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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:

This statement (consisting of 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: GE Hamblin Date: 17/02/2006

I am Gillian Elizabeth HAMBLIN and am currently employed as a Night Sister in a local nursing home.

My nursing and midwifery council number is Code A

I started my career in nursing in 1965 as a cadet nurse and trained for three years, qualifying at Hackney Hospital, London in 1969. I worked on all wards until my qualification as a Registered Staff Nurse, (RSN) to the Surgical Ward.

I commenced employment at the Gosport War Memorial Hospital (GWMH) in1988 as a Staff Nurse, retiring in 2004 as a Clinical Manager (Senior Sister) at Dryad Ward, although I had been on sick leave since 2003.

I was responsible for twenty four hour care on Dryad Ward. I was also on a rota for the management at Redclyffe Annexe which was a fifteen bed unit for elderly mentally ill patients.

Redclyffe Annexe was a short distance from the GWMH and the facility moved to the main hospital in 1994.

I was responsible for the twenty four hour care of the patients on Dryad Ward and took on management roles when there were no managers at the hospital, i.e. weekends and evenings. I was responsible for all staff on the ward with regards to training, hiring, discipline, staff rotas and leave issues.

My hours of duty were 0730-1615 or 1200-2030 hrs. I also worked alternate weekends or more if required.

In 1999 my line manager was either Barbara ROBINSON or Jan PEACH . My position in 1999 was Clinical Manager.

In 1999 syringe drivers were in use at GWMH. These are a device loaded with the patient's prescribed drugs and administered sub-cutaneously, i.e. under the skin, mechanically, over a twenty four hour period. This prevents peaks and troughs of pain in the patient. Syringe drivers were in use at GWMH since about 1990.

Dr. Jane BARTON was Clinical Assistant at GWMH who started work at the Redclyffe Annexe around 1989.

Dr. BARTON visited GWMH about 0730hrs Monday to Friday and would see every patient on ward rounds before going on to her general practice. I would accompany her if I was on duty, if I was not she would be accompanied by the senior nurse present.

Dr. BARTON returned to GWMH to check in and arrange to speak with the relatives of patients, when she had finished her GP surgery, if required to do so.

On her visits Dr. BARTON prescribed the drugs she felt were required by patients depending upon their medical condition. She set the parameters of the amount of any given drug prescribed and the administration of them was carried out by trained nursing staff.

Dryad Ward was a continuing care ward that is to say a ward where care is provided in order to ensure that the patients return to either their home or on to a nursing or rest home, or, if they required palliative care, i.e. they were expected to die, to be looked after in a manner which would ensure a dignified death.

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My role was to be in charge of twenty beds, the named nurse may have had four to six patients to deal with, conducting the day to day aspects of patient's care.

I also had my administrative role and I was kept very busy, however my priority was care of the patients as it should have been.

I was also continence adviser for the whole hospital. Any staff who had patients with bladder or bowel problems would call me and I would attend whenever required in the hospital and advise regarding treatment or management of the problem. As GWMH is almost all elderly patients I was also busy in this role.

The administration of drugs was done by a trained member of staff. This could have been me or another member of staff, but always a trained nurse.

There were occasions where Dr. BARTON's partners refused to attend when I asked them. I remember Dr. PETERS as being the worst in this aspect. In those instances I would speak with a Consultant straight away regarding the issue.

I do not recall the content of any conversation between Dr. REID and Dr. BARTON. I am aware, through other members of nursing staff that Dr. REID withdrew a syringe driver which was given by Dr. BARTON to an elderly lady patient who died at 1am in pain. I cannot recall this patient's name.

I believe that when Dr. BARTON's colleagues attended GWMH in the morning, prior to their GP duties, it was because Dr. BARTON did this.

I have been asked about prognosis and diagnoses. A prognosis is what may be medically wrong with a patient, or what may develop. A diagnosis is the condition they actually have.

Diagnoses and prognosis are always determined by a doctor, never a nurse.

Dr. BARTON was responsible for both Dryad and Daedalus Wards.

Daedalus Ward was a rehabilitation ward, that is to say for the general rehabilitation and stroke rehabilitation of patients.

