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Surname: TUBBRITT

Forenames: ANITA

Age: Code A Date of Birth: Code A

Address: Code A Postcode: Code A

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Telephone No.: Code A

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I live at the address shown overleaf with my family.

I am employed by the **Fareham and Gosport Primary Care Trust** and I work as a Senior Staff Nurse at the **Gosport War Memorial Hospital** .

I qualified as a Registered General Nurse in July 1986 and I began working at the Beechcroft Manor Rest Home in Gosport in August 1986 as a Staff Nurse.

In May 1987 I left Beechcroft to take up a post at the Gosport War Memorial Hospital. I was employed as a staff nurse at the Redcliffe Annex, The Avenue, Gosport. I worked twenty five hours per week as a member of the night staff, working two nights one week, followed by three nights the following week. I didn't have set working days when I first started at the Annex and my hours were from 2030 hrs until 0745 hrs with a hour and a half break during the night.

The Redcliffe Annex was a geriatric ward for patients who couldn't cope on their own, they were not necessarily very ill but needed nursing care. I remember that some of the patients lived at Redcliffe for a number of years before they died.

The unit didn't have it's own medical staff each patient was treated by their own GP. If we had cause for concern over a patient then we would notify their GP and they would come to the unit and address any problems and prescribe any treatments.

I do not know if the unit had a consultant at this time but as I only ever worked nights I would not have seen them anyway.

I remember that when I first went on the unit the patients who required pain relief were given mild analgesics such as Paracetamol, coproxamol and we would try and manage their pain by changing their position and using distraction methods. Very occasionally a patient would be given Diamorphine or possibly morphine tablets. They would not be a regular constant dose, but the 'odd dose'.

The patients at this time were not in need of the acute ward, they were generally just elderly and unable to look after themselves.

I have been asked about procedures at this time if an occasion arose if I felt that a patient had been prescribed medication by their GP which I didn't agree the patient should have. I can say that I have no recollection of anything of this nature happening but if I had thought that a drug had been prescribed by a GP and I didn't think it was for the good of the patient then I would not have administered it and I would have passed my concerns onto the day shift for them to take it up with the patient's GP.

In 1991 the medical care for Redcliffe Annex changed. Instead of the patients own GP being responsible for their care a clinical assistant was appointed. The clinical assistant visited the ward daily and dealt with all medical matters concerning the patients in the unit.

The clinical assistant was **Dr Jane BARTON** N34 . She was a local GP who had her own practice. She would visit the annex before starting her morning surgery and other members of her practice would cover for her at the annex when she was on leave or away for any reason. I recall that **Dr PETERS** N231 / A237 / F1 , **Dr BEASLEY** N361 / A238 / F2 and **Dr KNAPMAN** N258 / A239 / F3 covered for Dr BARTON and I particularly remember that Dr PETERS would cover for Dr BARTON's holidays.

I am aware that at this time **Dr LORD** N68 / A240 / F4 was a consultant to the annex and I'm not sure but I believe that there may have been another consultant as well.

I remember that when Dr BARTON took over the medical side of running the unit it became better

organised and seemed to be better structured. Patients were seen on a regular basis whereas before if a patient was not ill then they could go for a long period of time without being seen by a doctor.

The nursing structure began to change as well. More staff were brought in as the number of beds increased. I recall that we seemed to get new equipment that the other units had for some time. At this point moral was good and I and the rest of the staff I worked with were happy.

I think it was also around this time that syringe drivers were introduced to the unit. I have no recollection of them being used in the unit prior to this.

I remember asking **Sister GREEN** N367 / A241 / F5 , the ward sister, how to use a **syringe driver** C43 . She told me that I must have seen one as a **student nurse** A242 / F6 and to get on and use it. She showed me how to use one and then I was left to work it out for myself.

A syringe driver is a device for administering a drug slowly and continuously over a 24 hr period.

It appeared to me that it became the preferred method of administering drugs. I certainly noticed them being used more and more. I do not know if this is because more were purchased and therefore available.

Our patient type then began to change. We began admitting people who were far more poorly and who required more nursing and medical intervention. More of our patients required palliative care, by this I mean the patient was made comfortable until his or her death. A patient who required palliative care was expected to die.

It was up to the nursing staff to read the notes to see if a patient was for palliative or rehabilative care, although we were given some information at handover.

At this point my main concerns were that the staff who had to set up the syringe drivers and then administer them had not been trained properly. I felt that I personally was not trained in an appropriate manner as to their use.

Such was the level of concern amongst staff about the use of the syringe driver that a staff meeting was called and **Mrs EVANS** N136 / A183 / F7 the patient care manager, listened to these concerns and some training was arranged for us. I recall I had 1 hour of training with a **Marie Curie nurse** N368 / A243 / F8 .

I then began an Elderly Care Course at the **Queen Alexandra Hospital** in Cosham and one of my projects was to study methods of pain control.

I was also trying to find out as much as I could about syringe drivers and the drugs that could be used with them. I did this for my course work and for my own benefit as I wanted to use them correctly. I completed a literary review on the syringe driver.

I also had to prepare for a class discussion as a part of my course, a conversation topic or something that bothered me at my place of work. I chose to speak on the 'use and abuse of the syringe driver'.

The course tutor, **Geri WHITNEY** N128 / A137 / F9 had heard of other people who had raised concerns about syringe drivers and the lack of proper training. I do not know if these people were from my hospital or other areas. Geri wanted to come to my hospital to see me in my place of work in order to clarify the position.

