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H A M P S H I R E C o n s t a b u l a r y

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Our Ref. : HQ/CID/DCI 7410/2001

Your Ref. :

Code A

14th April 2001

Mr P. CLOSE
Crown Prosecution Service
Casework Directorate
50, Ludgate Hill,
LONDON, EC4M 7EX

Dear Mr Close,

Allegations arising from the death of Gladys Mable RICHARDS N1

I am forwarding to you an additional statement that, I feel, has a bearing on this case.

Pauline Spilka worked as a Nursing Auxiliary on Daedalus Ward at the War Memorial Hospital, Gosport at the time when Gladys Richards was being treated there in 1998. As a result of recent publicity, concerning the allegation in question, the witness contacted the police and has been seen by Detective Sergeant Sackman who is a member of the investigation team. She was previously visited by police officers during 2000 in connection with this investigation but she declined, on that occasion, to be interviewed.

In addition to Pauline Spilka ^{N65} five other persons, thus far, have contacted the police, having read the publicity, and expressed concerns over family members or friends who died having been treated at the Hospital in question. Our current policy is to await the outcome of the decision concerning Mrs Richards deceased before considering our position regarding the scrutiny of other cases. I'm sure you will appreciate that this development, and the problem caused by the unwelcome media disclosure, is placing us under considerable pressure.

Yours sincerely,

Code A

pp Ray Burt
Detective Chief Inspector

osp

S. 25

MG11(T)



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Statement of : **Pauline SPILKA**

Age if under 18 : **Over 21** (if over 18 insert 'over 18')

Occupation : **Provident Agent**

This statement (consisting of **8** pages 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 in it anything which I know to be false or do not believe to be true.

Signature :

Code A

Dated the

12.4.01

I live at the address shown overleaf.

I have approximately 8 years experience in caring for elderly patients within both the Public and Private sectors. During the early 1990's I was employed at the Acacia House Nursing Home in Horndean as a night shift Nursing Auxiliary caring for elderly residents. I remained there for approximately 3.5 years. I left that placement to work at the Greylingwell Hospital in Chichester, West Sussex where I was a nursing Auxiliary on a Geriatric Psychiatry Ward. Once again I was responsible for elderly patients. Sadly due to travel costs and moving further away I had to leave this job and took up a post as Nursing Auxiliary at the Gosport War Memorial Hospital. I subsequently worked there from mid 1995 until I was forced to retire through ill health following an industrial accident in February 1999.

I have no specific medical qualification but throughout my time attended every course that was made available and achieved a Level 2 NVQ in Nursing.

The local news paper "*The News*" has this week been running a story concerning a Police Investigation into the suspicious death of Mrs Gladys RICHARDS at the Hospital during August 1998. This story has brought

Signed :

Pauline SPILKA

Signature witnessed by :

Code A

Code A



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

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Continuation of Statement of : **Pauline SPILKA**

back some disturbing memories of incidents that occurred whilst employed at the Hospital that I felt unable to highlight at the time. Having read this story I have decided that I am morally obliged to bring them up now. Prior to the story appearing I had been contacted by the Health Trust alerting me that a story was likely to be published.

I was approached by the Police during the year 2000 who wished to speak about my dealings with Mrs RICHARDS . Until now I have not spoken to the Police. I do recall the case because all of the staff were wary of one of her 2 daughters who was given to complaining. Due to this I recall Mrs RICHARDS being nursed rather better than the norm.

I remember the subsequent internal enquiry being carried out following a complaint made by the daughters. My only contact with their mother were general Auxiliary duties washing/feeding etc. I am aware that she suffered from Dementia and was violent on occasion. She would react in pain to the slightest contact. I was not present on the day she fell but subsequently was told about it. Nor was I present on the day that the Syringe Driver was set up. After the Driver was in situ I continued to wash her etc. until such time as she died.

The Indiscriminate use of Syringe Drivers on Patients in the Daedalus Ward at Gosport War Memorial Hospital is my main concern. It appeared to me then and more so now that euthanasia was practised by the nursing staff. I cannot offer an explanation as to why I did not challenge what I saw at that time. I remain deeply upset and feel terribly guilty about one particular death that I will detail shortly.

