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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: DOUGLAS, TINA MARIE

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

This statement (consisting of 7 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: T DOUGLAS Date: 12/08/2004

I am the above named person. I live at an address known to the Hampshire Police.

My Nursing Midwifery Council Pin Number is **Code A**

Further to my statement dated the 9th October 2003 (09/10/2003) I can confirm that I qualified as an RGN in 1988.

In 1993 I worked as a bank nurse on all the wards at the Gosport War Memorial Hospital (GWMH). These included the Redcliffe Annex, Daedalus Ward and Sultan Ward. I worked on these wards where ever I was needed for 6 months.

For the next 3 months I worked at the Redcliffe Annex on a 3 month temporary contract.

I then worked at the QA Hospital on permanent nights on the elderly ward in South block.

I returned to Dryad Ward GWMH in 1995 as an F Grade RGN. I worked on the Dryad Ward until November or December of 1996 when I took a years maternity leave.

Upon my return from maternity leave I worked on the Sultan Ward until September 2003. At the time of leaving I was an E Grade Staff Nurse.

I have been using syringe drivers on a regular basis when I started working on the Dryad Ward in 1995.

I was given on the job training by another trained nurse with regards to how a syringe driver worked, how it was to be loaded with the various prescribed drugs and which drugs were commonly used in the drivers.

It was policy at that time that required two trained nurses to set up a syringe driver.

A syringe driver is administered subcutaneously and normally delivers a constant dosage over a 24 hour period.

The controlled drugs were kept locked within a secure cupboard within another secure cupboard located in the treatment room on the ward.

A register was kept recording the administration, dosage of each type of controlled drug used for each patient.

I received/attended an ENB (ie, English National Board) course at the Hospice School of Nursing at St Mary's in Newport, Isle of Wight. This course commenced in January 1996 and finished in July 1996. I attended this course covering palliative care for approximately 1 week every month during the course.

The ward sister for Dryad at that time was Gill HAMBLIN .

My responsibilities as an F Grade Staff Nurse on Dryad Ward involved general nursing care, ward management, ie of staff, running of the ward, recording patients notes, drug administration. Dealing with the patient's relatives.

Dryad Ward consisted of approximately 17 beds caring for patients aged 65 and over who required continuing care.

I have been shown a printed copy of a microfiche ref BJC71, page no.6.

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I can confirm that I have made a written entry on page 6 as follows on the medication drug chart.

Nozinan 100mgs s/c in 24 hours (dose) 100mg, (date) 20/1/96 (20/01/1996) (where it states signature - I have written the following) 'verbal order - Dr BRIGG 1720 hrs, T DOUGLAS (countersigned) P S RIGG .

In the columns next to the above entry it is dated 20/1/96 (20/01/1996), 1800, 100mg TD - This entry has been signed by Dr BRIGG.

The above entry relates to prescribed drugs to the patient Code A .

In relation to the above entry where I have written S/C this refers to subcutaneous doseage of this drug to be given in 24 hours.

Where I have written 'verbal order'- from my memory I would have phoned the on call doctor as a result of a change in the patient's, Code A , condition.

The doctor called was Dr BRIGG. He authorised verbally over the phone an increase in the dosage of Nozinan to 100mg. This would then have been reiterated to staff nurse Pam RIGG verbally by Dr BRIGG.

I can confirm that the entry on page 8 of the printed record of BJC71 is an entry written by me as follows - 20/1/96 (20/01/1996), 1530, Haloperidol - omitted Dr BRIGG's request, (signed by) T DOUGLAS, PS RIGG.

On the request of Dr BRIGG (after informing him of Code A change in medical condition) the drug Haloperidol was stopped.

I cannot recollect exactly what change or deterioration of the patient Code A had occurred.

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I would add that with reference to the time recorded as 1530 on page 8. This is an error written by me. I believe, as far as I can recollect, that this entry should have been 1730 NOT 1530.

There is no record written on the patients summary explaining the reason for calling Dr BRIGG that I have recorded. However Dr BRIGG's has made an entry on the medical notes.

