# WITNESS STATEMENT

**STATEMENT OF** **FIONA LORRAINE WALKER**

AGE: OVER 18

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This Statement consisting of 5 pages 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.

DATED this 14th day of June 2009

Signed Code A

**FIONA LORRAINE WALKER**

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I am Fiona Lorraine Walker of Code A I am a Registered General Nurse and qualified in 1972.

Following qualification I worked at a number of hospitals until 1976 when I was appointed as Night Sister at Portsmouth Royal Infirmary covering mainly surgical and medical wards.

In 1979 I then moved to St Christopher's Hospital in Fareham, again as a Night Sister, having responsibility for elderly care.

In 1982 I was then appointed to the position of Night Sister (or Clinical Manager) at the Gosport War Memorial Hospital. In that position, I covered the whole hospital including Northcote and Redcliffe Annexes, though I was based principally on Sultan Ward when the new hospital was completed. I then left the Hospital in 2003.

Signed Code A

Witnessed Code A .....

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Following redevelopment at the Hospital, and the creation of Daedalus and Dryad Wards in about 1993 or so, I would have responsibilities on those Wards too, together with two other Night Sisters at the Hospital. My practice would be to visit a patient on a Ward when specifically called to do so, but would in any event visit Daedalus and Dryad Wards in the course of a period on duty.

From the time of the rebuilding and the creation of Daedalus Dryad Wards through to 2000, it was apparent to me that patients admitted to these Wards were increasingly unwell and needed a lot of care. I believe that one of the reasons for this was an attempt to free up beds in the main hospitals.

In consequence, this certainly created extra demands on the Nursing Staff, and the same would have been true for the part time Clinical Assistant on Daedalus and Dryad Wards, Dr Jane Barton.

It was Dr Barton who would provide day to day medical care for the patients on Daedalus and Dryad Wards. Consultants were responsible for the care of patients on the Wards, but they would visit once a week as best I was aware of it.

Dr Barton would come to the Hospital early each week day morning to see patients on the two wards. I would see her from time to time when she would arrive on Dryad Ward, shortly after 7:00a.m., and before I then left having come off Night Duty. I was aware that she would carry out her Ward Round on Dryad Ward, then attend on Daedalus Ward, and would then leave to attend at her GP Surgery.

I also saw Dr Barton from time to time on Sultan Ward, the GP Ward at the Hospital, when she had patients there or when she was on duty. It was often necessary to call the out of hours service and speak with a doctor or ask a doctor to attend to a patient at the Hospital if there was a problem. On occasions the Doctor on duty would be Dr Barton.

Signe Code A Witnessed Code A

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Over the years, I believe I had a significant amount of contact with Dr Barton but no more than I did with any of the other Consultants. I found her to be always helpful. Her concern was always for the patients – they were her priority, and I think she is a lovely lady. I feel that what Dr Barton has gone through in relation to the investigations concerning the Gosport War Memorial Hospital and the publicity associated with that is quite dreadful. I believe that all the staff at the Hospital feel the same. Sadly, it seems that some people have been willing to leave because of what has been reported in newspapers from time to time. I recall that on one occasion following unpleasant publicity, the Nursing Staff came off night duty at the Hospital to find that all the tyres on their cars had been slashed.

Dr Barton was very caring, and very committed to her work. I never had any difficulty about contacting her for advice concerning a patient if that was necessary. Her manner could seem a bit abrupt, but that was simply her nature.

Dr Barton would always write information in the notes about a patient's condition.

I did not feel that there was anything wrong with Dr Barton's notes. If we needed information we have the relevant information from her notes, from the Nursing Notes, and from the process of handover. I always felt that I had enough information through this process.

Dr Barton would write in a patient's notes if she was expecting that patient to die. If the patient's death was expected, this meant that the Nursing Staff could process the matter rather than calling a doctor in to certify death. We were able then to inform the family.

I am aware of a system of anticipatory prescribing at the Hospital. This was established so that it was possible for Nursing Staff to provide medication which was needed for patients when a doctor was not at the Hospital. There could be problems in contacting out of hours doctors who could be reluctant to prescribe medication for patients they did not know. Indeed, on occasion I have had to contact the deputising service and wait 2 or 3 hours with a patient in pain before the

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Doctor arrived to attend to the patient's needs. In my view there is nothing worse than seeing a patient in pain who is dying when you cannot relieve their symptoms.

Accordingly, Dr Barton would prescribe medication for patients on an anticipatory basis, for example, opiate analgesia, where she felt the patient might need that medication soon. The medication would be prescribed in a dose range, and she knew that all the Staff at the Hospital understood that if such medication was commenced, the smallest dose would be administered. The medication would only be increased if previous amounts were insufficient for the patient, but the increases would be small. Administration of medication as a result of such a prescription was not automatic. If, for example, Diamorphine was to be administered via syringe driver the Nursing Staff would assess the patient first, and it would only be given if necessary. Two nurses would be involved in the process. Similarly, if medication was being increased on the basis of such a prescription, again it would only be following an assessment by Nurses, and where it was necessary to increase it. I felt we had knowledge and experience as Nurses to judge properly when patients were in pain and required appropriate medication. In 1993, I took a course – ENB 931 – for continuing care of the dying patient and the family. As part of this I worked in a hospice on the Isle of Wight for a period. The course lasted several months. This gave me a good understanding of opiates, syringe drivers, and the levels of analgesia required to manage pain. I believe that the highest dose of Diamorphine administered at the War Memorial Hospital in my experience was something just over 100mg. In the Hospice in which I worked on this course, the levels could be significantly more. I have certainly seen levels of 500mg of Diamorphine and more.

When commencing medication in this way or increasing, it we would not make contact with Dr Barton, as it was taking place out of hours. Dr Barton would though learn of what had taken place when she next attended at the Hospital – usually the following morning. I would estimate that medication might be initiated or increased by way of an anticipatory prescription on average about once a week.

Signed..... Code A

Witness Code A

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At no time did I have any concern that the medication given to a patient should not in fact be administered. If I had not been happy with the medication provided I would have contacted the Doctor concerned, but I never felt it necessary to do this.

Dr Barton did have a lot of patients with multiple medical problems who were coming to the end of their lives and who needed a lot of medical input and care. She had more than her fair share of poorly patients.

In my view, there was insufficient medical input. We were lucky if a Consultant came to the Ward once a week. I believe that was not enough. Dr Barton ought to have had more support.

In my statement to the Police of 30th November 2005, I stated that "in 1991 I became aware that some staff at GWMH were expressing concerns over the levels of Diamorphine being prescribed. My belief is that this was resolved internally and that a member of the palliative care team visited from the Countess of Mountbtatten Hospice and fully explained their use to the Nursing Staff. One to one training was also available to staff." I understood that training was given to the Nursing Staff in this regard, but I was not involved. I understood that following that training, the issue was resolved.

I am not aware of anyone raising with Dr Barton any concern at any time about her standard of care of patients, her note keeping, her assessment of patients, or her prescribing practice. Certainly I have no such concerns myself.

Signed..Code A.....Witness Code A.....