Dr. BARTON's line managers were the Consultants.

Ward rounds were conducted on a daily basis. Dr. BARTON would go round every patient and speak with them in order to assess how they felt that day. She would also read any reports from nursing staff as regards to any change in the patient's condition and, if appropriate, change medication, as she saw fit. She would always discuss this with the nursing staff. There were occasions where she contacted a Consultant before making any amendment to medication or for other issues, as she felt appropriate.

When Dr. BARTON was on leave or off for any other reason, a member of her Practice deputised for her, although to my knowledge, never conducted ward rounds.

In those instances I would do the ward round myself, although I sought advice when I thought it was necessary, from a Consultant. In my case I would speak with Dr. BARTON's deputy, I should say that their attendance at GWMH was brief and before their GP surgery started.

Dr. BARTON returned almost every day and in any case she was always available on the telephone for advice or to discuss patient issues. She would return and address any newly admitted patients, talk with relatives when required and receive updates from nursing staff. As the senior nurse this would generally mean consultation with me. I felt she was very good in this regard. She always tried to get to know patients relatives and to discuss the patient's well being with them.

When necessary Dr. BARTON would see patients in the afternoon or evening to reassess them. Dryad Ward held twenty beds, Daedalus twenty four. Dryad would have at least two trained nursing staff and four or five support workers. Daedalus would have slightly more due to its

twenty four beds.

The Consultants conducted ward rounds either once fortnightly, later, once a week. On those occasions Dr. BARTON and the senior member of nursing staff was also in attendance. If Dr. BARTON was not available none of her partners attended.

Ward rounds involve all the patient's needs, not only their types and levels of medication. My duties were the administration of drugs, the doctors to prescribe them.

If I felt a patient was being adversely affected by a drug I would speak with Dr. BARTON or a Consultant. In some cases this would result in a decrease or cessation of a particular drug, in other cases drugs may have been changed or the amounts increased.

If the doctor decided to change the type or amount of drug to be given they would either come in at once or as soon as they could and write up the prescription. In exceptional cases, and this was rare, authorisation to change types or levels would be granted over the telephone. The doctor would then have twenty four hours to write the prescription and sign it. In the event of this happening in respect of telephone authorisation two trained members of nursing staff would accept the doctor's decision, enter it on the prescription chart and both sign the entry.

As a manager I was in charge of all aspects of the patient's care with the exception of the prescription of drugs.

My duties involved personal hygiene, nutrition and general nursing care.

No nurse is qualified to determine a patient's medical condition. Experienced members of nursing staff may voice an opinion to a doctor but no more.

In 1999 I would following the Wessex protocols and the analgesic ladder. At that time the protocols and the ladder were very similar and are guidelines as to medication. Basically the lowest drug for pain control or alleviation was Paracetamol. The scale increases using stronger

drugs, the highest being Opiates, ultimately Diamorphine . Drugs are given according to each patient's individual needs.

Dr. BARTON would write up the types of drugs required by patients.

There are four types of prescription, one off, regular, daily review and as required. 'As required' prescriptions would have a set of parameters of the amount of any given drug. 'Regular' is one unvaried dose as is the 'daily review'.

'One off' may be if a patient required, for example a diuretic, where a patient had fluid retention.

I have today been referred to Police exhibit BJC/34 the medical notes of Geoffrey PACKMAN . I do not recall him.

My writing on page 55 dated 30/8/99 reads, 'Recatheterised Bard pre filled. Size 14ch. Ref 226414 lot 49J1R198.'

His catheter may have been blocked or due for change.

A catheter is a tube inserted into the bladder in order to drain urine.

I refer to pages 62 to 64 of the notes. These are nursing notes.

My entry on 25/8/99 reads, 'passing fresh blood PR - ? Clexame. Verbal message from Dr. BEASLEY to withhold 1800 dose to review i/c Dr. BARTON mané. Mick also vomiting. Metaclopromide 10mg given I/M at 1755 i/c good effect.'