I have been shown the controlled drug register for the Dryad Ward, GWMH, issued 6/3/95 (06/03/1995) -

On page 7 there is a written record by Nurse Pamela RIGG which has been signed by me and countersigned by Pamela. The entry is as follows.

20/1/96 (20/01/1996) - 1530 Code A 20mg - discarded.

On page 16 of the drug register there is a written record by Staff Nurse Pamela RIGG which has been signed by me and countersigned by Pamela RIGG. The entry is as follows.

20/1/96 (20/01/1996) - 1530, Code A 100mg - discarded.

I cannot recollect whey these two doseages of Diamorphine were discarded at this time.

On page 7 there is an entry in the drug register there is a further written record by Staff Nurse P RIGG which has been signed by me and countersigned by Staff Nurse RIGG - The entry is as follows -

20/1/96 (20/01/1996), 1800, Code A , 20mg.

On page 16 of the drug register there is again a further entry by Staff Nurse RIGG and signed by me countersigned by S/N RIGG. The entry is as follows.

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20/1/96 (20/01/1996) 1800 Code A 100mg.

With regards to the above entry it is at this time that I believe the syringe driver for the patient Code A was recharged as per the entry by S/Nurse RIGG on page 28, dated 20/1/96 (20/01/1996).

I can see from the records having checked the entries on page 7 of BJC71 that I have completed making up a syringe driver for Code A at 1530 on 20/1/96 (20/01/1996). For some reason that I cannot specifically recollect this doseage was discarded.

Dr BRIGG's was spoken to reference Code A at 1720 hrs and the syringe driver was administered with the reviewed medication at 1800 hrs.

I can confirm that I wrote the following entry on page 26 of BJC71 which is as follows.

15/1/96 (15/01/1996), 1900 hrs, daughter informed of father's deterioration during the afternoon. Now unresponsive, unable to take fluids and diet, pulse strong and regular - T DOUGLAS.

I can confirm that I wrote the following entry on page 27 BJC71 which is as follows -

17/1/95 (17/01/1995) (which should be 1996) 0900 - S/B Dr BARTON , medication increased 0825 as patient remains tense and agitated, chest very 'bubbly' suction required frequently this morning. Patient bed bathed, mouth care tolerated, well skin marking easily despite hourly turning and use of Pegasus mattress and remains distressed on turning. 1430 S/B Dr BARTON, medication reviewed and altered, syringe driver reviewed at 1535 (two drivers), one set 47mm/24 hr - (2) 50mm/24hr.

Daughter informed of deterioration.

With reference to this entry where I have recorded the time 0900 (S/B) seen by Dr BARTON

this would have been after Dr BARTON had completed her ward round, which was normally between 0815 and 0845.

I have recorded that I administered the doseage at 0825 on the 17/1/96 (17/01/1996) in the medication drug chart on pages 18 and 20.

However on checking the drug register for the administration of Diamorphine which has been written by Staff Nurse RING then signed by me and countersigned by Sharon RING. I can see that she has written the 16/1/96 (16/01/1996), this should have been 17/1/96 (17/01/1996) at 0830. This entry is recorded on pages 7 of BJC71 and page 16 giving a total of 120mg of Diamorphine given to the patient. The date is wrong on both pages.

The following drug doseages were increased as follows - Diamorphine was increased from 80mg to 120mg. Hyoscine was increased from 400mcg to 600mcg. Haliperidol was increased from 5mg to 10mg. The Midazalam remained the same doseage. This is recorded on pages 18 and 20 of BJC71.

The doseage was increased as a result of my observations of the patient's medical condition. I would have informed Dr BARTON whilst she was conducting her rounds.

The doseage was increased for the patient Code A as a result of Dr BARTON's examination.

I have been asked to explain why I set two (2) syringe drivers.

Firstly a syringe driver would at that time only hold 10mils of fluid.

On reviewing the patient Code A s drugs chart for 17/1/96 (17/01/1996) the quantity of fluid in which the prescribed drugs were diluted/mixed exceeded the capacity of the syringe driver. Therefore as far as I can recollect I would have used two syringe drivers. Another reason would because of the concentration of the mixture of drugs within the driver.

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I am not able to state which drugs were in each driver.

Taken by: I Redacted