RESTRICTED

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: FLORIO, JEANETTE ELIZABETH

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: 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: Jeanette FLORIO Date: 08/02/2006

I am a Registered General Nurse. I am currently a D Grade Staff Nurse.

My Nursing Midwifery Identification Number is 89Y0501E.

I am currently employed by the Portsmouth Hospitals NHS Trust. I am working at St Mary's Hospital, Portsmouth on the gynaecology unit as a Staff Nurse.

I qualified as a Registered General Nurse in August 1992. I trained at the School of Nursing Queen Alexandra Hospital, Portsmouth.

From 1992 until November 1996 I worked on the new born unit at St Mary's Hospital, Portsmouth as a D Grade Staff Nurse.

From November 1996 until December 1999 I was employed as a D Grade Staff Nurse working night shift on Daedalus Ward at the Gosport War Memorial Hospital. On occasions I was required to work on other wards including Dryad.

My responsibilities as a D Grade Staff Nurse included overall charge of the ward which consisted of 24 beds. The ward was a mixture of continuing care for elderly patients and slow stream stroke rehabilitation for elderly patients.

I supervised two health care support workers. My responsibilities included administering drugs prescribed to patients.

I also looked after the patient's general well being during my shift.

It was part of my duties to document the care given to each patient.

Night shift commenced at 2015 and finished at approximately 0745.

During the night I was occasionally asked to check the administration of a controlled drug on another ward. This is a standard requirement as laid down by the Nursing Midwifery Council and formerly known as the United Kingdom Council (UKCC).

My experience in the use application of Syringe Drivers began whilst working on the newborn unit, neonatal at St Mary's Hospital.

At that stage between 1992 and 1996 I received training from senior colleagues in the use of Syringe Drivers. The Syringe Drivers were used for delivering intravenous drugs to newborn babies.

I received training for competence in the administration of intravenous drugs and additives on the 28/1/1993 (28/01/1993).

When I commenced working at Daedalus ward in November 1996 I was given supervision from senior colleagues in the administration of drugs delivered subcutaneously via a Syringe Driver to patients requiring palliative or terminal care.

I can recollect using Graseby model Syringe Drivers on Daedalus ward and later when I worked on Dryad ward.

From December 1998 until May 2001 I worked as an E Grade Staff Nurse on Dryad ward which was on day shifts. I can confirm that I was on duty as a D Grade Staff Nurse for night duty in 1999 on Dryad Ward.

I worked part time 30 hours per week at that time and my tour of duty would have been between 0730 and 1300 and between 1415 and 2030

My understanding of the named nurse is that they would be the person who has the overall care of the patient when on duty and would be the person to whom the patient's family could confer.

The time and date of entries in the medical notes would usually be done when time allowed.

My responsibilities on the ward could that be that I was in charge of the ward and the bleep holder for the hospital. That I would supervise Health Care Support Workers and Students. But my overall responsibility was the care of the patients.

I had not received training or certification in the administration of I/V drugs.

I have heard of the term the "Wessex Protocols", the Analgesic Ladder.
The term TLC, tender loving care, would indicate that a patient was coming to the end of their days. We would make them as comfortable and pain free as possible.

The term "I am happy for staff to verify death" is a term I am familiar with at GWMH. This would mean that two members of staff would be available to verify death of a patient, when there was no Dr's on site.

Ward rounds were done most days at about 0800 hrs and Dr BARTON would see any patient to whom it was indicated there was a problem.

I have been asked to detail my involvement in the care and treatment of the patient Geoffrey PACKMAN . I do recall this patient due to his size and terrible bed sores on his buttocks. I believe that he had been stuck on the toilet. From reference to his medical notes (Exhibit Reference BJC/34) I can state that on page 64 of those notes, dated 2/9/99, I have written, Diamorphine increased to 90 mgs/24hrs. Midazolam 80mgs" I have signed that entry.

RESTRICTED

I can cross refer this to an entry on page 15 dated 2/9/99 of the Dryad Ward Controlled Drugs Record Book (Exhibit Reference JP/CDRB/48) where I have witnessed Shirley HALLMANN administer 90 mgs of Diamorphine Geoffrey PACKMAN.

I can cross refer this to page 171 of the notes dated 2/9/99 at 1840 hrs which indicates that 90 mgs of Diamorphine and 80 mgs of Midazolam were administered to Geoffrey PACKMAN by Shirley HALLMANN and initialled by her.

These entries were written up by Dr BARTON.
In relation to the Diamophine, this indicates that the dose was variable between 40 - 200 mgs in 5 mls, over 24hrs. The dose appears to have increased from 40 mgs to 60mgs to 90 mgs, which is quite a step up.

In relation to the Midazolam, the entry indicates that the dose was variable between 20 and 80 mgs in 5mls over 24 hrs. This dose appears to have increased from 20mgs to 40 mgs to 60 mgs to 80 mgs over the same period of time as the increase in Diamorphine.

The entry between 26/8/99 and 2/9/99 on page 171 of 40 mgs of both Diamorphine and Midazolam administered at 1545 on what appears to be the Ist, is marked "Dose Discarded" and initialled by Gill HAMBLIN.

This medication was administered not by me but by Shirley HALLMANN. The decision to increase the medication would have been taken by a Dr, either by way of a verbal message or a phone call.

I can't imagine that an increase in medication especially the Diamorphine increase from 60 - 90 mgs without authority of a Dr, and would depend on the patient's condition.

All nurses do is administer drugs which are prescribed by a Doctor.

RESTRICTED

I do not however see on the notes where this decision was recorded.

Signed: Jeanette FLORIO

Signature Witnessed by: D WILLIAMSON