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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 ELIZABETH

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: CLINICAL MANAGER

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: G HAMBLIN Date: 10/09/2004

Further to my statement dated 2/2/2003 (02/02/2003) I have been asked to detail my involvement in the case and treatment of Code A.

I have been shown a photocopy of the microfich BJC/71.

From this I can say that I made an entry on 10th January 1996 (10/01/1996) in Code A's summary of significant events the entry reads.

10.1.96 (10/01/1996) condition remains poor. Seen by Dr TANDY & Dr BARTON . To commence on Oramorph 4 hourly this evening. Code A seen & is aware of poor condition. To stay on long stay bed.

I have then signed the entry.

This entry is on page 25 of the record.

On the 17th January 1996 (17/01/1996) at 2030 hrs I have made another entry that appears on page 27. This entry reads.

2030 further deterioration in already poor condition. Appears more settled. Although still aware of when he is being attended to. Syringe drivers running satisfactorily. Has been visited by ward chaplin this evening who will inform his wife.

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I have then signed this entry.

In January 1996 I was employed by the National Health Service working as a Clinical Manager on Dryad Ward at the Gosport War Memorial Hospital I worked 37½ hour a week, this would have been on a shift rota, earlies being 0730 hrs to 1615 hrs and lates 12 midday to 8.30pm (2030). I invariable worked on finishing off or handing over. I was responsible for 24 hrs care of the patients on Dryad Ward. If there was a problem when I wasn't on duty I could be contacted at home the night sisters were able to cope with patient care but I was contacted a couple of times with regard to staffing issues. I was on a duty rota list for the management of the hospital and would take on management roles when there were no managers at the hospitals, ie, evenings and weekends. I was responsible for all the staff on my ward hiring them, training, discipline matters, staff rotas and leave. Ordering, stocking and administration of drugs and that the trained staff on the ward had there drug competencies to allow them to administer drugs. This particularly applied to enrolled nurses, oversea students and return to nursing and student nurses. I was responsible for the running of the ward and general patient care. Dr BARTON was responsible for the medical care on a day to day basis, medical care means when the patient had a medical condition, pain, infection or other complaint. She was also responsible for any admissions. The consultants had the overall responsibilities for the patients.

Barbara ROBINSON was my line manager at that time, she was a service manager and had an office away from the ward.

The note dated 10.1.96 (10/01/1996) with regard to Code A means condition remains poor, this was a way of writing that the patient was very likely going to die. It would have not been appropriate for nursing staff to write 'patient is going to die'. Relatives have rights of access to a patients notes and to see that sort of comment written down would have been extremely insensitive. Code A had been seen by both Dr TANDY and Dr BARTON. Dr BARTON would have seen Code A in the morning and then returned in the afternoon to do a ward round with Dr TANDY. Dr TANDY is a consultant geriatrician. To commence on Oramorph every 4 hours. Oramorph is an opiate, it is a liquid form of diamorphine and is given to ease pain.

Oramorph was given instead of diamorphine while the patient could still swallow. Once the patient was unable to swallow or there was a risk of the patient choking on the liquid they were given the pain killer via a syringe driver. Code A seen and is aware of poor condition. It was not me who saw Code A, I believe that it was the consultant who told her of the likelihood that Code A was going to die. To stay on long stay bed, means that Mr Code A would stay with us until he died.

By referring to the ward controlled drugs record book (identification reference JP/CDRB/20) I can say that the Oramorphy oral solution 10mgs in 5mls was first administered on 10.1.96 (10/01/1996) at 10.20pm (2220) by a member of the night staff. The practice is that to administer controlled drugs two trained nurses, level one nurses would administer the drugs together. This is to ensure that they are administer correctly. In exceptional circumstances the second nurse could be a health care support worker, ie untrained, albeit they would have had the procedure explained to them and they would be experienced.

I have witnessed the giving of the Oramorph on the 11.1.96 (11/01/1996) at 1015 am, when 5mgms in 2.5mls was given, this is half the amount given at night. There are a number of reasons why the dose varied ie, he was in pain or the night the doses were higher to see him through the night. I also witnessed the administration on the 14.1.96 (14/01/1996) at 1000 and I actually administered it on the 11.1.96 (11/01/1996) at 1415 hrs.

The entry on the 17.1.96 (17/01/1996) at 2030 hrs, Code A at this time was fading fast (deteriorating). Appears more settled, this could have been his breathing, pain, chest was more settled. Code A was aware, ie, he knew what was happening to him. Syringe driver running satisfactory. Every time you turn a patient you check the syringe driver on this occasion I found that it was running correctly. Has been visited by the ward chaplain this evening. Patients when nearing the end of their lives were visited by the ward chaplain. She also spent a lot of time with the patients relatives. The ward chaplain was going to tell his wife of the deterioration of his health.

From page 19 of the microfiche BJC/71 I can say that the Oramorph was not given after 6am (0600) on 15.1.96 (15/01/1996). From page 18 I can say that I commenced a syringe driver consisting of 80mgms of diamorphine. This is also shown in the controlled drug record book (identification reference JP/CDRB/21 pages 7 (20mgms) and page 11 (60mgms). I have signed both entries showing that I administered the drug at 0825 hrs that day.

At some stage Code A dose of diamorphine was increased to 120mgms and I witnessed the administration of the drugs on the 17.1.96 (17/01/1996) (page 16 and page 7) and administered the drug on the 18.1.96 (18/01/1996) and 1500 hrs (again page 16 & 7).

I have no personal recollection of Code A Oramorph is given every four hours to relieve pain. It is taken orally and its effects gradually wear off.

The entries that I have referred to in the ward controlled drugs record book (JP/CDRB/20) with regard to the Oramorph are found on pages 76 and 77.

Taken by: Redacted