I knew that Geri was involved in 'Elderly care' and I think that she was a senior steward in the **Royal College of Nursing** at this time.

I told some other members of staff who I knew were concerned about the use of syringe drivers and the pain killers they were used to administer about the meeting with Geri at the hospital and they wanted to be present, these included **Sylvia GIFFIN** N22 / A130 / F10, **Beverley TURNBULL** N6 / A124 / F11 and **Agnes HOWARD** N127 / A132 / F12, who everyone called 'Maggie'. I also told two members of the day staff, **Betty WILLIAMS** N371 / A245 / F13 and **Lizzy BALL** N370 / A244 / F14 but they didn't come although I know that they had the same concerns.

Geri came to my ward and we explained our concerns and showed her drugs charts relating to patients in the ward, she then checked the **controlled drugs register** A121 / F15 and it then became apparent to me that a large amount of Diamorphine was being used on the ward.

Geri told us that this was an issue that we had to take further and that we would be in breach of our **UKCC code** A247 / F16 if we did not. It would be a breach of our 'code of conduct'. I was worried about the consequences as this was around the time of **Graham PINK** N373 / A248 / F17. He was a nurse who had voiced his concerns over some practice in his work place and had been sacked because of it. I remember that it was in all the papers at the time.

I know that **minutes were kept** A249 / F18 of the meeting with Geri. I think that everyone who attended got a copy.

I had been aware that we had more patients dying but we had been admitting people who were far more poorly than our previous patients and I thought this to be the reason.

I informed Mrs EVANS, the Patient Care Manager at the hospital of our meeting with Geri. She was pleased that I had told her of the meeting but concerned that she hadn't been present.

I know that I spoke with her on a few occasions about my concerns but I remember that my mother was dying of a tumour at this time and Mrs EVANS thought that I was not being objective in my opinions of the use of Diamorphine and syringe drivers. My mother received Diamorphine via a syringe driver and was in a lot of pain so I could see the benefits of this method of pain relief, but my

mother's circumstances were different to the patients receiving Diamorphine in my ward.

I have been asked if I can remember if there were any patients who recovered and went home after being placed on a syringe driver. I do recall that some did although I cannot remember any details.

I remember that after the meeting with Geri I, as a member of the night staff seemed to be better updated by Dr BARTON. I spoke of my concerns to her but after a couple of occasions of being given to belief that 'she was the expert' 'she knew more about these things'.

I felt that I was getting the cold shoulder from Dr BARTON and from **Gill HAMBLIN** N131 / A126 / F19 , who was at that time the ward manager. I felt that I was being ignored and not being supported by my managers.

I have been asked why I did not continue with my concerns but I felt that more senior people were involved and had knowledge of my concerns which included Dr LOGAN.

Later I went for promotion for Senior Staff Nurse and Mrs EVANS was on the interviewing panel. I distinctly remember her saying to the rest of the panel that I had a heart of gold but was a trouble maker.

Because of this reference and because I had raised my concerns with management at the hospital and with the RCN I believed that my concerns over the use of the syringe driver was now a matter of record and was on file.

I cannot recall when but the unit moved to the main hospital site and the Redcliffe annex became Dryad Ward.

This ward still had long stay patients but also admitted patients who were for assessment and rehabilitation.

As I remember I didn't have the same issues concerning the syringe drivers. I had more training in their use and I was happy with my knowledge and understanding of the way they worked. There was more communication between the day and night shift and I believed that Dr BARTON appeared more accessible. I do not remember feeling that I needed to speak to her.

I have been asked why I did not bring up my concerns about the use of syringe drivers when I was spoken to by the **CHI.**

When I was interviewed the CHI were interested in the running of the ward in 1997/1998. By this time the practices and procedures had changed as had the medical cover and management. They didn't mention 1991 and because I believed it to be a matter of record I didn't bring it up either.

I had kept all of the documents that were generated as the result of my and others concerns and I had made a list of all the training I had received whilst at the hospital, especially relating to pain control.

When the report was finally published by the CHI it stated that staff at the hospital had received little training in 'pain control'. I was annoyed at this because had the CHI asked me when they spoke to me, I would have been able to tell them exactly what training I and my colleagues had received.

Recently we were informed that the man who had investigated the **Harold SHIPMAN** N1404 cases was coming to look at the hospital records. I believed that if he did so then the use of the Diamorphine and syringe driver would become known and I wanted it known that I and my colleagues were concerned at the time. I felt very unsupported and vulnerable.

I spoke with my colleague Beverley TURNBULL and we decided to take our documentation to the meeting that had been called to inform us of the enquiry.

I had my documents in a document holder with a clear front and red plastic back, Beverley had hers in a clear wallet.

I have been shown a red backed document holder containing correspondence addressed to me. I can confirm that these are the documents I handed to **Toni SCAMMELL** N198 / A165 / F20 (**JEP/GWMH/1** X87).

On the following Wednesday I and Beverley went to a meeting with **Jane PARVIN** N138 / A140 / F21, Toni SCAMMELL and **Betty WOODLAND** N185 / A170 / F22, the RCN representative. The meeting was minuted. I have been shown a copy of the minutes of the meeting which took place on 18th September 2002 (18/09/2002) and I agree with their content and accuracy.

I produce the list of my training whilst at the hospital **(JEP/GWMH/1/A).** exh

I have been asked if any of the names of patients stick in my memory, I can remember only one. There was an elderly lady who came to the Redcliffe Annex and was put on a syringe driver. She lived for about three months which was unusual. Her name was **Edith CHILVERS** N374.

Signed: A TUBBRITT Signature witnessed by: