WITNESS STATEMENT

STATEMENT OF SIOBHAN MARIE COLLINS

AGE: OVER 18

This Statement consisting of 10 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 day of December 2007

Signed Code A

SIOBHAN COLLINS

I am Siobhan Marie Collins of Code A
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I am a Registered General Nurse having qualified in Limmerick in 1987. From 1987 to 1994 I worked as an RGN at the Limmerick Regional Hospital. From July 1994 until October 1995 I carried out agency work with the Crown Nursing Agency. I also worked as a D Grade Nurse at the Queen Alexandra Hospital in Portsmouth, normally working on B3 Ward, a general medical ward.

From October 1995 I was employed by the Fareham and Gosport Primary Care NHS Trust as a D Grade RGN, working at St Christopher's Hospital, Fareham. Whilst at St Christopher's, in 1996 I applied for and was accepted as an E Grade RGN.

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In November 1997 I then commenced working as an E Grade RGN on Dyrad Ward, at the Gosport War Memorial Hospital. At that time, Dryad Ward was a continuing care ward comprising of 20 beds for elderly patients. Four of the beds were for respite care.

In July 2003 I moved from Dryad Ward to Sultan Ward at the Gosport War Memorial Hospital, as an F Grade RGN. I resigned from this position in March 2006 for family reasons, although it is my intention to return to nursing shortly, this time at Alverstoke House, a local nursing home.

I believe that the Gosport War Memorial Hospital was built after the First World War, and that a section of it is still owned by the community. As I understand it, the Hospital is now run by two primary care trusts, the Fareham and Gosport PCT, and the East Hampshire PCT. The Hospital is essentially a cottage hospital, although it does rather more than most cottage hospitals, in particular in relation to palliative care.

Relatives tended to be concerned that patients from Gosport and the surrounding areas should be nearby where they could visit them, which was more difficult if they were admitted to hospital in Portsmouth. I felt that over time, patients were being transferred to Dryad Ward in a condition in which they were more acutely ill. This produced increasing demands on the nursing staff. The problem on Dryad Ward was not so much the quantity of patients, but rather their needs. In my view, over the period of time I worked on Dryad Ward, the needs of those admitted increased significantly. Unfortunately, there was no increase in the numbers of nursing staff to accommodate that need.

A lot of the patients who were admitted to Dryad Ward were transferred from Acute Units, mainly at the Queen Alexandra Hospital. I would estimate that during the time I was there approximately 60% of the patients admitted to the Ward would have had major medical issues that in the short or long term would become terminal.

As I recall it, while I worked on Dryad Ward there was not an increase in bed occupancy – that remained about the same over the period, but I am conscious that the turnover of patients

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increased significantly. Patients were transferred from the Queen Alexandra Hospital in order to alleviate the demand for acute beds. In some instances, patients were transferred who then developed more problems and ended up being moved back to the Queen Alexandra Hospital. I am conscious that this is a situation which exists in all hospitals in terms of the demand for beds. The staff at the Queen Alexandra Hospital were trying to do their best with the resources available to them. However, I was unhappy with the transfer of some of the patients to Dryad Ward in that their needs were too great. In an ideal position, they should not have been transferred. This became quite a demanding situation for the staff on Dryad Ward.

While on Dryad Ward I would usually work on the night shift. Ordinarily, I would work three nights one week, and two nights the next. However, I also liked to work on days in order to see the difference, and to be involved in the routine of working days. Accordingly I would undertake a measure of day work, which might range from very little in one month through to 10 or 20 hours in another.

The medical input on Dryad Ward was provided by a consultant who carried out one ward round a week, with the remaining care being undertaken by Dr Barton, as the part time Clinical Assistant. I understood that she was in charge of the day-to-day medical care, dealing with acute problems as they arose. In the same way in which there was no increase in nursing staff over the time when I was on Dryad Ward similarly there was no increase in medical staff during the time Dr Barton was Clinical Assistant I recall that Dr Barton left in about 1999 or 2000. She was replaced by another staff grade doctor in elderly medicine, but this time the appointment was full time, with the doctor working from 9:00a.m. through to 5:00p.m. each weekday.

I anticipate that the Consultants had 100% trust in Dr Barton and they did not feel the need to oversee a lot of her work. Their main input would be in the next step in the patient's care, in terms of deciding whether the patient should be transferred to a nursing home, or kept on the Ward, if the patient should go to rehabilitation or should go home for a period.

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Dr Barton was the Clinical Assistant for both Dryad and Daedelus Wards. She would come to Dryad Ward between 7:20 and 7:30a.m. each weekday. My shifts did not finish until 7:45 when I was working nights, and I would therefore see her most mornings. She would normally speak to Sister Gill Hamblin, who was the Clinical Manager on Dryad Ward, to receive information about the patients, and how their conditions might have varied overnight. On occasions, however, she would speak to me about the patients. Dr Barton would then go to see each of the patients on Dryad Ward individually. She dealt with any acute problems that had arisen overnight. A nurse would accompany her when she went round to see each of the patients, and from time to time I acted in this capacity. This was something I had not seen before in my nursing experience, and I thought it was very thorough. Dr Barton didn't simply deal with the problem at the desk, but was concerned to see each patient, to speak with them and ask how they felt. Having attended the patients on Dryad Ward, she would then go to Daedelus Ward, before leaving to go to her own general practice surgery at about 8:30a.m.

I tended to have more contact with Dr Barton when I was on day duty, although there were also many occasions when I was on night duty when I would speak to Dr Barton the telephone in order to seek her guidance about a patient.

Having seen all of the patients on both wards each morning, Dr Barton would then regularly return to the Hospital at lunchtime in order to see patients again then if necessary, to clerk in patients who might have been admitted in the morning, and to see relatives who might be anxious to discuss issues with her. In practice, this meant she was there at lunchtime on most weekdays. Dr Barton would also return to the Hospital in the evenings to see patients, to clerk them in and to see relatives as necessary, although this tended to be less frequent.

If a new patient had been transferred to Dryad Ward and needed to be clerked in, we would usually leave a message at Dr Barton's Surgery so that she was aware of the need to attend to clerk in the patient. Usually Dr Barton would then attend to take care of this, though on occasions one of her partner's would attend in her place.

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I would say that in hindsight, the nursing record keeping on Dryad Ward was minimal. This was partly due to the fact that there was not the same emphasis then as now in relation to the importance of recordkeeping. However, it also resulted largely from the fact that there was a very significant demand on our time in terms of the care required for patients, and our written work suffered in consequence. I did not feel that we had enough time to put more into the nursing records. If I had written more by way of entries in a patient's records, I would simply not have had the opportunity to deliver the actual care.

In hindsight, Dr Barton's input into the medical records could have been greater. In my view, her input in meeting with patients and her actual patient contact was excellent. In consequence, what Dr Barton wrote in the records was concise. It could have been more in depth, but she was under even greater constraints in terms of her time than the nursing staff, and her recordkeeping suffered accordingly. However, I never saw a situation in which patient safety or the quality of care was compromised by the fact that Dr Barton's notes were more limited.

In my view, Dr Barton did not have sufficient consultant input, not in the sense that she did not know what to do, but simply in terms of demands on her time. These demands were very high.

I always found Dr Barton to be very approachable. When I needed to call her, even out of hours, I felt able to do this. If a patient became acutely ill, if they became distressed or they were in pain, I was aware that I could telephone her for advice. We generally felt able to contact Dr Barton during waking hours – in the main up to about 10:00p.m. if we felt that something could be dealt with over the phone with the patient not actually needing to be seen by a doctor. From time to time it was necessary to contact a doctor during the night, and if Dr Barton was on duty we would contact her. If, however, she was not on duty, we would telephone the duty doctor.

Over the period of time I was on Dryad Ward, the Consultants responsible for the Ward changed frequently. I recall that Dr Lord, Dr Reid and Dr Logan were all consultants who had responsibility for Dryad Ward, but there were the others also. It seemed to me that no sooner had a consultant found their feet than they then moved on. The Consultants must have been aware of

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the problem of the significant demand on nursing and medical time brought about by the significant medical needs of the patients, and the way in which these needs and the dependency of patients increased over time. In my view more doctors were certainly required to cover Dryad and Daedelus Wards, and probably more nurses, although NVQ trained carers would certainly have eased the burden on the qualified nurses, enabling us to carry out other responsibilities.

I did not raise the need for extra staff numbers with anyone at the Hospital. I felt that the quality of care we were all able to deliver was excellent. However, in consequence of the delivery of that care, the recordkeeping suffered. Had the quality of care been compromised, I would have raised the matter.

When the Commission for Healthcare Improvement carried out its investigation of the Hospital, the Investigators spoke to a number of members of the Nursing Staff, but I believe that these were individuals who were randomly picked from each ward, and I was not picked, and so did not speak to any of the Investigators. I think all of the Clinical Managers spoke to Investigators.

Following the Commission for Healthcare Improvement Report concerning the Hospital, different criteria for admissions were put in place, although my perception was that the dependency of patients did not reduce. Arrangements for drug prescribing changed, and Consultant visits improved. I cannot recall now that there was any increase in the number of medical or nursing staff.

I would say that Dr Barton was a very kind individual, and a clinician who was genuinely interested in the wellbeing of her patients. She always treated them with respect and I never heard any patient complain about her dealings with them in any way. She was approachable, and always put patient welfare first. I cannot recall anyone making criticisms of her during my time at the Hospital. I found that I never had any problem getting hold of her when I called, and she was always quite happy to be contacted. Dr Barton seemed very conscientious. She was always very pleasant, and was respectful of the views of nurses.

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Having undertaken day duty on a not infrequent basis, I was present from time to time when Dr Barton would carry out an initial assessment of a patient following their admission. I have of course seen many doctors carrying out such initial assessments or clerking in of patients in my career as a nurse. In my view, Dr Barton's initial assessment was quite thorough. She would usually carry out a full top to toe examination. I did not feel that she missed anything of significance. Basic measurements, including the taking of the patient's pulse, blood pressure and respiration and temperature would be carried out by the Nursing Staff. Dr Barton would review the measurements and there would always be a communication between her and the Nursing Staff. Any problems initially observed by the Nursing Staff were communicated to her, and she would take them on board and investigate accordingly. Patient medical records would usually accompany the patient, although from time to time they were not available. Dr Barton would review the records, and could focus her examination with the benefit of them. The assessment of a patient would continue over a day or so to ensure that everything we needed to know about the patient was available. For example, blood and urine tests might be undertaken.

When I first arrived at Dryad Ward a practice was in operation whereby, in addition to the prescribing of a patient's regular drugs, drugs might also be prescribed for a patient in anticipation. If a patient was deteriorating, Dr Barton might prescribe some drugs to be used if a patient's condition later required it. This was an arrangement to prevent a patient having to wait a number of hours in order for a duty doctor to come and review them and then prescribe the necessary medications. It was quite apparent to me that this arrangement was based on a great element of trust and a good rapport which existed between the Nursing Staff and Dr Barton, whereby she knew that the drugs would not be used inappropriately.

The drugs used on this basis were usually Diamorphine and Midazolam. These drugs were used in a syringe driver ordinarily when a patient was no longer able to swallow. Up to that point, if a patient might require opiate medication for pain relief, we would tend to use Oramorph, an oral morphine preparation. Dr Barton would usually prescribe the drugs on this basis in a relatively wide dose range, so that the medication could be increased if necessary without having to wait for a doctor to attend.

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Some patients were only prescribed their regular medication, and would not need to have drugs prescribed on this anticipatory basis. However, a lot of patients had many ailments and were quite ill. This form of prescribing was undertaken for those patients who were perceived to be terminally ill. This might be apparent on admission. However, it might also be instituted if a patient's condition deteriorated and they were then perceived to be terminally ill. The rationale was that patients should not suffer needlessly, and that medication should be available rapidly in this way if necessary.

