INTERROGATION (Gillian Hamblin)

Statement 16 MARCH 2005

1998, Clinical Manager (Senior Sister) of Dryad Ward

Para 7: Responsible for 24 hour care of the patients and for all staff on the ward **and their training**

Para 8: In 1999 syringe-drivers were introduced to Redcliffe Annexe

Para 12: You mention that Sister GREEN introduced syringe-drivers into 'the annexe'. **Do you mean Redcliffe Annex (1999)??**

Para 13: You mention that there were no courses available in the use of syringe-drivers, yet their use was permitted - **COMMENT???**

When were syringe-drivers introduced into Dryad Ward? By whom??

Para 8: You mention that in 1998 Dr Barton became responsible for Dryad Ward. **Did she bring the syringe-driver technology with her?**

Para 12: You mention that Dr Barton would visit daily (early), prescribe drugs to each patient and return later to see visiting relatives. **Was any reference made to the Care-Plans prepared by a patient's specialist?**

Para 13: **Who decided when the time has come to use a syringe-driver???**

Para 15: You say you were unsure about what was contained in the Wessex Protocol and that there was no training in the use of syringe-drivers, yet you were instrumental in their use – **TRUE???**

Pare 15: How would **you** have expected to gain adequate information for their use?

Was it usual for patients admitted to Dryad Ward to be afforded similar treatment???

Where you aware of the dangers associated with excessive diamorphone???

In all your experience in nursing, were you never suspicious that patients were being over-prescribed and over-administered with dangerous opiate drugs???

Can you say why this patient was admitted for aggressive treatment of a bed-sore, to find himself being given termination care within 12 hours????

Whose judgement was this??

Did you not consider this to be excessive, but did nothing about it???

Para 19/20: You describe ADBC as an extremely uncooperative patient with a very bad sacral sore, he was non-compliant and would pull-off and throw his dressings across the floor. **Do you know why he might have done this??**

Was this the reason why he was put on a syringe-driver on the same day that he was admitted?

Who did this and upon whose instructions???

Your police statements reveal the pattern of drugs administered, thus:

Mon (21 Sep)	1450	Oramorph 5mgs/2.5mls	Hamblin, Hallman
	2015	Oramorph 10mgs/5mls	Hallman, Collins
	2310	Diamorphine 20mgs, Midazolam 20mgs	Walker, Lloyd
Tues (22 Sep)	2000	Diamorphine 20mgs, Midazolam 20mgs	Shaw, Barker
Wed (23 Sep)	0925	Diamorphine 20mgs, Midazolam 60mgs, Hyosine 400mcgs	Shaw, Hallman
	2000	Diamorphine 20mgs, Midazolam 60mgs, Hyosine 400mcgs	Hamblin, Ring
Thur (24 Sep)	1055	Diamorphine 40mgs, Midazolam 80mgs, Hyosine 800mcgs	Hamblin, Ring
	? 10.1	Diamorphine 60mgs, Midazolam 80mgs, Hyosine 800mcgs	Hamblin, Ring
Fri (25 Sep)	1055	Diamorphine 60mgs, Midazolam 80mgs, Hyosine 1200mcgs	Shaw, Ring
Sat (26 Sep)	1050	Diamorphine 60mgs, Midazolam 100mgs, Hyosine 1200mcgs. **RIP Saturday Evening**	Ring, Rigg
Sun (27 Sep)	1150	Further drugs were drawn	Ring, Rigg

Questions:

1. Why wasn't the same 5mgs of Oramorph given at 1450 not given 4 hours later?
2. Why was a doubled-dosage given at 2015 (not authorised by the Care Plan)?????
3. What effect would this have on behaviour??????
4. Who decided that a syringe-driver should be used at 2310?????? -probably already comatose???
5. On 23 Sep, the daily dosage of diamorphine was given twice, WHY???
6. The supposed prescription chart error strongly **suggests** a second dosage of 60mgs was administered on 24 Sep (2nd Statement – Para 16). **Comment**!!!
7. 20mgs diamorphine drawn on the day **after death**, why and where used?? (2nd Statement – Para 15)

Para 22: You mention administering 800mcgms of Hyoscine and 80mgms of Midazolam ON THAT DAY at 1055. Which day?? (the only day the figures and time correspond is 24 Sep), and mention of no further doses after that **does not tally** with his Personal File for 25th and 26th????

Para 26: You mention that on 23 Sep, **CRSF was very angry that the driver had been commenced**, is this true??? (I WOULD PARTICULARLY LIKE THE JURY TO NOTE THIS REPLY)*****

Para 26: You say consultant's permission would be needed to discontinue the driver. Is this correct?? It follows does it not that his consultant knew of its use??????? How does this reconcile with the Care Plan of two days before????

