STATEMENT

Number: S6

Surname: [GIFFIN]

Forenames: [SYLVIA ROBERTA]

Age: [ ] Date of Birth: [ ]

Address: [ ]

Postcode: [ ]

Occupation: [STAFF NURSE]

Telephone No: [ ]

Statement Date: [06/06/2000] Number of Pages: [8]

I am employed by Portsmouth Health Care Trust at Gosport War Memorial as a Staff Nurse. I have worked as a Staff Nurse at the War Memorial since 1972.
I work mainly at Daedalus Ward on night duty for about the last three years, covering August 1998.
The ward is mainly occupied by elderly patients. The ward is visited daily by a General Practitioner responsible for the treatment of the patients. The GP will prescribe drugs and treatment which will be administered by the Staff Nurses on the ward.
In August 1998, the GP in question was Doctor BARTON . A consultant would visit the ward once a week. This was Doctor LORD.
Dr BARTON is also on call for any emergency cases. On other occasions when Dr BARTON was not on duty, a GP would be contacted via a Healthcall system based at Cosham.
The patient capacity at Daedalus is twenty four.
I work a permanent night duty at Daedalus Ward which would consist of 8.15pm (2015) to 7.45am (0745). I work mainly Friday and Saturday nights.
In relation to the inquiry regarding Gladys RICHARDS, I was at work on Thursday 20th August 1998 (20/08/1998) and Friday 21st August 1998 (21/08/1998).
On the ward with me on 20th August 1998 (20/08/1998) was Anita TURBRITT, Senior Staff Nurse, Anne FLETCHER, Health Care Support Worker Monique GALLACHER, Health Care Support Worker. These three were on night duty with me on Friday 21st August 1998 (21/08/98).
When I started work at 8.15pm (2015) on Thursday 20th August 1998, (20/08/1998) I was made aware that Gladys RICHARDS was on the ward. I do not recall receiving any specific instructions regarding Mrs RICHARDS care or treatment. I do not remember who gave me the handover. I was aware at this time that Mrs RICHARDS was on a syringe driver. The practice of using a Syringe Driver subcutaneously at the hospital has been in use for about ten to twelve years.

The syringe driver is commonly used at the hospital in order to relieve a lot of pain or discomfort. The driver is able to provide a constant level of pain relief as opposed to oral pain killers which wear off after a period of time causing the patient discomfort prior to the next administration of pain killers.
In relation to the drugs administered by Syringe Driver, in August 1998, Dr BARTON as the GP responsible for the ward, would have completed the prescriptions. This was backed up by a weekly ward visit by Dr LORD who would assess the treatment given to the patients.
The syringe drivers are used on all wards at the hospital to the best of my knowledge.
The care and treatment of Mrs RICHARDS would have been part of my responsibilities overnight. Anita TURBRITT was in overall charge of the ward and the hospital on the 20th August 1998 (20/08/1998) and 21st August 1998 (21/08/1998).
I was made aware, I believe by Jenny BREWER, another Staff Nurse, that Mrs RICHARDS had had a fall. I can not remember if Jenny BREWER told me anymore about the incident.
I also remember that Mrs RICHARDS had been in the ward previously before returning to Haslar and then returning to Daedalus Ward.
Mrs RICHARDS daughter was present with her on Thursday 20th August 1998 (20/08/1998) to Friday 21st August 1998 (21/08/1998). I spoke to her and learnt that she had previously worked in a nursing capacity. The daughter had concerns over the transport of Mrs RICHARDS from Haslar Hospital to the War Memorial. The daughter also believed that her mother was far healthier mentally than what had been diagnosed.
I do not recall administering any drugs to Mrs RICHARDS. I would have checked her treatment card to ensure any drugs prescribed were to be administered however it would be unusual to administer drugs overnight.
I have been shown LH/1/C/24, a prescription record for Gladys RICHARDS being part of health record LH/1/C. Having looked at this record I can state that I did not administer any drugs through the syringe driver or otherwise to Mrs RICHARDS. I have looked at the record and noted that the syringe driver was loaded at 11.15am (1115) on Thursday 20th August 1998 (20/08/1998). The driver should last for 24 hours meaning that the night duty would not normally be expected to reload the driver.
I have noted the drugs that were administered to Mrs RICHARDS on the health record were as follows.
Diamorphine, Haloperidol, Hyoscine and Midazolam. My perception of their effects are as follows
Diamorphine is for pain relief. Haloperidol quietens the patient down if they are agitated or jittery. Hyoscine stops fluid building up on the chest. Midazolam also quietens the patient down. Midazolam is not a strong drug.
Mrs RICHARDS may have been taken off Oramorph and put on to Diamorphine via syringe driver as the Oramorph was not holding the pain. The syringe driver would ensure the pain relief was constant.
I do not recall giving Mrs RICHARDS any fluids either by mouth or subcutaneously.
Mrs RICHARDS would not have been given fluids by mouth due to the fact that Mrs RICHARDS was not conscious. She therefore would have choked if anyone had tried to force fluids or food into her mouth.
Mrs RICHARDS was not given fluids subcutaneously. I recall that there was nothing to

alarm me over Mrs RICHARDS condition. I did not receive any instruction to administer or not to administer any fluids to Mrs RICHARDS.
I was not concerned about the drugs Mrs RICHARDS was being administered. I could not comment on what effect the drugs were having on Mrs RICHARDS as I had not seen her prior to the drugs being administered. I did not speak to a Doctor regarding her drugs dosage nor did I alter the card of drugs given to Mrs RICHARDS. I checked regularly on Mrs RICHARDS and she appeared comfortable. I can not recall the make of syringe driver used. The training received for the driver was on the ward with an instruction booklet in the treatment room. Without having looked at Mrs RICHARDS case notes I believe Mrs RICHARDS died at about 4am (0400) on Friday 21st August 1998 (21/08/1998). There was no attempt to resuscitate. In Mrs RICHARDS case, I was able to pronounce death as her death was expected.
At that time both Mrs RICHARDS daughters and a granddaughter were present. I recorded death pronounced on the case notes and the nursing notes.
Mrs RICHARDS daughters then prepared her for the mortuary. They laid a rose on her and put a crucifix around her. Part of the preparation included ensuring Mrs RICHARDS was clean however the staff carried this out later on.
The procedure from this point is that later in the morning Dr BARTON would attend and certify the cause of death. If Mrs RICHARDS was to be cremated then two doctors signatures would be required on the cause of death. I would add that the other reason why a patient may not be able to take Oramorph is if they are unable to swallow. In this case the patient may be transferred to a syringe driver.
Signed: [S R GIFFIN] Signature witnessed by: [ ]