Signed :

Pauline SPILKA

Signature witnessed by :

Code A

Code A



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

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Continuation of Statement of : **Pauline SPILKA**

The Daedalus ward was known throughout the Hospital as the "Dead Loss" ward this was a reference to the abnormally high levels of mortality on the ward. . The ward cares for in the main three categories of patient. Those requiring rehabilitation after strokes Elderly patients who have suffered from falls etc prior to their placement in nursing homes and Some Respite care patients.

A consultant is ultimately responsible for the ward. In this case Dr LORD has been the consultant for some while. Secondly a local GP has the position of Clinical Assistant. During my time this role was carried out by Dr Jane BARTON. Next in command was the Ward Manager , during my time at the hospital this role was carried out by 2 people. Initially Sheila JOINS who retired to be replaced by

CAT. Info ,

N67

Code A

Also employed on the ward were a number of registered nurses who were normally D , E or F grades. Lastly there were a number of Nursing Auxiliaries. My role as an auxiliary would involve tasks such as Washing , Dressing , Feeding , Changing dressings , taking blood pressures and Checking sugar levels.

Patients would arrive on the ward to be admitted by the Clinical assistant or if she was not available then occasionally Dr LORD. If the patient was accompanied by relatives then a discussion would be held and a care plan would be drawn up. The care plan would involve other specialists such as the Physiotherapist , Occupational Health , Dieticians etc. Each patients care plan was included with their general notes and another of my functions would be to ensure that I knew what the care plan was in respect of each patient.

N.68

It was some while later that I was to learn that all patients upon their admission were written up (by the doctor) who authorised the use of a syringe driver if appropriate. This enabled any member of the nursing

Signed : **Pauline SPILKA**

Signature witnessed by :

Code A

Code A



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

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Continuation of Statement of : **Pauline SPILKA**

staff to set up a syringe driver for a patient without any further reference to the doctor . Although I cannot be certain I think this was explained to me by the Staff Nurse Margaret COUCHMAN. I am sure however that this was not common knowledge among the majority of the nursing auxiliaries.

Despite my experience in elderly care I had never heard of a syringe driver prior to working at the War Memorial Hospital. I was later to learn that it was a device used for pain relief in seriously ill patients, the driver delivers a constant dosage over a period of time.. It was also clear to me that any patient put onto a syringe driver would die shortly after. During the whole time I worked there I do not recall a single instance of a patient not dying having been put onto a driver.

I have never received any training in respect of a syringe driver nor have I ever used one in order to administer drugs to any patient.

The regime on the ward was as follows. If one of the trained members of nursing staff considered that a patient required the use of a syringe driver then they would seek the approval of another trained nurse. Having reached agreement then the driver would be set up. The needle would be inserted into the patients back so as to make it impossible for it to be removed.

I have witnessed disagreements between nurses where one of them did not agree that a patient required the use of a syringe driver. These disagreements would be resolved by the nurse requiring the syringe driver

Signed : **Pauline SPILKA**

Signature witnessed by :

Code A

Code A



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

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Continuation of Statement of : **Pauline SPILKA**

approaching a more senior nurse and obtaining their consent. Once that consent had been obtained then the syringe driver would be set up.

I have never known of a case where a staff member did not obtain permission to use a syringe driver from senior staff.

I referred earlier to a particular case that troubled me deeply. The patients name was

^{N69}
Code A

Code A

Code A

Code A

Mentally he was alert and capable of long conversations I recall that he was in room 8B which is a ward for 4 patients all of whom spent many hours chatting together and watching TV. If I am right, at the same time another of the other patients had been a professional footballer with Portsmouth and the patients would chat for hours about old matches.