Para 26: You mention driver RENEWED at 2000. As it was never suspended, do you mean re-charged??? And why was this necessary when the previous day one charge was sufficient??????

Para 30: You state that you believed the use of a syringe-driver was **not an issue**. How does that tally with ***** above. It was of course the **ONLY ISSUE**, as it rendered ADBC unconscious and CRSF was being actively obstructed from speaking to him.

Para 31: In what way was CRSF off-hand with the nursing staff????? In fact, he was absolutely furious when, from your position of authority and trust, you were

making it impossible for him to speak to his step-father and not in the slightest way prepared to make this possible. CRSF remembers you supposedly going off to speak to Barton about getting permission to stop the driver and you later telling him it had been refused, also that she herself would **not** now be visiting the hospital that day – that he would have to wait a further 24 hours to see her. His wife was apologetic for his venting his anger on you, which remains undiminished to this day.

Para 34: How could it be possible for ADBC to be admitted for **dementure**???? This was NEVER an issue at any stage, and FOR THE FIRST TIME only vaguely mentioned in Dr Lord's admission notes where she mentions an ELEMENT of dementia' (pages 642 and 643 of her medical notes)

Para 36: Mentions 'Patient not eating or drinking'.

1. Why do you think I was sent off to the local shops in the morning for a supply of chocolate if he wasn't capable of eating it????
2. Could this statement refer to the situation after the 2015 double-dosage of Oramorph?????
3. How is a patient not drinking kept hydrated?????

Statement 10 JUNE 2005

Para 1: Dr Lord clearly prescribed .5 mgs of Oramorph every 4 hours (Care Plan at Page 875 known to Freda Shaw, his NAMED NURSE), and 5 mgs was administered by you at 1450 on 21 Sep. Why no dosage 4 hours later? Why stepped up to 10 mgs at 2015??

What effect would the double dose have had???

Para 2: Did Barton authorise the change of medication on 21 Sep (ie. what is written up)?????

Para.3: Both statements are **bare-faced lies**

Para 6: **When** did Dr Lord prescribe Diamorphine.

Para 7: Utter rubbish. He was on 20mg for **2½ days only** (60 hours). Also, Midazolam and Hyoscine had been added. Who deleted **REGULAR PRESCRIPTION** (and inserted PRN*) **and WHEN???**

When was it apparent to you that he was incapable of swallowing?

How is a patient hydrated in such circumstances?

Why wasn't ADBC given a saline drip at any stage? **(PTO)**

Were you aware that ADBC had told Dr Lord that HE WISHED TO DIE? (If yes, ask WHY the family were not informed)

Have you ever heard of Dryad Ward called THE DEATH WARD??

How many patients who went into this ward ever CAME OUT??? (1998)

SUMMING-UP

As the sister in charge of Dryad Ward, ***Hamblin*** *was in a position of supreme trust and responsibility and at the very least failed in her duty to acknowledge that ADBC was being over-prescribed and over-treated with opiate drugs, indeed, she was personally involved in their application, despite a clear Care Plan prescribing Oramorph produced* ***on the same day*** *that Diamorphine was first used. It is incomprehensible how someone in her position could ever sanction the use of syringe-drivers knowing, as she did, there was a clear Care Plan available prescribing Oramorph* ***if required****. This is compounded by the lack of training available in the use of syringe-drivers and (she says) without even knowing the content of the Wessex protocol. That itself is a highly suspicious statement when one of her own nurses was familiar with its content. She is also curiously vague about who decided to apply a syringe-driver and, and the reasons for this, and made false assertions in her police statements that CRSF had been informed by telephone that a syringe-driver had commenced. That* ***most definitely was not the case****, and accounts for his angry outburst and demands upon his arrival at the hospital on 23 Sep, realising its significance having seen his mother end her days in a similar manner in Gosport in 1989.* ***Hamblin*** *has also demonstrated her untrustworthiness as a witness by stating more than once that CRSF had no objection to the use of a syringe-driver when, in fact, its use was the very reason why his suspicions were raised and the cause of his behaviour (it is a fact that she* ***directly contradicts her own remarks*** *in Para 26 of her police evidence). Indeed,* ***Hamblin*** *has shown herself to be a thoroughly unreliable witness who has not only been economical with the truth but has been prepared to lie to the police, presumably in an attempt to throw any suspicion away from herself. In the opinion of CRSF,* ***Hamblin*** *is a primary accessory to the deliberate execution of his step-father and is probably just as responsible as* ***Barton*** *for his premature demise.*

*PRN means AS REQUIRED