WITNESS STATEMENT

STATEMENT OF **PATRICIA WILKINS**

AGE: OVER 18

This Statement consisting of 8 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 8 day of JUNE 2009

Signed Code A .....

PATRICIA WILKINS

I am Patricia Wilkins of Code A I am a Registered General Nurse. I qualified as a State Enrolled Nurse in 1971, having trained in the Navy before then doing conversion to Registered General Nurse in the 1990s. I first employed as a Nurse at the Gosport War Memorial Hospital in 1985 as a State Enrolled Nurse on Redcliffe Annex. Redcliffe Annex was a unit designed to look after elderly patients. After a short time I then moved to the male ward at the Gosport War Memorial Hospital. Following rebuilding work at the Hospital I then moved to the newly created Daedalus Ward in 1993 as a Staff Nurse, later being appointed as Senior Staff Nurse on the Ward in 1998. I remained on Daedalus Ward for 10 years, before moving to the Dolphin Day Hospital at Gosport in 2003.

Initially, local patients admitted to the male ward would be under the care of their own General Practitioners. If someone was admitted to the Hospital from outside the local area, then one of the local GPs would be appointed on a rotation basis to have responsibility for their medical care. However, following the appointment of Dr Jane Barton as Clinical Assistant, she assumed

responsibility for the day to day medical care of patients on the Ward. She would attend to see the patients each weekday, and if I happened to be on charge, I would go round with her to see all of the patients. There were 8 beds on the Ward in total. In addition, Consultants would do Ward Rounds every week or every fortnight, and Dr Barton would attend with the Consultants on those occasions.

Following the creation of Daedalus Ward and Dryad Ward at the War Memorial Hospital, Dr Barton became Clinical Assistant for those two wards and carried out the day to day medical care for the patients. She would routinely attend on Daedalus Ward at about 8:00a.m. each morning, depending on what she had had to do previously on Dryad Ward. We would then go through all of the patients with her, focusing on anyone about whom there had been concerns in the course of the night. We would then go round and see the various patients with Dr Barton. Dr Barton would then write up any investigations which were necessary, and note up anything else that needed to be done, and would prescribe for patients as necessary. Having completed her responsibilities on Daedalus Ward, she would then go to her GP Surgery to see her patients there.

Following Dr Barton's Ward Round, if we became concerned about any patients or they subsequently deteriorated, we would be able to contact Dr Barton for advice.

Dr Barton would then return to the Hospital at lunchtime to see any patients about whom we had concern, and she would also clerk in any new patients who had been admitted. If we later received a patient who had been transferred from another hospital or a patient's relatives needed to be seen, Dr Barton would come back to the Hospital again later in the day, and so could be at the Hospital as many as 3 times in the one day.

Dr Barton also carried out a Ward Round with the Consultant on Monday afternoons, which I think took place each week.

It was apparent to me that over time the patients admitted to Daedalus Ward were increasingly unwell. In the late 90s, patients were a lot sicker than they had been previously, and it was

apparent that there was pressure from local hospitals including the Queen Alexandra Hospital to discharge patients who were termed 'delayed discharge' patients, by which it was understood that they were 'bed blockers'. Increasingly, patients had greater and more acute medical needs.

In addition, the expectation of relatives appeared to increase. It became apparent that relatives were being told by the discharging Hospital that patients were coming for rehabilitation, but when those patients were very poorly indeed. I recall one lady in particular who had had a very dense stroke and who was totally dependent. Her family remonstrated with us saying words to the effect 'but we were told she was sent to you for rehabilitation'. In addition to managing the patients with increasing needs, it was also necessary to manage the expectations of the relatives.

As Nurses, we wanted to make sure that our patients were given good care. With the increase in the needs of the patients and their dependency, the Nursing workload increased in consequence, as the number of Nursing Staff remained the same. Nursing Staff were therefore under a greater pressure.

As I recall it, the Consultant input consisted of a Ward Round conducted once a week. I think in due course the Ward was divided into two, with two Consultants then being deployed, but I cannot remember when that change took place, and specifically if it was before or after Dr Barton left the Hospital as Clinical Assistant in 2000. Beyond Dr Barton as the Clinical Assistant, and the Ward Rounds conducted by the Consultant, there was no other medical input on Daedalus Ward although it was possible to telephone and speak to the Duty Consultant out of hours if that was necessary.

I believe it is fair to say that the same increase in workload and demands will have affected Dr Barton in a similar way. Indeed, the whole Department of Elderly Medicine was under pressure, including the Consultants, but inevitably Dr Barton would have been affected. I anticipate, for example, that we would have been calling on Dr Barton for help more often.

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Looking back now, it is apparent to me that this was a gradual process in terms of increasing demands. Staff tried to cope with it as best they could and ensure that the patients were cared for. I think amongst ourselves we felt that there was a lot of pressure but we just got on with it rather than complaining.

After Dr Barton resigned from her position as Clinical Assistant in 2000, she was replaced by a Staff Grade Doctor who worked on Daedalus Ward on a full time basis. In addition, she also covered Dryad Ward and clinics in the Day Hospital. She would be available to see patients between the hours of 9:00a.m. and 5:00p.m. Outside those hours I think there was an arrangement with the local practice, possibly Dr Barton's, to provide cover.

I always found Dr Barton to be a very honest person. She was someone who was very caring and would come in at weekends to see patients about whom there was concern even though she might not be on duty.

