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# STATEMENT PRINT

Surname: EVANS

Forenames: ISOBEL

Age: OVER 18 Date of Birth: Code A

Address: Code A

Occupation: RETIRED PATIENT CARE MANAGER

Telephone No.: Code A

Statement Date: 12/11/2002

Appearance Code: 1 Height: Code A Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

I am the person named above and live at the address shown on the attached form.

In 1961 after completing my training I became a State Registered Nurse.

Then in 1966 I commenced employment at the **Gosport War Memorial Hospital** C35 as a Staff Nurse in the Accident and Emergency Department.

In 1978 I became Ward Sister in the female ward at the hospital.

Eventually, in 1988 I progressed to become a Matron and a few years later I then became Patient Care Manager. I fulfilled this role until my retirement in 1996.

My responsibilities in 1991 as Patient Care Manager was for all nursing care within the hospital units. Which consisted of 3 wards, operating theatre, outpatients and the Accident and Emergency Department.

There was also two annexes known as **Redcliffe House** C54 and **Northcote House** C52, which I was also responsible for.

In regard to the Redcliffe House annexe this was a 22 bed unit for the long term care of elderly patients who were all under the care of a consultant.

The staff requirements for the unit was 5/6 in the morning, 3/4 in the afternoon and evening and a minimum of 2 at night.

When I took control of the Redcliffe House annexe it was obvious that there were problems with the unit and the staff. These were mainly due to outdated nursing practices, poor morale and inappropriate treatment of patients.

A nursing auxiliary indicated that some patients were being force fed and that the general manner in which patients were treated by some staff was quite poor.

One example given was of a patient who was incapable of moving who was sat in chair one day. When two nurses told her that there was a rat behind her and that if she did not cease to be troublesome they would leave it there. I conducted an enquiry into these allegations but was unable to prove or disprove. However as a result of this enquiry one member of staff was moved and another retired.

I also started implementing other measures to improve nursing practices and help morale at the unit. Unfortunately some of these ideas were resisted by some of the nurses at the unit, who were not happy with this 'culture change'.

In 1991 we started using **syringe drivers** C43 at the unit. This was a result of some staff attending study days where it was recommended that pain relief given a regular/constant basis would alleviate pain better than giving painkilling drugs irregularly, which was the normal practice.

One of the painkilling drugs we used on a regular basis was **Diamorphine** and sometimes a syringe driver was used.

Shortly after we began this practice some of the staff from Redcliffe House approached me, this included **Anita TUBBRITT** N7 and **Sylvia GIFFIN** N22. They expressed concerns over the amount of Diamorphine used at the unit.

I was already aware at this time that Sylvia GIFFIN, who was a staff nurse at the unit, did not give patients Diamorphine at night unless they were awake, when she was on duty. She complained that she had been criticised for this. After listening to their concerns I spoke to **Dr BARTON** N34, who was the clinical assistant for the unit and the unit sister, **Gill HAMBLIN** N131. They satisfied me that all usage of the drivers at the unit was safe and appropriate.

I felt that the problem was that the drivers were new and the staff did understand the thinking behind their usage.

Therefore I arranged training for them and **Steve KING** N139 / A141 / F1, a pain control expert, to attend on study days to give lecture on drivers.

Another expert **Linda FOSTER** N199 / A250 / F2, also came along and showed them how to set the drivers up and who to use them on.

In regard to the amount of Diamorphine used some of the staff were under the perception that patients were getting more. This was because they were used to giving the patient for example 10 milligrams of Diamorphine orally every four hours.

However, now with the use of the syringe drivers they were getting 60 milligrams at once but this was fed to them over a 24 hour period by the driver at a constant level. This obviously equated to 6 doses of 10 milligrams over 24 hours but some of the staff could not originally comprehend this.

The other complaint by the staff was that patients who were not in pain were placed on the syringe driver. However they could not give any examples. I think the problem here was that at the time we had patients who could not express themselves due to the fact they were suffering from strokes or were confused. Therefore they could not indicate if they were in pain.

At the time I had no concerns about syringe drivers and indeed I instigated their purchase. I believed that they offered the highest level of pain control on the smallest dosage possible.

Furthermore in 1991 there was only five syringe drivers in the entire hospital complex, with Redcliffe House only having one driver with access to another spare one. So their usage then was rather conservative. Although I was totally surprised by the staff fears, I did not think it was likely to become a problem.

I did make **Doctor LOGAN** N184 / A184 / F3, the senior consultant at the unit, aware of their concerns. I must add here that the doctors were responsible for the prescription of painkillers to patients and who should be placed on a syringe driver.

In respect of Doctor LOGAN and Doctor BARTON, I found them both approachable and capable professionals.

However despite the training I received a letter from the staff representative stating that they still had concerns over the syringe drivers.

I spoke to Doctor LOGAN who said that he would not respond to this letter without examples of their misuse. Therefore I sent a memo to all the staff at the unit requesting examples. Unfortunately I did not receive one reply. I was still anxious to address this problem so a meeting was arranged. Which

was attended by Doctors BARTON and LOGAN and all the trained staff and myself from the unit.

I brought up all the concerns raised by the staff and gave them the opportunity to amplify these. Doctor LOGAN answered all their concerns over the syringe drivers and the prescribing of Diamorphine. I felt that everyone was satisfied by the answers given. Indeed the issue was never again raised between then and my retirement in 1996.

I would like to state that Dr BARTON was also the clinical assistant to two other units within the hospital complex, the Northcote House annexe and the geriatric beds within the female/male ward in the main building.

There was never any complaints forthcoming from those units about Dr BARTON prescribing medication.

My personal opinion is that these problems in 1991 were due to the culture changes at the unit which I helped impose there.

These were mainly the use of painkillers and bringing the nursing practices up to date.

I was supported in the effort to impose the changes by Gill HAMBLIN, the sister in charge of the unit.

I recently became aware of problems at the hospital through the local papers.

On 23rd October 2002 (23/10/2002) I was shown various papers with identification reference number **JEP/GWMH/1/7** exh. This is a collection of meeting minutes, letters and memos. Some of which I recognise. In respect of the report by **Gerri WHITNEY** N128 I cannot recall seeing it but I may have seen it at the time.

However in respect of the minutes of the meeting held on 18th September 2002 (18/09/2002). This document is misleading and does not show the full circumstances.

I can honestly say that I did not do anything incorrectly and I am satisfied that all patients who were placed on syringe drivers were appropriate.

Signed: I EVANS Signature witnessed by: