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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: HAMBLIN, G

Age if under 18: (if over 18 insert 'over 18') Occupation:

This statement (consisting of page(s) each 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 anything which I know to be false or do not believe to be true.

Signed: Code A Date: 11/06/2005

I am Gillian Elizabeth HAMBLIN and I live at an address known to Hampshire Police. I am currently employed as a Night sister in a local Nursing Home. Up until February 2004 when I retired from the Gosport War Memorial Hospital was a Clinical Manager (Senior Sister) at Dryad Ward, my Nursing and Midwifery Number is 170G0632E. I did not work at that hospital however since May 2003 though, due to sickness.

In 1963 I became a Cadet Nurse and commenced a 3 year qualification course in 1965 at Hackney Hospital, East London. I worked on all wards until my qualification as a Registered Staff Nurse to the surgical ward.

I commenced employment at Gosport War Memorial Hospital in 1988 in the capacity of Staff Nurse.

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management Redclyffe Annexe which was 23 bed unit for continuing care, terminally ill patients, who's length of stay at the hospital was variable, but basically to assist relatives and give them a period of respite.

Redclyffe Annexe was situated a short distance from the hospital and moved to the main hospital in 1994 and thus became Dryad ward.

In January 1996 I was working as a Clinical Manager at the GWMH. I worked 37 ½ hours a week on a shift rota, earlies being 0730 to 1615 and lates 12 midday to 2030.

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management of the Hospital and would take on management roles when there were no managers at the hospital, i.e. at weekends and evenings. I was responsible for all of the staff on the ward re the training, hiring discipline, staff rotas and leave issues.

My line manager at that time was Barbara ROBINSON .

In 1999, Diamorphine Syringe drivers were introduced to those of us working on Redclyffe Annexe and in 1998 Dr Jane BARTON became the Doctor responsible for the patients, prior to this, each patients GP was responsible for their individual patients on the ward.

Responsibility for medical care was "Elderly Medicine" based at the Queen Alexandra Hospital Cosham.

Dr BARTON would visit at 0730 each morning Monday to Friday and see every patient, before returning to her own practice.

She would return to the GWMH to check in and arrange to see relatives either that day or later.

On her visits Dr BARTON would prescribe the drugs that were required by each patient. This was a new concept to staff at this time. Sister GREEN who was in charge at this time bought syringe drivers to the annexe and explained the system to the nurses and they would have learnt their use from her.

At this time there were no courses in the use of syringe drivers, but these have since been started. I am aware that there have been some concerns in relation to the syringe drivers and Diamorphine, but I have not had any doubts myself. The main reason for the use of a syringe driver is to administer drugs to a patient once oral medication has ceased, generally due to the patient's inability to swallow.

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Drugs that I am aware of that have been administered in this way as well as Diamorphine, are Midazolam , a sedative, Hyoscine , to stop secretions and Cyclizine to stop vomiting.

I have been asked about the "Wessex Protocols". I am unfamiliar with this name but am aware of certain protocols in relation to the setting up and use of syringe drivers, I am unsure if they are one and the same.

The Named Nurse is the person with the responsibility for the nursing care of the patient. The named nurse would also be the person to whom the family would speak to, in order to keep them up to date on the patient's condition.

The time and date of all entries in the nursing notes would either be completed at the time if the patient was seriously ill, but in other cases they would be completed when there was time but in any case at the end of the tour of duty.

I have been asked to detail my involvement in the case of Robert WILSON Code A
I do not remember the patient Robert WILSON.

I have been shown page 119 of exhibit BJC/55 and I can confirm that I have written the following entries on the spell summary of the medical notes.

The spell summary is the discharge notes which outline the diagnosis/treatment and follow up if necessary for the patient. This is ultimately sent to medical records at GWMH and then onto clinical coding either at QA or St Mary's Hospital.

The spell summary is typed on the day, or day after admission, which not only details the patient's personal details, but the diagnosis and the relevant medical codes showing the patient's medical history. It is also based on the transfer letter which accompanies the patient. The transfer letter appears to be missing from Mr WILSON's medical notes.

I have written the following diagnosis.

Diagnosis

 # L humerus = Broken left upper arm

End stage CCF = Congestive cardiac failure

Renal failure

Liver failure

Treatment/Recommendation

Syringe driver 16/10/98

This shows the treatment which was administered by the patient. In this case the commencement of the syringe driver which was on the 16/10/98.

This diagnosis has been obtained by me, as a result of reading the medical records, which accompanied the patient.

Prior to a patient being transferred to my ward, Elderly Services at the QA hospital would ring the ward and let us know of the forthcoming admissions.

At this stage, normally, the ward clerk at Dryad, would ring the transferring ward, to obtain a more detailed diagnosis of the patient awaiting transfer. This procedure made sure that we had a suitable available bed and any other equipment that was needed.

On referring to the notes of this patient Robert WILSON Code A I noted that he had multi organ failure. The prognosis that I made was that he was being admitted for terminal care at Dryad Ward.

When a patient is being transferred from another hospital the patient would have already been seen by a Consultant Geriatrician. It may not be the same consultant that works on Dryad Ward.

I have written the following entry under the heading Diagnosis.

 # broken L arm - self explanatory

End stage CCF - Congestive cardiac failure.

This means that the heart is not functioning properly. There was a build up of fluid around the heart.

This diagnosis is based on entry at page 168 of the medical records which details that Mr WILSON was in QA hospital in 1997 with heart problems.

Dr LORD is shown as the Consultant Geriatrician for Mr WILSON.

Dr LORD conducted ward rounds once a fortnight on a Monday with Dr BARTON and me, or whichever trained nurse was on duty at the time.

The diagnosis is also based on the transfer letter which accompanies the patient. However I cannot find the transfer letter in the medical notes of Mr WILSON.

Renal failure - This means that the patient's kidneys are not functioning - As a result fluid builds up within the body such as the legs of Mr WILSON which were oedematous.

Liver failure - This is indicated by yellowing of the skin. It can be due to gall stones.

Treatment/Recommendation

Syringe driver has been commenced by the medical staff which would have been Dr BARTON initially.

The doctors rely on the nursing staff admitting the patient to do the initial assessment. The doctor will then subsequently write up the drug treatment chart for that patient.

The final entry on the spell summary that I have written is the date of death of the patient, which I have recorded as *18/10/98 2340*. This entry was signed by me as being entered on the

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19/10/08.

I have been shown the prescription chart on p.262 of the medical record, I note that at 0515 17/10/98 that 20 mgs of Diamorphine , 600 mcgs of Hyoscine were administered to the patient by Staff Nurse Code A and witnessed by Senior Staff Nurse Code A .

At 1550 hours that day I have increased the dose of Diamorphine to 40 mgs and increased the Hyoscine to 800 mcgs. I have also added 20 mcgs of Midazolam.

The previous dose of Diamorphine and Hyoscine has been destroyed. A record of the controlled drugs destroyed is normally recorded next to the entry showing the original dose administered.

It is easier to destroy the dose which is already in situ and then administer the new dosage in a fresh syringe driver.

I have checked the drugs register for the 17/10/98 which show that Staff nurse Code A and Code A recorded the entry.

The stock of controlled drugs was transferred to a new drug register on the 17/10/98.
I have not been shown the drug register that follows on from the 17/10/98

Where there is a reference to drugs being destroyed the drugs are poured down the sink which is witnessed by two nursing staff.

The prescription of Oramorph which is a liquid form of Diamorphine I note was prescribed by Dr BARTON (PRN means whenever necessary).

The Diamorphine, Hyoscine and Midazolam as recorded on p 262 were prescribed by Dr BARTON. There is no date recorded showing when this was written.

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At the bottom of pg 262 of the Prescription Chart there is an entry relating to Hyoscine 1200 mcgs - SC - (subcutaneous) in 24 hrs.

This was a verbal order that I have taken from Dr PETERS at 1430 hrs on the 18/10/98. This entry was subsequently countersigned by Dr PETERS when he came into the ward later that day.

I have been shown the entry recorded at 17/10/98 on p 265 - 0515 - This relates to the renewal of the syringe driver containing 20 mgs of Diamorphine and 600 mcgs of Hyoscine. The Diamorphine remained the same, the Hyoscine was increased from 400 to 600 mcgs.

Hyoscine is used to dry up the secretion where fluids collect on the lungs. This condition normally occurs when a person is dying.

The dosage of 400 mcgs was not controlling the secretions that were occurring. I therefore, increased the dosage up to 600 mcgs to try and dry up the secretions.

The dosage of Diamorphine was increased from 20 mgs to 40 mgs at 1550 on 17/10/98. The Hyoscine was increased from 600 to 800 mcgs. Also we added 20 mgs of Midazolam to the syringe driver.

The dose of Hyoscine was increased to cope with the increase of secretions on the chest which is recorded as per my entry on 17/10/98. The Diamorphine was increased because of pain. The Midazolam was administered to relieve the anxiety.

This dosage of Diamorphine, Hyoscine and Midazolam was administered by Staff Nurse BARKER.

The Midazolam was given because the patient had a tube inserted down his throat to relieve the secretions. It is an unpleasant procedure.

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I can confirm that I have written the following entry on p 265 of exhibit BJC/55.

Pm - slow deterioration in already poor condition requiring suction very regularly copious amounts suctioned syringe driver renewed at 1550 o/c (= with) Diamorphine 40 mgs, Midazolam 20 mgs and Hyoscine 800 mcgs. Mrs WILSON visited again this evening and is aware that his condition is poorly. She will remain on the ward overnight.

This entry is self explanatory; Mr WILSON's condition has continued to deteriorate.

Neither I, nor my staff, have recorded the reason for the increase in Diamorphine in the nursing notes. However it would have been increased due to pain level not being controlled by the previous dose.