Physically he was able to walk with the aid of a Zimmer frame and was able to wash himself. It is important that patients are encouraged to continue with these tasks allowing themselves a level of independence and more importantly dignity. **Code A** however tended to be rather lazy in this respect and in many ways was quite a difficult patient. He liked to think of himself as being more ill than the other patients and

Signed : **Pauline SPILKA**

Signature witnessed by :

Code A

Code A



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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Continuation of Statement of : **Pauline SPILKA**

seemed to quite enjoy the attention this brought. However he would sometimes get quite tearful about his condition .

I remember having a conversation with one of the other auxiliaries Marion BERRY we agreed that If he wasn't careful he would "talk himself onto a syringe driver". **Code A** although frail was not (in my opinion) near death at that time.

One day I left work after my shift and he was his normal self. Upon returning to work the following day I was shocked to find him on a syringe driver and unconscious. I was so shocked and angered by this that Marion and I went to confront **Code A** the ward manager . He told us that **Code A** was ill.

I said "Did you tell him he'd be dead at the end of this"

Code A said " You know he's gone downhill we don't know how long he's got left"

I said " That's not the issue did you tell him he'd be dead"

Code A was unable to answer me.

The previous evening **Code A** had been alert and perfectly capable of decision making and conversation I was concerned that the inevitable outcome if he succumbed to a syringe driver would be his death. I wanted to be reassured that he had been given a full explanation before allowing a syringe driver to be introduced. **Code A** was unable to provide me with any reassurance . Knowing **Code A** as I

Signed : **Pauline SPILKA**

Code A

Signature witnessed by :

Code A



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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Continuation of Statement of : **Pauline SPILKA**

did I am confident that he to would not have allowed the introduction of a syringe driver had he known of the outcome.

Code A subsequently remained unconscious until his death. He lasted some while. Whilst accepting that I have no medical qualification I am concerned that he was certainly not in imminent fear of death when he allowed the syringe driver to be introduced.

I know that there was considerable disquiet amongst both the nursing and auxiliary staff over Mr

Code A

After the syringe driver had been introduced I felt unable to discuss **Code A** with his family when they visited . Families often naturally seek reassurance from any member of staff when they visit. Things like "how does he look to you". I was so upset by the whole situation that I felt unable to face them until his death. I was worried that I would say something out of turn.

There was an atmosphere between **Code A** and I which led to us speaking in his office on a couple of occasions over the following week. He accused me of "Failing to come to terms with death". This was ludicrous by then I had over 7 years experience in elderly care and had seen many many deaths. He failed to see my point that this death had been unnecessary.

Signed : **Pauline SPILKA**

Signature witnessed by :

Code A

Code A



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

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Continuation of Statement of : **Pauline SPILKA**

I cannot explain why I didn't speak out against the regime within the ward. I feel incredibly guilty about The death of **Code A**

Prior to **Code A** the ward manger was lady called Sheila JOINS. I can recall a patient being admitted onto the ward almost unconscious. She was an elderly Welsh lady . Mrs JOINS spoke to the family and explained that the lady was in pain and that all in all the syringe driver should be used to relieve her pain. The family were united in the belief that all medication should be stopped to see if that brought about a change in their mothers condition.

The medication was withdrawn and over the next couple of days the lady improved beyond all recognition within a short time I remember walking arm in arm with her along the corridor having a conversation. She was subsequently discharged home to live with her daughter. I understand that she lived for a further year. This would certainly not have happened were the Syringe Driver set up upon her arrival.

Signed : **Pauline SPILKA**

Signature witnessed by :

Code A

Code A



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Statement of : **Pauline SPILKA**

Home address :

Code A

Home telephone No. :

Code A

Business telephone No. :

Code A

Sex : **Female**

Date and place of birth :

Code A

Maiden name :

Height :

Identity Code :

Dates to be avoided. Delete dates of non-availability of witness (not police officers)

Month of :							Month of :							Month of :						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31					29	30	31				
Month of :							Month of :							Month of :						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31					29	30	31				

Contact point, if different from above :

Address :

Telephone No. :

STATEMENT TAKEN BY :

Code A

Station : **MCIT**

Time statement taken :

Place statement taken : **Commenced at Locks Heath 5/4/01**

Signed :

Pauline SPILKA

Signature witnessed by :

Code A

Code A