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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: TUBRITT, ANITA

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: SENIOR STAFF 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: A Code A Date: 01/12/2004

I am a Senior Staff Nurse at Gosport War Memorial Hospital , where I work nights on Sultan Ward. I trained at The Royal Hants County Hospital, Winchester from 1982 to 1986, my Nursing and Midwifery Council number is 82Y3321E. After my training I worked at Beechcroft Manor Nursing Home for 9 months until May 1987 when I started work at Gosport War Memorial Hospital. I have been there ever since. In 1998 I was the Senior Staff Nurse on Dryad Ward when I was working nights.

I have made previous statements to the police concerning Operation Rochester, I have been asked to make this statement in relation to a patient named Ruby LAKE . I have no recollection of this patient but I have been shown her hospital notes BJC/67. These notes show that Mrs LAKE was admitted to Dryad Ward on 18th August 1998 (18/08/1998) and that she passed away on 21st August 1998 (21/08/1998) (pages 394 and 395).

I have been asked about the prescribing and administration of certain drugs to Mrs LAKE, I emphasise that my replies have been made after reading the hospital notes (BJC/67) and the Ward Controlled Drugs Record Book (JP/CDRB/23).

Pages 368 and 369 of BJC/67 are the Prescription Sheet for Mrs LAKE, on these pages Dr BARTON has prescribed drugs to the patient, the sheet also shows when and in what quantity drugs were administered, these entries are signed by the senior nurse involved. The following were prescribed by Dr BARTON on the 18th August 1998 (18/08/1998), I recognise her handwriting and signature for each entry. Oramorph (pain control) range 2.5 to 5 mls, Digoxin (regulates the heart) range 62.5mcg, Slow K (slow release potassium), Bunetanide (diuretic, to

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reduce blood pressure/chest fluid) 1 mg and Allopurinol (for gout/arthritis) 100mg.

In addition, on the 19th August 1998 (19/08/1998) Dr BARTON, also prescribed Temazepam (night sedation) 10 to 20 mg. The following were also prescribed by Dr BARTON, Diamorphine (pain control) 20 to 200 mg, Hyoscine (to dry up oral secretions) 200 to 800 mcg and Midazolam (muscle relaxant) 20 to 80 mg. These last three drugs were written up as SC in 24 hours which means that they were to be introduced by way of a syringe driver over a 24 hour period, they are not dated but I make the assumption that it would have been on the 18th August 1998 (18/08/1998), I make this on the basis that the first prescription was made on that date and that Code A made an entry about commencing the syringe driver on the 19th August, (page 394) had the Diamorphine not already been prescribed I would have expected to see that reflected in Nurse Code A s note, ie, it would have read something along the lines "Dr prescribed or Dr visited". Clearly the nurse could not have withdrawn the drug nor given it without a Doctor having first prescribed it. I will explain the procedure for controlled drugs. Doctors may also write prescribed drugs up in the medical notes but on this occasion there are no such entries.

On each occasion that a controlled drug is withdrawn and administered control measures are adhered to. These include checking that the correct drug is withdrawn, the correct amount is prepared according to the prescription sheet, the correct amount is given to the right patient at the right time and that the drug is in date. This is why I assume that Dr BARTON must have signed up the Diamorphine/Hyoscine/Medazolam prescription on the 18th August 1998 (18/08/1998).

The prescription sheet shows that Oramorph was last administered at 1150 on 19th August 1998 (19/08/1998) and that at 1600 the same day the syringe driver was commenced, I will make clear what the prescription sheet and Controlled Drugs Record book show.

The entry in the book dated and timed at 1600 on the 19th August shows that 20mg Diamorphine was withdrawn, this was in two 10mg ampoules, the entry is witnessed by Senior Staff Nurse Code A and shows that it was given by Ward Sister HAMBLIN , the patient's

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name is recorded as Ruby LANE, the entry is signed by Sister HAMBLIN and Nurse Code A The corresponding entry on the prescription sheet shows that at 1600 on the same day the same dose was given to Ruby LAKE by Sister HAMBLIN, it also shows that 20mg of Midazolam was given at the same time, Sister HAMBLIN has signed both entries on the sheet.