If I considered that a patient required such medication which had been prescribed on this basis by Dr Barton, or indeed an increase was required, I would ordinarily telephone her to advise her if this arose during waking hours. Similarly, if Dr Barton was on duty, and the issue arose in the middle of the night, I would also feel able to contact her. However, if the issue arose during the night and Dr Barton was not on duty, I did not contact the Duty Doctor. Rather, I would review the position with a nursing colleague of the same or greater seniority. We would assess the position together, and so the decision would then be taken by two senior nursing staff members. If I was uncertain about something I would ask Gill Hamblin, my Manager, or Code A the Night Sister.

When initiating the medication prescribed in this way, we would always start at the lowest dose in the range prescribed by Dr Barton, unless the patient had already been receiving similar medication. Accordingly, if the patient had been receiving quantities of opiates, it might be necessary to administer a higher quantity of Diamorphine than the lowest dose stated in the range, in order to produce the appropriate equivalent.

The Consultants responsible for Dryad Ward must have been aware of the practice of prescribing drugs in this way. It was there for everyone to see on the medical records, which would be reviewed when the Consultants carried out their Ward Rounds each week. However, I never heard any expression of disquiet or concern from Consultants about the operation of this policy. I think the Consultants may also have operated this system of prescribing on occasion. Had I had

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any concern myself I would certainly have felt able to say so. However, in my view it was quite an appropriate and efficient system considering the resources we had available. I would accept that it was not perfect. In theory there was the potential for someone to be started on a very high dose within the significant range which was usually prescribed. However, this was not a real risk as there was a complete understanding with everyone that a patient would not be started on a very high dose, unless as I have indicated there was a specific reason for this in terms of the medication they were already receiving. All of the nurses knew how the system was supposed to work, and we were all professionals who worked in a professional manner. I never saw a situation in which this system of prescribing compromised patient safety or the quality of care.

I considered that I had appropriate relevant experience in the treatment of patients with such drugs from my previous experience as a nurse, and through specific training. In particular, in February 1998 I spent a day and a half at the Rowans Hospice, a local hospice, which provided a very thorough course in the use of syringe drivers, conversion rates, the compatibility of drugs, and the use of opiates and benzodiazipines, including the effects of such drugs in the body, in particular for patients whose health is compromised. I believe that most of my colleagues had similar training, and from my experience, they all had a thorough knowledge of the relevant issues.

From my experience, I never felt that what Dr Barton had prescribed for a patient was inappropriate. It wasn't always necessary to use the medication. The patient's condition might improve, or they might pass away before the medication was actually required. We would only consider the administration of such medication or its increase when the patient showed signs of significant pain or discomfort. It was not unusual for a patient to have, for example, a fractured femur, and such patients will inevitably experience some degree of pain and discomfort on being moved or turned, but this could be transient and might settle down. Such patients would not receive Diamorphine in consequence. We would give them moderate pain relief, for example, paracetamol or something slightly stronger, and usually in advance of their being moved. The administration of Diamorphine was on a completely different basis, and was considered only where there was indication of continuous and quite severe pain and distress, and when the patient

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was unable to take oral preparations. I believe from my experience and training as a nurse I was able to distinguish between pain which might be transient and limited, and pain and distress which was significant and continuing.

I am aware that from time to time Dr Barton would record in the medical records *"I am happy for nursing staff to confirm death"*. I was conscious that Dr Barton knew that the nursing staff were competent to make the assessment of death. She would usually write this in the notes when she felt that a patient was terminally ill.

I am not aware of any concerns being expressed on the part of consultants about Dr Barton, whether this be in relation to general issues relating to care, her prescribing, or her note keeping. Similarly I am not aware of anyone else expressing any such concerns. I certainly did not have any such concerns about Dr Barton for my own part.

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