She was someone who would say things how they were to relatives and would not give false hopes. I always found her to be very approachable. She is not someone who would do anything to harm a patient at all. She was very cooperative when we needed to contact her. You could get advice and she was very supportive to the Nursing Staff. If necessary, we would phone her Surgery and explain we needed to speak with her. We would then be put through and could discuss a patient with her. At weekends Dr Barton would leave her home number and could be contacted that way. We did not abuse that, but it was always available as a safeguard. It was always possible to discuss anything with her, and any concerns we might have about a patient in particular. We could review a patient's condition and devise a plan. Dr Barton was very much part of the Team and knew us.

I recall that Dr Barton had a very good attitude towards patients and was very respectful. She listened to what they had to say and would explain to them what they needed. She would banter with those who wanted that. In my view, she had an absolutely first class attitude towards work.

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I saw Dr Barton clerking patients in from time to time following their admission. I would go with her to see the patients and was with her when she carried out the clerking in process. She would examine the patients and then document that. In terms of what Dr Barton did by way of examining the patients on these occasions, I would say that her practise did not differ from that of any other doctor I have seen undertaking this exercise. However, the documentation she produced in consequence did differ. I am aware that clerking in notes now are very much more detailed than the notes Dr Barton produced. However, I did not feel this was a situation in which we were lacking information because although the notes might be limited, there was good verbal communication to supplement that.

As Nurses, I recall that we could have situations in which we were faced with having to care for the patient or writing in a patient's notes. It might become necessary to attend to care for a patient immediately and one would then forget to write what one had been otherwise about to do in the records. There were 24 patients on the Ward, all of whom could be heavily dependent. In a late shift, for example, it would be necessary to do a drug round, feed the patients, speak to the relatives and get the patients to bed. Things might then be forgotten in making a full note, but certainly the relevant information about the patients was communicated to colleagues.

If there were deficiencies with Dr Barton's notes it is possible that this could have come about for the same reason. I am conscious that often Dr Barton would have to go back to her Surgery in the afternoon having come to the Hospital at lunchtime, and indeed would have to go back for evening surgeries as well. Nevertheless, if we needed information from Dr Barton we could have it by way of verbal discussion.

I am aware of a process of anticipatory prescribing on Daedalus Ward, whereby medication would be prescribed by Dr Barton for patients in anticipation that it might become necessary for the medication to be administered in the near future. On occasions, if a patient was in need of medication and Dr Barton was not available, it was possible to take an instruction from her or indeed another doctor, as a verbal order. The medication could then be administered by the

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Nursing Staff and the prescription would be confirmed when the Doctor next attended. However, that was not possible with controlled drugs.

Accordingly, for drugs like Oramorph, Diamorphine and Midazolam drugs could be prescribed by Dr Barton on this anticipatory basis so that they were available for patients should that become necessary. I understood that this practice was adopted to ensure that patients could be made comfortable with appropriate medication being given, rather than having to wait for a doctor to attend at the Hospital in order to provide a prescription, particularly at weekends when Dr Barton was on duty. I recall that when the Commission for Health Improvement attended at the Hospital and I was interviewed, I told the investigators that there were occasions when we had had to wait for hours for an on-call deputising service to attend in order for patients to be given medication, with patients writhing in pain before that medication could then be given.

If medication such as Diamorphine and Midazolam was going to be administered via syringe driver, Dr Barton or the Nursing Staff would discuss this with the relatives first. Syringe drivers were started where, for example, a patient had become unable to swallow. Such medication would usually be written up with a dose range available, but it was always understood by the Nursing Staff that the patient should receive the lowest dose when that medication was commenced. In addition, the Nursing Staff had the Wessex Analgesic Ladder and would follow that.

Such medication might be commenced by the Nursing Staff for a patient after Dr Barton had attended for the morning Ward Round, but the patient might have been discussed with her that morning, and the possibility considered that the patient might require it. I cannot say that we ever contacted Dr Barton to say that we were going to set up such medication via a syringe driver by telephoning her, but she would be informed of the position when she next attended at the hospital.

I never had any concerns that what was being administered to a patient by way of medication was inappropriate. For the needs of the patients I saw, I thought that what they were being given by

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me or my colleagues was appropriate. If I had felt that medication was inappropriate I would have challenged Dr Barton. In my view she was someone one could have approached in that way.

Not all patients had medication prescribed in this way. It was usually made available for those who were quite poorly.

If we wanted to increase the dosage of medication given in this way, Dr Barton might be available for discussion if she was present in the Hospital, or it might happen when she was simply not available. We would not though ordinarily telephone her solely to advise her of the fact that we intended to increase medication, but again she would be aware of the position when she next attended.

I have seen notes made by Dr Barton in the medical records of patients to the effect 'I am happy for the Nursing Staff to confirm death'. It was possible for Nursing Staff to verify the death of a patient. If Dr Barton was available we could call her in to certify a death, but the ability of a Nurse to verify death meant that we could cover periods when Dr Barton was not available.

I am not aware of any consultant raising with Dr Barton concern with her about her general standard of care of patients, her note keeping, the nature of her assessments of patients, or her prescribing practice. Similarly, I am not aware of anyone else raising such concerns with her. Certainly I had no such concerns myself about Dr Barton's practice.

I can recall a patient on Daedalus Ward by the name of Gladys Richards. I recall that I was not directly involved in her care as I had gone on holiday during the time of her admission, and when

After I got back from leave, a number of my colleagues told me that one of Mrs Richards' daughters had been concerned to write everything down in a notebook and had wanted to know the names of Nurses involved in her mother's care. I understood that Mrs Richards' daughters

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had been very difficult. Shortly thereafter I received a telephone call from one of Mrs Richards' daughters, to tell me that she wanted to apologise for her sister's behaviour.

Signed. Code A ..... Witnessed... Code A .....