WITNESS STATEMENT

STATEMENT OF Code A

AGE: OVER 18

This Statement consisting of 6 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 9th day of June 2009

Signed Code A

I am Code A I am a Registered General Nurse, having qualified in 1979. As indicated in my statement for the Police dated 6th June 2003, I have worked at hospitals all over the United Kingdom, and in January 1993 I commenced working at the Gosport War Memorial Hospital, initially in Redcliffe Annex, but shortly thereafter on what became Dryad Ward. In 1997 I moved from Dryad Ward to Sultan Ward, which was the general practitioner ward at the Hospital. Then in May 2003 I left the Hospital as I felt there was a lack of structure or strength in leadership within the Hospital.

From my experience on Redcliffe Annex, I would describe this unit as something akin to a good nursing home. When Dryad Ward, a new Ward sited at the Hospital, was established in1995, the nature of the patients differed to those at Redcliffe Annex, with the patients generally having more acute and greater medical/nursing needs. In my view the care provided to the patients was very good throughout my time on the Redcliffe Annex and Dryad Ward, but gradually patients

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came to need more care and there was a quicker turnover of patients, resulting in greater pressures on the Nursing Staff. It sometimes became difficult to maintain a high standard of care.

The nature of this change was not immediately apparent, but it certainly became clear after about a year. I think that this was followed by a progressive change, with increasing medical/nursing needs of patients up until 1997 when I decided to move to Sultan Ward.

As we were now part of the bigger Hospital, we sometimes received transfers of mental health patients from the Elderly Mental Health Wards if physical nursing and acute medical care was required. That brought about an added pressure with an area of required knowledge which we did not have on Dryad Ward.

Dr Jane Barton was the Clinical Assistant for Redcliffe Annex. I believe the demands on her were reasonable given that the patients were generally stable. Every patient would be reviewed daily by her or by her locum.

Similarly, when we moved to Dryad Ward, Dr Barton would attend first thing in the morning in order to carry out a Ward Round. Very often she would take a report from the Nursing Sister (Gill Hamblin) and if there was a specific problem they would then go to see the patient. Having completed the Ward Round, she would then leave and I understood she would go to review her patients on Daedelus Ward, before attending her GP practice. Dr Barton would return to the Hospital later if she was needed. I do not recall her coming back routinely to see if there were problems, but she would if we asked her to. She would also come back to clerk a patient in if they had been admitted that day. Any patient admitted would always be seen on the day of their admission.

Dr Barton would speak with relatives and give information when indicated that is was required. I think sometimes the relatives did not get all the ongoing/updated information needed but I believe this has always been (and still is) a very difficult goal to achieve.

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I would have seen Dr Barton clerking patients in from time to time, and indeed in the course of my career I have seen many doctors carrying out this function. Normally a doctor would go through a full assessment of all the physical systems. My recollection was that Dr Barton did not do this. She would consider what problem the patient had come to us with and would concentrate on that. In my view this was an adequate clerking in because she would have, in hand, the patient's notes from whichever ward they had been transferred. If I remember correctly we did not admit directly from the community – only from other hospital wards. Therefore these notes would have had all the patient's previous health history and were absolutely up to date. It was a brief clerking in.

In my opinion, a greater amount of medical input was not required. I believe the physical presence of a medical person being available at all times during the day (to answer relatives questions) would have been beneficial. I was aware that Dr Barton needed to go on to her GP practice, but nurses were always able to talk to her if necessary in that we could ring the Surgery if we had a problem. Dr Barton would generally return the call between seeing her patients in clinic. Given the increasing medical demands of the patients, I think Dr Barton must have become more pressurised, but she did not let it show.

With reference to note keeping, there were times when we wanted information from the notes, but information was not there or notes were limited. In those circumstances it was possible to get the relevant information from the Ward Sister or indeed from Dr Barton herself. I am not aware why notes were limited. I think Dr Barton felt that the Nurses knew their job well and she trusted us to do it well.

Nursing Staff took on an extended role on Dryad Ward, as it became a palliative care ward, and more was expected of them in consequence.

My view of Dr Barton is that she is an excellent doctor. She is a Clinician who has understanding and is very knowledgeable. I believe she is able to do her job well.

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Dr Barton comes across as quite a forthright person. Occasionally patient's relatives do not like this, but the majority appreciate it because she delivers the information they need truthfully and they can then deal with the matter from there. Certainly I never had any problems with Dr. Barton in terms of communication. If she was in surgery it was always possible for the Nursing Staff to leave a message for her and she would then get back to us - albeit between patient consultations during her surgeries. Dr Barton's attitude was the same to everyone in terms of having a forthright approach.