My next entry is on 26/8/99 which reads, 'Fairly good morning. No further vomiting. Dr. RAVI contacted re Clexame. Advised to discontinue and repeat H/B today and tomorrow. Not for resuscitation. Unwell at lunchtime. Colour pale - c/o feeling unwell. Seen by Dr. BARTON this afternoon. Await results of HB. Further deterioration c/o query indigestion, pain

in throat. Not radiating - vomited again this morning. Verbal order from Dr. BARTON Diamorphine 10 mgms stat - same given at 1800, Metaclopromide 10mgms, given IM. Mrs. PACKMAN informed - will visit this evening.

PR is 'pro rectum'.
Clexame is anti coagulant.
I/c means with.
Mané is morning.
Metoclopromide is an anti-emetic.
I/M is intra muscular.
HB is haemoglobin.
Not radiating means that the pain was not spreading.

Both entries were signed by me. I contacted both Dr. BEASLEY and Dr. RAVINDRANE regarding Mr. PACKMAN's condition. I may well have thought, because of his colour and the pain in his throat that he had a heart attack but I would not have written this as I am not a doctor.

My contact with Dr. BEASLEY was that one telephone call.

On page 55, the medical notes I see that Dr. BARTON has written, on 26/8/99 '? MI', that is to say query myocardial infarction, i.e. heart attack.

I also note that she stated he was too unwell to transfer to an acute unit. This was normal practice in cases where patients may well die in an ambulance. Mr. PACKMAN was assessed at the Queen Alexandra Hospital as not for resuscitation.

On page 168 of the prescription sheet I wrote on 26/8/99 1800 Diamorphine IM 10 mgms. I confirm this was a verbal authority from Dr. BARTON. As was practice, if I was on duty as the only member of trained staff, I would not have a counter signatory. This would have been the case. It was not something I liked doing but it had to be done.

When a patient cannot take medication orally the practice is for nursing staff to make contact with the doctor and propose the use of a syringe driver. Nine times out of ten the doctor agrees and we go ahead unless the doctor objects. An entry is then made in the nursing notes. In this case the entry is on page 63 dated 30/8/99 and is my entry. The entry reads, 'Condition remains poor. Syringe driver commenced at 1445 i/c Diamorphine 40mgs, Midazolam 20 mgms. No further complaints of abdominal pain - very small amount diet taken, mainly puddings. Recatheterised this afternoon, draining when possible, encourage fluids, dressings also removed.'

Referring to page 171 I see that the prescription was written up for Diamorphine, was written up by Dr. BARTON on 26/8/99. Until 30/8/99 Mr. PACKMAN was being given Oramorph as illustrated on page 172. I note that Midazolam was also written up on 26/8/99. Although it is not dated, I believe this was not administered until 30/8/99. Midazolam is a sedative. It can be given on its own but is often given with Diamorphine.

I believe that in this case Mr. PACKMAN started on the above drugs on 30/8/99. I have been shown a photocopied page of a conversion scale of oral Morphine into Diamorphine. As Mr. PACKMAN was on 10mg six times daily, the scale is 20mg of Diamorphine. As this patient was in pain and had been on Oramorph which was not controlling his pain he was put on to 40mg of Diamorphine. As I made the syringe driver it was me who put him on to 40mg. I would have called Dr. BARTON to agree this. If she was not there I would have left a message and she would have rung back at some point. Although I can see no record of a call, this was standard practise.

On page 64 dated 1/9/99 the entry reads, 'Dr. REID here, Mr. PACKMAN off ward. To discuss discharge plans with Mrs. PACKMAN OT & Physio. S HALLMAN. To continue.' This entry was written in error and was written for some other patient.

'Syringe driver renewed at 1915 i/c Diamorphine 60mgs and Midazolam 60mgs as previous dose not controlling symptoms. Dressings renewed this afternoon. Mrs. PACKMAN has

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visited this afternoon and is aware of his poor condition. Mrs. PACKMAN being admitted to E1 ward at QA tomorrow for surgery. Please contact her son in the event of Mick's death. No night calls please.' This is signed by me.

We ask next of kin if they wish to be called in event of death. In this case they did not.

On page 171 of the notes the increase in Diamorphine went to 40mg which was discarded as it was not controlling the patient's pain and the dose increased to 60mg.

The authority to do this would always be a doctor, either Dr. BARTON or a member of her practice. You would not necessarily call the doctor first, as the parameters were set but a call would be made at some point.

