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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: (if over 18 insert 'over 18') Occupation: NURSING HOME NIGHT SISTER

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: G HAMBLIN Date: 15/09/2005

I am Gillian Elizabeth HAMBLIN and I live at an address known to Hampshire Police. I am currently employed as a Night sister in a local Nursing Home. Up until February 2004 when I retired from the GWMH I was a Clinical Manager (Senior Sister) at Dryad Ward, my Nursing and Midwifery Number is Code A I did not work at that hospital however since May 2003 though, due to sickness.

In 1963 I became a Cadet Nurse and commenced a 3 year qualification course in 1965 at Hackney Hospital, East London. I worked on all wards until my qualification as a Registered Staff Nurse to the surgical ward.

I commenced employment at Gosport War Memorial Hospital in 1988 in the capacity of Staff Nurse

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management Redclyffe Annexe which was 23 bed unit caring for long stay palliative and terminally ill patients. We also shared care patients which gave relatives a break from caring and gave them a period of respite.

Redclyffe Annexe was situated a short distance from the hospital and moved to Gosport War Memorial in 1995 and thus became Dryad ward comprising of 20 beds.
Redclyffe then became a 15 bed unit which was taken over by the Mental Health department. When on duty at evenings and weekends we had managerial/ Clinical responsibility when required.

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In January 1996 I was working as a Clinical Manager at the GWMH. I worked 37½ hours a week on a shift rota, earlies being 0730 to 1615 and lates 12 midday to 2030.

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management of the Hospital and would take on management roles when there were no managers at the hospital, i.e. at weekends and evenings. I was responsible for all of the staff on the ward re the training, hiring discipline, staff rotas and leave issues.

My line manager at that time was Barbara ROBINSON .

In 1999, Diamorphine Syringe drivers were introduced to those of us working on Redclyffe Annexe and in 1998 Dr Jane BARTON became the Doctor responsible for the patients, prior to this, each patients GP was responsible for their individual patients on the ward.

Responsibility for medical care was "Elderly Medicine" based at the Queen Alexandra Hospital Cosham.

Dr BARTON would visit at 0730 each morning Monday to Friday and see every patient, before returning to her own practice.

She would return to the GWMH to check in and arrange to see relatives either that day or later.

On her visits Dr BARTON would prescribe the drugs that were required by each patient. This was a new concept to staff at this time. Sister GREEN who was in charge at this time bought syringe drivers to the annexe and explained the system to the nurses and they would have learnt their use from her.

At this time there were no courses in the use of syringe drivers, but these have since been started. I am aware that there have been some concerns in relation to the syringe drivers and diamorphine , but I have not had any doubts myself. The main reason for the use of a syringe

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driver is to administer drugs to a patient once oral medication has ceased, generally due to the patient's inability to swallow.

Drugs that I am aware of that have been administered in this way as well as Diamorphine, are Midazolam , a sedative, Hyoscine , to stop secretions and Cyclizine to stop vomiting.

I have been asked about the "Wessex Protocols". I am unfamiliar with this name but am aware of certain protocols I relation to the setting up and use of syringe drivers and am unsure if they are one and the same.

The Named Nurse is the person with the responsibility for the nursing care of the patient. The named nurse would also be the person to whom the family would speak to, in order to keep them up to date on the patient's condition.

The time and date of all entries in the nursing notes would either be completed at the time if the patient was seriously ill, but in other cases they would be completed when there was time but in any case at the end of the tour of duty.

I have been asked to detail my involvement in the care and treatment of Sheila GREGORY b. 12/07/1908. I cannot recollect this patient or the subsequent treatment that she received.

From referring to her medical records (exhibit ref BJC/21) page 7. I can confirm that I have written entries on the Spell summary.

The spell summary is the discharge summary, primarily for the benefit for the patient's own Doctor to inform them of the treatment the patient has received whilst in hospital.

A copy is also forwarded to Clinical coding at Portsmouth.

I can confirm that on the 22/11/99 I have written the following

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Diagnosis

 # NOF this is a Fracture to the neck of Femur. (That is the patient had broken the top half of the thigh)

Recorded on the spell summary are the patient's personal details and contact numbers.

Under the heading "Date of Discharge" I have written the date of death as *22/11/99* and signed the entry.

The patient Sheila GREGORY was diagnosed "broken neck of Femur" this procedure may well have contributed to her death. However from referring to the Clinical notes I note that Doctor BARTON has written down under her Past medical History (PMH) on page 66 of the records as having suffered from;

Cardiac Failure = (Heart Failure)

Hypothyroidism = (Under Functioning thyroid)

I note that on page 70 of the medical records that Dr BARTON has written *"Further CVA?"* CVA = (Cardiovascular Accident/Stroke). I cannot find any reference to a previous CVA.

However cause of death in my opinion is most likely to be a CVA.

I can confirm that I have countersigned the entry written by Staff Nurse Freda SHAW which is recorded on page 70 of the medical records (BJC/21). This entry confirms that the correct procedure for verifying death has been complied with. Two trained members of nursing staff need to be present.

Checks to the patient's vital signs were conducted which show that there was no Carotid artery pulse.

There was no Radial pulse. There was no heart beat when listening through a stethoscope.

There was no pupil reaction to light. No visible respiration was observed. There were no inspiratory sounds of breathing when using a stethoscope.

