquiry and published its report in June 2002.

The hospital was then informed that Professor BAKER , the gentleman who had carried out the research for the SHIPMAN enquiry would be reviewing all patient records. As a result of this, a staff meeting was arranged for staff on duty at the GWMH for the afternoon of 16th September

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2002 (16/09/2002).

I went to the meeting at the GWMH with Jane PARVIN , Personnel Director F&GPCT and Lucy DOCHERTY , Chair of F&GPCT.

Prior to going into the meeting I was approached by Toni SCAMMELL , Senior Nurse for GWMH who wanted to speak with me urgently. I was about to go into the meeting so I asked her to wait until its conclusion.

After the meeting I saw Toni in her office. She gave me a red folder with a number of documents in it. I flicked through them and saw that they were minutes of meetings held and a number of letters. I don't know how many documents were there or the entire contents.

I did note that they raised concerns about the use of Diamorphine in Redcliffe House and Dryad Ward in 1991. I was joined by Jane PARVIN and I handed the folder and its contents to her.

I have been asked how I felt upon scanning the documents. I was stunned to think that concerns that had been around in 1991 were still around in 1998 and I didn't understand why they had not been produced to CHI or the police enquiry.

Later that afternoon I attended a meeting with Jane PARVIN, Ian PIPER , Alan PICKERING and Kathryn ROWLES . Its purpose was to discuss the documents, their contents, how they came into our possession and why at this particular moment in time.

I am aware that Ian telephoned Toni to ensure that the staff that had produced the documents were all right and to discover why they had taken so long to produce them.
Toni later confirmed to me that she had this conversation with Ian.

It was decided at the meeting that the nurses who had produced the documents would be spoken to and that as Toni SCAMMELL was their line manager and that the nurses had handed the documents to her, she would be present with Jane PARVIN during the meeting.

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I have been shown copies of a number of documents exhibited as JEP/GWMH/1/KMR/COPY/5. They appear to be copies of the documents handed to me by Toni SCAMMELL, which in turn I handed to Jane PARVIN.