The entries in the nursing notes are in red. This is so the Diamorphine dosage is easily read.

Mr. PACKMAN's dose was increased on 2/9/99 to 90mgs, the entry made by Jeanette FLORIO . On page 171 I see that Shirley HALLMAN made the entry for the increase. They were obviously working together.

On page 83 my entry of 25/8/99 reads, 'several loose bowel actions throughout the afternoon and evening - 7-8. Some fresh blood present ? due to medication. Same stopped. For review later.' This entry is covered on page 7 of this statement and refers to the Clexame.

My entry on page 85 dated 30/8/99 reads, 'Recatheterised - previous catheter blocked, washout unsuccessful. Bard prefilled Size 14 ch. Ref 226414. Lot 4 9S1R 198. Due to debris collecting in valve on S4 bag - cysto care bag applied.'

This means that the catheter was not draining as I explained previously. A Cysto care bag is a bag with a large drainage valve which is used when patients have a lot of debris in their bladder or blood clots.

As for the increases in Diamorphine, in this case from 40mg to 60mg to 90mg, this is what I would describe as a sliding scale in the same way as the analgesic ladder.

A patient would not go from 20 to 200 mg in one jump. The amount given is incremental and in direct relation to their level of pain. To do so would kill the patient.

It would be practice to increase from 20mg to 40mg or less, the dosage administered to control the pain and no more. The doctor's authorisation is always required.

With reference to page 168 as stated on page 8 of my statement, I see that on 26/8/99, Dr. BARTON prescribed a one off dose of 10 mgms of Diamorphine to be given intra muscularly and again on 28/8/99. I gave the first dose and signed the treatment chart. The second dose was never given. It may have been that the first dose was required due to the fact that the analgesia was not controlling Mr. PACKMAN's pain but when the second dose was authorised it was not required. The second dose may have been prescribed by Dr. BARTON as an emergency measure if required. Dr. BARTON has recorded this in page 55 of the notes.

This was normal procedure. It is also recorded on page 3 of the Ward Controlled Drugs Record Book, exhibit JP/CDRB/48 . At 1800 hrs the Diamorphine was signed out by me and the entry countersigned by Shirley HALLMAN.

On page 171 I recorded the Oramorph prescription which was signed by Dr. BARTON. This entry was for 26/8/99 on, however on page 172, Dr. BARTON has rewritten the dosage. The first entry on this page, written by Dr. BARTON was for the day staff, the second for the night staff, in that case a double dose being given at 2200 hrs from 26/8/99 to 29/8/99.

The entries in relation to this are on page 54 of the Ward Controlled Drugs Record Book exhibit JP/CDRB/24.

I can say that Mr. PACKMAN was given 10mg of Oramorph at 1000, 1400 and 1800hrs on 27th to 29th August 1999 and the night staff gave him 20mg at 2200hrs from 26/8/99 and 10mg at

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0600hrs 27/8/99.

On page 171 of the notes I see that as regards to the Metoclopromide which is an anti emetic, the patient was obviously vomiting, and is an uncontrolled drug, that on 25/8/99 I wrote the prescription. The authorisation was given by Dr. BEASLEY and signed post authorisation by him. The signature is not timed however I believe he signed it that evening after his surgery. It is not practice for nursing staff to write the prescription however in this case it was a verbal order. I called Dr. BEASLEY as the patient was vomiting and he prescribed the drug, which was given at 1755 hrs by Lynne BARRETT and again on 26/8/99 at 1740 hrs by Shirley HALLMAN. This is recorded on page 62 of the notes.

I am now referred to pages 96 to100 of the notes this being a nursing care plan in respect of Mr. PACKMAN. Page 96 is dated 24/8/99 and reads as follows:

'Geoffrey has several malodorous sores to buttocks and between thighs. Also blistered areas to both feet/heels - pressure sore no.5.

Pressure sore No.1, small lt. buttock.
No.2, large lt. buttock.
No.3, upper rt. buttock.
No.4, lower rt. buttock.

The desired outcome was: Him to heal wounds and prevent further tissue breakdown. His evaluation was daily.

