RESTRICTED

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 ELIZABETH

Age if under 18: Over 18 (if over 18 insert 'over 18') Occupation: NURSING HOME NIGHT SISTER

This statement (consisting of 8 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: 16/03/2005

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 GWMH I 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 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 371/2 hours a week on a shift rota, earlies being 07:30 to 1615 and lates 12 midday to 20:30.

Signed: Code A Signature Witnessed by: Code A

2004(1)

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 07:30 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.

I have been asked about the "Wessex Protocols". I am unfamiliar with this name but am aware of certain protocols I relation to the setting up and use of syringe drivers and 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 care and treatment of Arthur Brian CUNNINGHAM . From memory and referral to his medical notes (Exhibit BJC/15) I remember this patient. I think he came from the Thylassa Rest Home and had huge bed sore on his back, through to his spine. He was seeing Dr LORD at the Dolphin Day Hospital and she rang me and asked me to take him on the spot because of the bed sores. I actually collected him from the DDH myself and Dr BARTON helped me push his bed to Dryad Ward.

I remember Mr CUNNINGHAM to be an extremely uncooperative patient, as he was at Thalassa Nursing Home at Alverstoke and as I recall at the other nursing homes he had been resident at locally.

I recall that the whole of his sacral area had a deep recess and this was due to the fact that he was non compliant in all aspects with regard to his sitting/laying, and that he would pull off his dressings and throw them across the floor.

On page 756 of the medical notes is a prescription chart for the patient. The entries of the

24/9/98 (24/09/1998) show that the patient was administered variable doses via syringe driver of Diamorphine, 20 to 200 Mgms, Hyoscine, 200 to 800Mcgms and Midazolam, 20 to 80 Mgms. He was given 40 Mgms of Diamorphine at 1055 hrs by and initialled by me and 60Mgms at what appears to be 10.1 which is a wrong time and is not initialled. He was administered 20Mgms on 21/9/98 (21/09/1998), 20Mgms on 22/9/98 (22/09/1998), 20mgms on 23/9/98 and was clearly not holding him . The administration of 60Mgms on 24/9/98 (24/09/1998) was possibly done by night duty . I am certain that the two doses were not given at the same time. The dose administered could be anything from 20 to 200 Mgms, so the doses administered were well within acceptable limits, and could only be increased in consultation with the Doctor .

The patient was given 800 Mcgms of Hyoscine at 1055 hrs that day by and initialled by me, and also 80Mgms of Midazolam at 1055 hrs that day by and initialled by me. It would appear that he was given no further doses of neither Hyoscine nor Midazolam.

The Diamorphine is a pain killer.

The Hyoscine is used in chest infections to clear secretions

The Midazolam would be used to calm the patient

The drugs were written up by Dr BARTON in consultation with Dr LORD . At 1300 on 23/9/98 (23/09/1998) I have written, "Mr and Mrs Farthing seen by me - SN Gillian Hamblin & SN Freda Shaw . Very angry that driver has been commenced. It was explained yet again that the contents of his syringe driver were to control his pain. It was also explained that the consultant would need to give her permission to discontinue the driver & we would need an alternative method of giving pain relief. Has also been seen by Pastor Mary for 11/2 hours this afternoon. He is now fully aware that Brian is dying and needs to be made comfortable. Driver renewed at 20:00 I/c Diamorphine 20 Mgms, Midazolam 60 Mgms, Hyoscine 400 Mcgms. Family have visited."

Page 868 of the medical notes is a Summary regarding Arthur CUNNINGHAM.

At 1300 on 23/9/98 (23/09/1998) I have written, "Mr and Mrs Farthing seen by me - SN Gillian Hamblin & SN Freda Shaw. Very angry that driver has been commenced. It was explained yet again that the contents of his syringe driver were to control his pain. It was also explained that the consultant would need to give her permission to discontinue the driver & we would need an alternative method of giving pain relief. Has also been seen by Pastor Mary for 11/2 hours this afternoon. He is now fully aware that Brian is dying and needs to be made comfortable. Driver renewed at 20:00 I/c Diamorphine 20 Mgms, Midazolam 60 Mgms, Hyoscine 400 Mcgms. Family have visited."

I have signed this entry.

I/c means with

Pastor Mary is Mary SANDELL

Any text entry in nursing notes with the word Diamorphine is written in red, it is always in red.

I believe that the main feature that the step son had in relation to this, was that he couldn't talk to his Father;

I believe that the syringe driver use WAS not an issue .

Mr FARTHING was offhand with the nursing staff on some occasions and I do remember his wife apologising to us for his behaviour.

The previous entry to that which I have mentioned, also on 23/9/98 (23/09/1998). "SB Dr Barton. Has become chesty overnight to have Hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to the syringe driver and informed that Mr Cunningham was on a small dosage which he needed. To phone him if any further

deterioration."

This entry was signed by Code A

Page 869 of the medical notes BJC 15 dated 24/9/98 (24/09/1998) is an entry written by me, "Report from night staff that Brian was in pain when being attended to, also in pain I/c day staff especially his knees. Syringe driver renewed at 1055 I/c Diamorphine 40 Mgms Midazolam 80 Mgms & Hyoscine 800 Mcgms. Dressing renewed this afternoon, see care plan. Son Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition. In the event of death Brian is for cremation"

I have signed this entry.

This entry corresponds with the entry on the prescription chart on page 756 of the notes.

On page 867 of the medical notes dated 21/9/98 (21/09/1998) the initial entry states,"Admitted from DDH with history of Parkinson's, Dementia and Diabetes. Diet controlled diabetic. Catheterised on previous admission for retention of urine. Large necrotic sore on sacrum. S/B Dr Barton"

Code A has signed this entry

"Dropped left foot. Back pain from old spinal injury"
Code A has initialled this entry.
"1450 Oramorph 5Mg given prior to the wound dressing"
Code A has initialled this entry.
Dr LORD wrote up this prescription

Code A and I administered the doses of Oramorph given to the patient at both 1450 and 2015 hrs on 21/9/98 (21/09/1998). We have initialled the entries .

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Continuation of Statement of: HAMBLIN, GILLIAN ELIZABETH

Form MG11(T)(CONT)

The patient was not eating nor drinking.

DDH is Dolphin Day Hospital

S/B means Seen by.

STATEMENT TAKEN - Code A

Signed: Code A
2004(1)

Signature Witnessed by: Code A