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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, GILLIAN

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: 30/09/2005

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 I was a Clinical Manager (Senior Sister) at Dryad Ward, my Nursing and Midwifery Number is 70G0632E. 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 15 bed unit for elderly mentally ill patients.

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 37½ 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.

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.

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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.

Further to my previous statement of 11th June 2005 I have been asked whether I remember having a conversation concerning the usage of Diamorphine with Shirley Code A who was my senior staff nurse on Dryad Ward at Gosport War Memorial Hospital.

I cannot recollect having a conversation with staff nurse Code A relating to concerns about the usage of Diamorphine on Dryad Ward whilst she was employed as a senior staff nurse.

However there were concerns when syringe drivers were introduced around 1988 or 1989 at the Redclyffe Annexe, The Avenue, Gosport.

I remember a number of staff in particular the night staff nurse Sylvia GIFFIN being very reluctant to use Diamorphine via a syringe driver.

Sister GREEN was in charge of the unit at the time arranged numerous meetings and study sessions with various palliative care team members from the palliative care ward at the Queen Alexandra Hospital, Portsmouth . All staff at the Redclyffe unit were required to attend. I

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remember Steve KING , a palliative care charge nurse, together with Dr Robert LOGAN from the Queen Alexandra attending a number of meetings with staff to allay their fears over the use Diamorphine via a syringe driver.

They explained the benefit of using a syringe driver and also gave practical demonstrations on how to use/administer Diamorphine via a syringe driver.

I am aware of at least 2 or 3 sessions where Steve KING and Dr LOGAN attended the Redclyffe Annexe. I also remember Dr BEE WEE a consultant specialist in palliative care attending at the Dryad Ward who gave a couple of talks relating to the use of syringe drivers, care of the dying and the drugs that could be used in palliative/terminal care.

Trained and untrained staff were present for these sessions.

I have been asked to comment about the increased dosage of Diamorphine I administered on the 17/10/98 to the patient Robert WILSON, Code A .

I would have assessed the patient's condition and deemed it necessary to increase the Diamorphine to 40mg and also add in Midazolam 20mg and increase the Hyoscine to 800mcg.

This increase was necessary due to the patient's increased pain and anxiety.

However there is no written record within the nursing notes recording that Mr WILSON's pain and anxiety.

The practice of increasing the dosage to alleviate pain and anxiety was not always recorded as it was evident that the patient needed the increase.

A record was always made in the ward drugs register showing the actual amounts of controlled drugs administered to each patient.

I would always inform the doctor (normally Dr BARTON) of the change in medication given and explain the reason to the doctor.

I would not necessarily inform Dr BARTON at the time, if the change in circumstances occurred to the patient at night.

I would inform Dr BARTON the following day.

I was happy to increase the dosage of Diamorphine on a sliding scale, ie, from a small starting dose initially administered to the patient a) to alleviate the pain, b) to monitor its effectiveness.

The drugs such as Diamorphine, Midazolam and Hyoscine normally used in a syringe driver were prescribed by Dr BARTON in a range according to the patient's needs as assessed by Dr BARTON.

In this case these drugs were prescribed on admission of this patient to Dryad Ward on the 14/10/98.

It was policy and the guidelines to double the dosage of Diamorphine as per the Wessex Guideline book (a small green book).

The important factor was the assessment of the patient, ie, if the patient was frail, then the dosage would only be increased a small amount to alleviate the problem.

With regards to this patient Robert WILSON was a large man who was an alcoholic; it therefore took longer for the drugs to have effect, which is the reason why he needed bigger doses.

Mr WILSON had been admitted to Dryad Ward for palliative care as he had multi organ failure as recorded on the spell summary.