Nursing Action reads - Refer to care plan sent from tissue viability adviser B WINTERBOURNE for buttock sores (in care plan). Evaluate daily. If problems with dressings or healing review - consider asking above for further advice.
Barbara WINTERBOURNE was the tissue viability nurse.

Page 97 shows the named nurse to be Staff Nurse SHAW.
The entries here are as follows:

24/8/99, dressings reviewed today, swabs taken from wound sites this morning. This is signed by Jeanette FLORIO

25/8/99, some dressings removed as coming off and contaminated æ faeces - non-adherent dressings applied on temporary basis - until wounds assessed again this pm.
This entry is signed by Jeanette FLORIO.

PM dressings removed as per care plan. This is signed by me and Lynne BARRATT.

27/8/99, dressings removed to all areas - some improvement since Wednesday - especially to the two areas on the left buttock - area on rt. Buttock remains offensive and some exudate on larger of the two sores.
This entry is signed by me.

Nocte, dressing between thighs has slipped off wound, removed as per care plan and re-secured with bioclusive.
This is signed by staff nurse TURNBULL.

29/8/99, left heel redressed with Paramet. Wound clean.
This is singed by Jeanette FLORIO.

Dressings to buttocks intact, leakage of some fluid from under largest dressings.
Smell is offensive. For redressing tomorrow.
This is signed by Jeanette FLORIO.

PM, as dressing on top of right thigh and right buttock starting to come away secured with another Combiderm on exposed area (equated under) and also Duoderm. Wounds healing a lot of offensive exudates.
This is signed by Jeanette FLORIO.

Page 98 reads:-

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30/8/99 pressure sore no.1 - much cleaner - Duoderm applied.
Pressure sore no.2 cleaned, equated and Intrasite applied, covered by Combiderm large.
Pressure sore no.3, aquated - no Intrasite applied to area towards scrotum - Aquacel i/c Intrasite applied to remainder of wound. Combiderm applied - large.
Pressure sore no.5 - lt. Heel - dead skin removed - 1 tin Paramet used - criss-cross gauze squares and cling bandage applied.
These entries are signed by me.

31.8 99 PM, Areas (1) and (2) needed securing tonight as exudates copious and edges coming away, Aquacel dressings misplaced and removed. All areas to be redressed tomorrow.
This is signed by Jeanette FLORIO.

1/9/99 areas (1) and (2) redressed am/as contaminated with loose faeces ++ and dressings from yesterday evening coming away.
This is signed by Jeanette FLORIO.

PM, pressure sores (1) as above - Duoderm applied.

Page 99 is blank.

Page 100 is a continuation of the above entry and reads:-
Pressure sore no.3 - packed i/c 3 pieces of Aquacel and 2 Combiderm to secure.
Pressure sore no.4 - Slough removed - 3 pieces of Aquacel inserted - into track. Combiderm applied
Pressure sore no.2 wound cleaned - some slough removed - Paramet applied - gauze and then Combiderm to secure.
Pressure sore no.5 lt heel cleaned. 1 tin Paramet applied - cling to secure.
I have signed this entry.

2/9/99 pressure sore no.1 - Duoderm applied for protection area healed.

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Pressure sore no.2 area cleaned - Paramet applied, secured by Combiderm - (large).

Pressure sore no.4 area syringed - cavity packed i/c 5 pieces of Aquacel - secured i/c Combiderm.

Pressure sore no.3 packed i/c 2 pieces of Aquacel gauze and Combiderm.

Pressure sore no.5, lt heel, cleaned, Paramet 1 tin applied. Cling to secure.

This entry is signed by me.

Aquacel and Combiderm are dressings used in order to attempt to deslough.

Mr. PACKMAN's skin had broken down and he was not taking enough nutrition. This is a contributory factor to his sores not healing. His general health had deteriorated and this also did not help.

The entry on 30/8/99, page 98, also includes, 'pressure sore no.4, area of slough removed, large crater exposed - deep - good 1" packed i/c Aquacel. Aquacel i/c Intrasite applied to remainder of wound. Combiderm applied - large.'

Intrasite is a gel which is applied to deslough.

STATEMENT TAKEN - Code A