I can confirm that I have written the following entry on p 266

18/10/98
Further deterioration in already poor condition, wife has remained overnight, seen by Dr PETERS who spoke to Mrs WILSON. Syringe driver renewed at 1450 °/c Diamorphine 60 mgs, Midazolam 40 mg, Hyoscine 1200 mcgs.
Continues to require regular suction. His children had also visited.

Signed Code A

The Diamorphine has been increased from 40 mgs to 60 mgs . This would have been to control his pain. I must point out that as well as multi organ failure, Mr WILSON was suffering from a fractured upper L arm.

Midazolam was increased from 20 to 40 mg. This was increased because he was suffering from liver failure, and as a result, the medication would not be working as effectively. Therefore the dosage was required to be increased.

The same applied to the Hyoscine which was increased to 1200 mcgs.

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With reference to the above entry I would have been present when Dr PETERS was called out to see the patient Mr WILSON.

The reason Dr PETERS was called out was because an increase in Hyoscine was required. This can only be authorised by a Doctor.

Ward rounds were conducted on Dryad Ward normally by Dr BARTON at 0730 Mon to Fri accompanied by the trained nurse in charge of the ward which was normally myself. The ward round would have to be finished by 0810 as Dr BARTON would then have to conduct a ward round on Daedalus ward.

Consultant ward rounds were conducted once a fortnight, on a Monday afternoon. The consultant was normally accompanied by Dr BARTON and a senior trained nurse.

The treatment of each patient was based on the observations of all the nursing staff. These observations would then be passed onto the consultant.

I have been shown the Dryad Ward Controlled drug register book for administration of Oral solutions exhibit ref JP/CDRB/24 .

I can confirm that I have written the following entries on page 53 of the medical records which are as follows.

15/10/98 -1015 Robert Wilson 10mgms 0.5mls this was administered by me and witnessed by Staff Nurse Freda SHAW .

To clarify this entry the actual strength of the solution of Oramorph is 20mgs in 1ml. Mr WILSON was only being prescribed 10mgs therefore he was only given 0-5ml.
15/10/98 - 1410 Robert Wilson 10mgs 0-5mls administered by me and witnessed by Staff Nurse Freda Shaw.

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I can confirm that I have written 2 entries on page 261 of the medical notes which is the Prescription chart.

Against the controlled drug Oramorph I have administered the drug at 1000 and 1400 hours on the 15/10/98 I have initialled both entries.

Oramorph was administered to Mr WILSON due to the pain from his fractured arm and also because he was an alcoholic- By this, I mean that, his Liver was not functioning as well as it should be. He was also suffering from Renal and liver failure.

I can confirm that I have written the following entry on page 85 in the Ward Controlled drugs register for Dryad ward exhibit ref JP/CDRB/23.

17/10/98 1550 Robert Wilson 30mgs administered by me and witnessed by Staff Nurse Freda Shaw.

This is also confirmed by the entry that I have written on page 262 of the medical notes which is the prescription chart.

17/10/98 1550 40mgs Diamorphine. I cannot confirm the additional 10mgs of Diamorphine as I have not been shown the drugs register relating to the remaining 10 mgs dosage of Diamorphine.

(Diamorphine is supplied in 10 mg and 30 mg ampoules and the record of there administration is recorded separately within the register under the appropriate dosage.)

The amount of Diamorphine administered on the 17/10/98 was initially 20mgs this was doubled to 40mgs.

As I have mentioned this was to control the patient's pain.

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The practice for administering Diamorphine to control pain was to double the dosage.

However other factors had to be taken into account, these would include the weight of the patient plus the diagnosis of the patient.

The dosage could only be given up to the maximum that the Doctor had prescribed.

I have been shown page 262 of the medical records exhibit ref BJC/55. I have been asked to comment in relation to the doses of Diamorphine and Hyoscine administered at 1610 on 16/10/98 to Robert WILSON.

I note that the syringe driver commenced and that 20mg of Diamorphine and 400 mcg of Hyocsine were administered, the entry was initialled by Senior Staff Nurse Shirley HALLMANN.

On the 17/10/98 0515 the syringe driver was renewed with 20mgs of 600mcgs of Hyoscine.

The previous dose of Diamorphine and Hyoscine of the 16/10/98 was destroyed by the night nurses Code A and Code A at 0515 on the 17/10/98.

The dosage administered at 0515 17/10/98 was then subsequently destroyed by myself and Staff Nurse Freda SHAW at 1550 on the 17/10/98.

I have made no record in the wastage section at the back of the Controlled Drug Register. I can not recollect the reason for not making a record showing that this dose was destroyed by me and witnessed by Staff Nurse SHAW.

At 1550 hours on the 17/10/98 I have recorded an increase of Diamorphine to 40 mgs, Hyoscine to 800 mcgs, I have also included 20 mgs of Midazolam to the syringe driver. This entry at 1550 hours has been initialled by me.

Signed: Code A
2004(1)

Signature Witnessed by:

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I have also at the same time written an entry showing that the 0515 hours dose of Diamorphine and Hyoscine has been destroyed by me which has been initialled by me.

I had no further dealings with this patient.