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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: TUBBRITT, ANITA

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: SENIOR STAFF NURSE

This statement (consisting of 5 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: 09/12/2005

I am a Senior Staff Nurse at Gosport War Memorial Hospital , where I work nights on Sultan Ward. I trained at The Royal Hants County Hospital, Winchester from 1982 to 1986, my Nursing and Midwifery Council number is 82Y3321E and my RCN no is 828054. After my training I worked at Beechcroft Manor Nursing Home Gosport for 9 months until May 1987 when I started work at Gosport War Memorial Hospital, first employed at the Redclyffe Annexe at the Avenue, Gosport which was a geriatric ward for patients who couldn't cope on their own, they were not necessarily ill but needed nursing care. In 1998 I was employed as a Senior Staff Nurse on Dryad Ward at Gosport War Memorial Hospital I have been employed there since that time as Senior Staff Nurse on Night Duty only, now covering Sultan Ward as well as Dryad Ward.

In 1999 I was a Senior Staff Nurse on Dryad Ward at GWMH and I was working on night duty, my role responsibility was that I was in charge of the ward and indeed of the whole hospital on nights in the absence of the night sister. My line manager at that time was Gill HAMBLIN.

At the time of the investigation I had received no training/certification in the administration of I.V. drugs. I have since 2003 received such training.

I understand the Wessex Protocols to be drug prescribing and administration guidelines.

I understand the analgesic ladder to be the administration of drugs beginning with low strength analgesia working up to strong opiates, depending on a particular patients need. The Doctor would decide regarding the drugs administered and also the patient would have input if they

were able to, regarding if still in pain. How the drugs are prescribed by the Dr would indicate if a nurse can make any decision as to increasing the dosage.

I had training before 1999 in the setting up of syringe drivers in a group session at GWMH and also at Queen Alexandra Hospital. The syringe drivers used were Graysby and were administered sub cutaneously (under the skin). Training was generally available then although widely so although as more were used more training became available. Nurses could also apply to attend training.

The Named Nurse was the nurse allocated to a particular patient. That nurse would be in charge of care and would also manage care, providing the link between the patient and the family if there were any questions to be answered.

The time and date of entries in the nursing notes would depend on the patient and how busy the shift was. But generally these would be completed when we had time or at the end of a round on nights when we were getting the patients ready to go to sleep.

Since qualification I have worked night duty. I worked 25 hours week from 2015 to 0745. Two nights on week, 1 then three nights on week 2.

There were no ward rounds on night duty.

Dr BARTON would usually be in the hospital by 0730 and would sometimes ask regarding specific patients.

I have heard the term All Nursing Care, but not the abbreviation ANC. This means that we were providing all the care that patient required, in that they were unable to do anything for themselves. Their Bartel score would be low. We would provide care in relation to washing, dressing, feeding, repositioning, bathing and toileting.

The term TLC means Tender Loving Care and would indicate to me that the patient was poorly

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and not expected to live very long.

The term, "I am happy for staff to verify death", I have heard of, and indicates that a patient is terminally ill and is expected to die fairly soon and the doctor is happy for nurses to verify death.

I have been asked to detail my involvement in the care and treatment of a patient named Enid SPURGIN. I do not recall that patient, but from referral to entries in her medical notes, BJC/45 I can state that on page 125 I have initialled that I have administered Oramorph on or around 2200 on 26/3/99. On the same page I have initialled that I have administered Oramorph on or around 0600 on 27/3/99.

On page 47 of the Dryad Ward Controlled Drug Record Book (Oramorph Oral Solutions only) JP/CDRB/24 I have written;

At 2315 on 26/3/99, that I have administered 10mg/5ml of Oramorph to Enid SPURGIN, which was witnessed by Staff Nurse Beverley TURNBULL.

At 0655 on 27/3/99, that I have administered 5mgs/2.5mls of Oramorph to Enid SPURGIN, which was again witnessed by Staff Nurse Beverley TURNBULL.
At 0700 on 28/3/99 that I have witnessed Staff nurse Code A administer 10mg/5ml of Oramorph to Enid SPURGIN.

At 0715 on 11/4/99, that I have administered 5mg/2.5mls of Oramorph to Enid SPURGIN, which was witnessed by Staff Nurse Code A.

I have had no further dealings with this patient.

The reason that I administered Oramorph to this patient was that it was prescribed by and written up by Dr BARTON on 26/3/99. The dose being 10mg / 5ml once a day, (a 2.5mg dose, 4 hourly). On admission it is written up on page 106 that the patient has complained of a lot of

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pain, for which she was receiving Oramorph regularly, with effect. I felt that the further administration of this drug was therefore appropriate in those circumstances.