RESTRICTED

STATEMENT

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Age	[Over 18]
Statement Date	[11/OCT/2002]
Signature Witness Name	Code A
Signed Name	[M Wigfall]
Telephone No	
Postcode	Code A
Date Of Birth	
Occupation	[ENROLLED NURSE]
Address	Code A
Forename 1	[MARGARET]
Surname	[WIGFALL]

I am the person named above and live at the address shown overleaf.

I am a D Grade Enrolled Nurse and I am employed by the Gosport and Fareham Primary Care Trust.

I started training as a Nurse in 1965 and qualified in 1967.

I began as a General Nurse, but in 1968 I became a Naval Nurse at the Haslar Hospital in Gosport.

In 1971 I had my first child, and then in 1977 I returned to work as an Agency Nurse.

Then in 1981 I was employed at the War Memorial Hospital in Gosport.

I worked at the Redcliffe Annexe part of the hospital which deals in caring for the elderly.

Most of the patients although elderly were there for long term care.

Several years ago, I cannot remember exactly when we started using 'syringe drivers' on the patients.

All of a sudden they were there. Their use caused me some concern and I was uncomfortable with their use.

This was because I felt that they were used too often.

Rather than being used to control pain they were used on patients who were approaching death and suffering from anxiety and distress.

The main medication used in the 'drivers' was Diamorphine. However, sometimes there would be an addictive or Midazolam.

The use of the 'driver' and the medication to be used within it would be prescribed by the doctor who covered the ward, who at that time was Doctor BARTON.

Then the decision when to use it would then be made by a Nurse who would choose the appropriate time.

However, I never made these decisions because they had to be made by a Senior Nurse.

My concerns were increased because it appeared that an awful lot of the patients that died were on syringe drivers.

Around this time the capacity at Redcliffe changed from 11 patients to 20, this was because the top floor was opened.

The type of patients we were receiving changed whereby we started having some with acute problems.

I discussed my concerns over the use of the drivers with Anita TUBBRITT, a Senior Nurse, and other nursing staff.

I recall that there was meetings with management at the hospital over the concerns that I and the other nursing staff had over the use of syringe drivers but I cannot recall anything about them.

I cannot remember what the management's response was to our concerns.

However, I have checked my training records and discovered that I received training on pain control and the use of syringe drivers on the 10/12/1990.

But I cannot recall if this was prior to or after the above incidents.

In regard to the use of syringe drivers by Nurses.

Because I am only an Enrolled Nurse I am not allowed to set them up. This can only be done by a Senior Nurse, and Enrolled Nurses can only assist.

Furthermore, it takes two Nurses to set a syringe driver up for use.

In the intervening years Anita has mentioned that she has papers relating to this period and the problems we had.

Approximately eight years ago we moved from the Redcliffe Annexe into the Dryad Ward at the new War Memorial Hospital.

Doctor BARTON has still remained the doctor who covered the ward until fairly recently.

Also throughout this time myself and some of the nursing staff have shared concerns over the use of syringe drivers.

I have worked at the Gosport War Memorial Hospital since 1981 to date. I wor k 10 hours one night every week.

I am aware that the 'papers' that Anita referred to over the years were handed over to the hospital management at a recent meeting.

I can confirm that I have never seen these papers.

I have always felt that Doctor BARTON and the Nursing Staff always acted in the best interest of the patients.

Just because I was concerned about the syringe drivers does not necessarily mean that their use was wrong.

Finally I never directly discussed my concerns with Doctor BARTON.