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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: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: DEPUTY NURSING MANAGER

This statement (consisting of 6 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: Code A Date: 02/07/2003

I am the above named person and I live at the address shown overleaf. I qualified as a nurse in April 1990 and between July 1990 and October 1991 I worked at the Redcliffe Annex of the Gosport War Memorial Hospital .

This was my first proper nursing post and from the outset I found the other staff very friendly. I was able to progress to an 'E' grade within six months. On the whole I felt that general patient care was excellent. This was in no small way due to the work of Gill HAMBLIN , the ward sister. Gill was someone who was what I would call a traditional ward sister. She made sure people worked hard and that patients were kept clean and given a very high level of nursing care.

However it is fair to say that whilst I was working at the hospital I did have several concerns regarding the use of syringe drivers and the use of diamorphine.

It appeared to me that if the ward sister stated a patient was in pain, she could call a local GP. This was normally Dr Jane BARTON . Dr BARTON would agree that diamorphine and give a starting dose over the phone. The driver would then be set up by two nurses. The procedure was that the doctor would do a visit within 24 hours to ensure that the drugs and the driver were being correctly used.

I was never present when Gill HAMBLIN called Dr BARTON but diamorphine would be prescribed with a note on the patients record that it was a telephone prescription. As far as I was concerned the follow up visit did not seem to happen. Since I left the GWMH I have

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worked as a Marie Curie/McMillan Nurse, my fears about the poor administration have been confirmed.

I also feel that there were cases when it was inappropriate to prescribe diamorphine. This is a drug that should only be used when a patient is in acute pain or long term terminal cancer cases. Patients were going onto diamorphine without having used the appropriate analgesic scale. In my opinion Gill HAMBLIN wanted to put patients onto diamorphine before it was required.

I also feel in hindsight that Dr BARTON was overly trusting of Gill HAMBLIN. I say this because Gill was able to call Dr BARTON and have patients placed on diamorphine without making a proper assessment first.

Once a patient was authorised to go on diamorphine it would be Gill who set up the syringe driver. She would show great care of the patients and spend time with the relatives. Although great care should be shown, it seemed that Gill would become obsessed about these people. It was as if she had an unhealthy interest in the death process.

At the time I found it unnerving, I would make excuses not to be around when the syringe drivers went up. I don't recall anyone going onto a syringe driver in the Redcliffe Annex who did not die. Of the patients that I recall one in particular has caused me real upset.

I only remember her as Marjorie we would call her Marjorie "Poop". She was a lady in her late 70's. She was a lovely person with a jolly demeanour. She could be quite demanding. She would bang her chair if she wanted something. She was one of our long term care cases. She had been at the hospital a couple of years prior to my arrival. Marjorie was in a wheelchair and this made her quite dependent on staff.

I recall that one day, I don't know when, she fell out of her wheelchair. She fell on the floor and because of the way she fell it appeared that she had fractured her neck of femur. I made her comfortable and called an ambulance. She went for an x-ray and it was discovered that there was no fracture but she did have bruising.

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The next day I was told off by Dr BARTON. She was quite severe and said "We don't do things like that here". I was told that it took money out of the budget. I thought Dr BARTON was wrong and I was angry. I told Dr BARTON that when I was trained I had been taught that if a patient fell they had an x-ray.

Marjorie was in some pain following the fall. I was told by someone, I don't know who, that Marjorie now had an abscess. Not long after this the syringe driver went up. I know that Gill set the driver up and I was told by another nurse that as Gill set it up Marjorie asked "Why are you doing this to me?". I think that Marjorie knew that this would lead to her death. Marjorie did not have any life threatening illness that required diamorphine. There are other cases that have caused me concern but I can't recall their names.

One lady in her 70's had a syringe driver put up out of the blue. Gill spoke with the relatives. She said to the relatives "Doesn't she look peaceful". She was a frail lady but I was not aware of any reason why she required diamorphine.

It seemed that people were going onto syringe drivers for no reason at all. They were not ill or in pain and yet they were dying shortly after going on the drivers. It was always Gill who was around when people went onto syringe drivers.

I began to share my concerns with other members of staff. Code A called a meeting with management, however I was unable to attend. Sue told me it was a waste of time. I don't know when the meeting was but it was prior to the death of Marjorie.

Even though I couldn't make the meeting I was supportive of Sue, I made no secret of the fact but after the meeting Gill didn't speak to me as much as she once had.

I left the hospital shortly afterwards. Looking back I am angry that management did not follow up the concerns of qualified staff.

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As a result of the training I have now had, I don't think Gill HAMBLIN had enough training in syringe drivers. In my opinion she needed this training to make proper informed decisions of when patients should go on the drivers. Gill did not consult other staff for their views. Therefore she was negligent in what she did.

I also feel that Dr BARTON was negligent in that she failed to maintain proper patient contact at critical times. As I have said she was overly trusting of Gill HAMBLIN's judgement.

With regard to Gill HAMBLIN I can't say that she intended to harm or kill any patient but she would have known the consequences of using the syringe driver.