The entry in the book dated and timed 0915 on the 20th August shows that 20mg of Diamorphine was withdrawn, this was in two 10mg ampoules, the entry is witnessed by Staff Nurse Patricia SHAW and shows that it was given by Staff Nurse Code A, the patient's name is recorded as Ruby LAKE, the entry is signed by Nurse SHAW and Nurse Code A. The corresponding entry on the prescription sheet shows that at 0915 on the same day the same dose was given to Ruby LAKE by Nurse Code A, it also shows that at the same time 400mcg of Hyoscine and 20 mg of Midazolam were also given. The entries are all signed by Nurse Code A.

There are two further entries in the book dated 20th August 1998 (20/08/1998) and timed at 1655, these show that 40mg of Diamorphine was withdrawn, this was in one 10mg and one 30mg ampoules, the entry is witnessed by Nurse Code A and shows that it was given by Ward Sister HAMBLIN, the patient's name is recorded as Ruby LAKE, the entry is signed by Nurse Code A and Sister HAMBLIN.

The corresponding entry on the prescription sheet shows that at the same date and time the same dose was given to Ruby LAKE by Sister HAMBLIN, it also shows that at the same time she gave Ruby LAKE 40mg of Medazolam and 800 mg of Hyoscine, she has signed all 3 entries.

The entry in the book dated and timed 0735, 21st August 1998 (21/08/1998) shows that 60mg of Diamorphine was withdrawn this was in two 30mg ampoules, the entry is witnessed by myself and shows that it was given by Nurse TURNBULL , the patient's name is recorded as Ruby LAKE and the entry is signed by myself and Nurse TURNBULL. The corresponding entry on the prescription sheet shows that at the same date and time the same dose was given to Ruby LAKE by Nurse TURNBULL, it also shows that at the same time she gave Ruby LAKE 800 mg of Hyoscine and 60mg of Medazolam, she has signed all 3 entries.

Signed: Code A

Signature Witnessed by:

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All of the above administrations of drugs to Ruby LAKE were in accordance with the prescriptions as written by Dr BARTON.

I have been asked why Hyoscine was given, this would be given to a patient who is 'bubbly' in other words typically she would have oral secretions, fluid in the back of the throat/top of the lungs. Having read through the notes at the foot of page 394 Nurse TURNBULL did describe her as being 'very bubbly'. I have also been asked why it was started at 400mcg rather than 200mcg. Having read the notes it may have been that 200mcg would not have been an effective dose and that is perhaps why 400mg was given initially. 200mcg is a small dose and Hyoscine comes in an 800mg ampoule.

I have also been asked in what circumstances drugs are destroyed. On the death of a patient any drugs left in a syringe driver would be destroyed, also when the syringe drivers are recharged any drugs from the previous 24 hour period left over would also be destroyed. On page 97 of the Drug Record Book (JP/CDRB/23) I have entered that at 0735 on 21st August 1998 (21/08/1998) I destroyed a combined total of 4mls of Diamorphine/Hyoscine/Medazolam. On this occasion Nurse TURNBULL witnessed this. The measurement can't be exact, it is calculated by rate and time so it is only an approximate amount. Normally when I destroy drugs they are poured down the drain. I also made an entry on the prescription sheet in red ink, this written over the top of the original dose, which was the one timed and dated 1655 20th August 1998 (20/08/1998). Also in red ink the previous entry on the prescription sheet shows that an amount of the same three drugs was destroyed from the original dose given at 1600 on 19th August, however it would appear that no Hyoscine was destroyed on that occasion as none had yet been given. These entries have been signed by Sister HAMBLIN. It was not uncommon for the only entry to be made on the prescription sheet as opposed to recording it on that and in the Drug Record Book, on nights we tended to do both. Apart from the entry made by myself on page 97 there are no other entries in the book relating to the destruction of any of Ruby LAKE's wasted drugs.