Relatives would be informed at the earliest opportunity.

I was not involved in the admission of this patient on the 3/9/99.

Ward rounds were conducted on Dryad ward by Dr BARTON at 0730 Monday to Friday. She was accompanied by the senior trained nurse in charge of the ward which was normally myself. The ward round would have to be finished by 0810 as Dr BARTON would then have to conduct a ward round on Daedalus ward.

Consultant ward rounds were conducted once a fortnight on a Monday afternoon normally accompanied by Dr BARTON and the senior trained nurse on duty.
The treatment of each patient was based on the observations of all the nursing staff. These observations would then be passed onto the Consultant.

I can confirm that on page 136 of the medical records I have recorded that I have given Sheila GREGORY a dose of Oramorph, the entry reads as follows;

17/11/99 2020 5mgs/2-5mls This was given orally to the patient.

Again on page 136 of the records I have recorded that I have given Metoclopramide to the patient the entry reads as follows;
11/11/99 1615 10mgs. This is not a controlled drug and would have been given for either nausea or vomiting. This was prescribed over the phone as a result of me ringing Dr BARTON and asking for something to stop the patient's vomiting or nausea.
There is no record within the nursing notes recording the fact that the patient was suffering from vomiting or nausea for this date. This drug was only administered on one occasion.

I can confirm that on page 151 of the medical notes I have written the following;

Magnesium Hydroxide 20mls BD =(Twice Daily) This was a verbal order taken on the phone from Dr BARTON which has subsequently been signed by Dr BEASLEY from the same practice who actually attended and authorised the prescription of Magnesium Hydroxide. This entry written by me was subsequently crossed out by Dr BARTON.
On page 151 of the medical records there is an entry for Magnesium Hydroxide with a reduced dose of *10 mls BD.* This entry has been signed by Dr BARTON.

Magnesium Hydroxide is a bowel preparation which is quite gentle on the bowels and not as strong as other preparations.

I can confirm that I have written the following entries in the medical notes of Sheila GREGORY commencing on page 238 which are as follows;

4/10/99 Seen by Dr REID continue to encourage food and fluids. Physio to commence this week.
This entry is self explanatory.

7/10/99 Generally unwell. C/o = (Complains of) *acute pain on top of head and side of face. Feeling nauseated. Rested on bed feeling better.*
This entry is again self explanatory.

15/11/99 Seen by Dr REID - Thyroidizine discontinue.
I note from the medical records that Thyroidizine was last given on the 7/10/99 at 0200. From memory Thyroidizine was no longer being used in Elderly care as it was being withdrawn.

I can confirm that I have written the entry on page 238 which is as follows;
19/11/99 - Poorly but stable morning -c/o shortness of breath this afternoon.
Frusemide 40mg given start at 1530. No residual urine. Drained 200mls in the first ½ hour following Catheterisation. Continue Oramorph.

To clarify this entry - Although Sheila GREGORY was unwell she was stable. She had complained of shortness of breath. Fruesmide which is a Diuretic was prescribed by Dr BARTON on the 19/11/99 at 1530hrs.
This is recorded on page 184 as a verbal message taken by me and countersigned by Staff Nurse Freda SHAW.
If a verbal order is given over the phone then where possible a second trained nurse was required to countersign any entry for the prescription of drugs.
As shown in this case Fruesmide was prescribed because it will relieve the fluid in her kidneys

and around her lungs which in turn will hopefully improve her breathing.

I have written the following entry on page 239 of the medical records

20/11/99 (I believe this entry was written in the morning) *Some deterioration during the morning Grand daughter advised to visit AM Vomited also- Cyclizine 50mgs IM* = (Intramuscularly) *1315 I/C* = (with) *good effect* (This was a one off dose that was given)

PM Good relief from Cyclizine IM Syringe driver commenced at 1700 with Diamorphine 20mgs and Cyclizine 50mgs. Please contact Pauline GREGORY during the night if sudden deterioration.

To clarify this entry - The patient was obviously getting worse. I would have rung her grand daughter and advised her to visit Sheila GREGORY.

She was prescribed Cyclizine as she had previously been vomiting.

Diamorphine was prescribed and given at this time to relieve her distress and discomfort.

At this stage Sheila GREGORY was dying.

I can confirm that I have signed the following entries within the Dryad ward Drugs register exhibit JP/CDRB/48 commencing on page 4 as follows relating to the administration of Diamorphine.

20/11/99 1700 Sheila GREGORY 20mg G.HAMBLIN witnessed by L.BARRETT

I can confirm that I have written the following entries in the Drugs register for Dryad ward for the administration of Oramorph which are as follows;

18/11/99 1030 Sheila GREGORY 5mgs/2.5mls G.HAMBLIN witnessed by F.SHAW
18/11/99 1430 Sheila GREGORY 5mgs/2.5mls G.HAMBLIN witnessed by L.BARRETT
19/11/99 1020 Sheila GREGORY 5mgs/2.5mls G.HAMBLIN witnessed by L.BARRETT

I would not necessarily check the nursing notes or clinical notes of the patients on the ward

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when I came on duty. However there was always a handover from nursing staff from the previous shift who would report on all patients. All changes would be reported to the incoming staff.

At a later stage normally when I was writing my notes in the patient's medical records I would check the previous entries of the nurses and Doctors if they were legible.

I had no further dealings with Sheila GREGORY.