Dr Barton respected the role of the Nursing Staff and the contribution that we could make. However, I feel that Sister Gill Hamblin took too strong a lead on the Ward and was too dominant. Sometimes information for Dr Barton was delivered second hand, through Gill Hamblin, to Dr Barton. It was, though, entirely possible to communicate with Dr Barton in the absence of Sister Hamblin as she was very approachable. Dr. Barton never ever gave the impression a concern or question was a nuisance.

It was apparent to me that Dr Barton aimed to do the right thing medically for all her patients. Sometimes she left it to the nurses to explain things to patients although maybe that was not always appropriate within the nursing role. Often patients were not well enough to understand, so a lot of the communication to various relatives was delivered by the nursing staff. This, however, was more of a problem resulting from the working arrangement than from any inadequacy on Dr Barton's part. Certainly she would come back to see relatives if that was asked of her.

Dr Barton was respectful and cared medically for her patients. She was not the sort of person to sit by a patient's bedside holding their hand, but she would do what was medically required. It could be seen that this more openly compassionate aspect was the natural role of the nurse. She was very caring but did not show this in a physically demonstrative way.

In my view, Dr Barton did not seem stressed by her work, if she was she did not let it show. She certainly was not lazy. She did her best for her patients.

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In addition to my role as a Nurse on Redcliffe Annex and Dryad Ward, I have also worked with Dr Barton in the capacity of Practice Nurse at her GP practice, carrying this out on a Bank Nurse basis for period of 6 months - plus. From this I was conscious that Dr Barton always had a full patient list and patients had to book some time ahead in order to be seen by her specifically. It was apparent that patients were keen to have an appointment with her if possible. I found that she was very supportive and helpful to me in my role as a Practice Nurse if I ever needed any medical advice.

On Dryad Ward it was apparent to me that occasionally notes made by nurses could be less than complete. I felt that this was in consequence of the increasing demands on the Nursing Staff to the point where the nurses might either have to attend to a patient, or write up the notes. On occasions things were missed in the notes. It is possible that the lack of notes made by Dr Barton could be due to the same difficulty, but I do not know.

Dr Barton would prescribe medication for a patient. On occasions she would prescribe medication in anticipation of near future needs. Not all patients would have this kind of prescription. She might do this if the patient was receiving opiates or if they were reported to be in pain or if pain was worsening.

It is possible for Nurses to take a verbal order from a doctor to administer drugs, but this is not possible when opiates are to be administered. Accordingly if opiates were required for pain relief, but had not yet been prescribed, it was not possible to give that medication until the Doctor arrived to prescribe it. I presume this is why the practice of prescribing such drugs, in advance, was adopted: avoiding the patient being in pain.

Such medication was usually written up with a dose range. I anticipate that the reason for this was again to ensure that adequate medication could be delivered to the patient immediately if they were in pain.

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When instituting medication prescribed in this way, or increasing it, it would not be necessary to ring Dr Barton but she would be informed of it when she came in the following day to carry out her ward round. I am not aware of any routine contact between Dr Barton and Nursing Staff before commencing such medication – if previously written up.

On Dryad Ward, if a patient was struggling to eat and drink, and we felt that it might become necessary to administer medication via a syringe driver within the very near future we would show this to the family and explain the reasoning to them. I cannot think of an occasion when a syringe driver was used and the implications had not previously been explained to the family.

I am not aware of anyone raising concerns with Dr Barton about the quality of her care or her prescribing practice. Consultants would have seen the drug charts during the weekly Ward Rounds, and I am not aware of anything ever being changed. Certainly I had no concerns about Dr Barton's prescribing or indeed her care of patients generally.

At the time on Dryad Ward I had concern that the Nursing Staff did not always know the regime to follow in relation to increasing doses of opiates – in terms of what level was appropriate and the percentage by which opiates should be increased. I felt there should have been more teaching on this issue.

In my view, Dryad Ward ultimately became a palliative care ward, but I do not recall any palliative care education being provided for the Nursing Staff. I had previously worked in a hospice, so I was aware that opiates should be increased by $^1/_3$ or ½ of the existing dose - depending on level of pain. I am not aware of any of the Nursing Staff going on courses and learning of this, or indeed being aware of it in my time on Dryad Ward.

In my view, patients were transferred to Dryad Ward for palliative care when very often they and their relatives had been told they were coming for rehabilitation. This was very difficult for us to deal with in terms of expectations.

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