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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: DOUGLAS, TINA MARIE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: STAFF NURSE

This statement (consisting of 4 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: J M DOUGLAS Date: 09/10/2003

I am the above named person and I live at the address shown overleaf. I qualified as an RGN in 1988 and in 1993 I started work at the Gosport War Memorial Hospital . I worked at the GWMH for a period of about ten years before I left in September 2003. During this period I worked at other hospitals.

I worked at various hospitals in the UK and abroad prior to working at the GWMH. I started on nights working on various wards including Daedelus and Sultan. When I started at the hospital I would describe general patient care as very good. Most staff seemed to want to do the best for the patients. However from an early stage I had some concerns about the use of syringe drivers and the drugs being used.

In the other hospitals I had worked at the use of syringe drivers was limited. However at the GWMH drivers seemed to be used more frequently. At this time I had not had any formal training in the use of drivers. I had had what I would call on the job training which in those days was more common than it is today.

I was fully aware of the benefits of the drivers and although their use was more frequent my concerns were with specific patients as opposed to the general use.

The first case I recall related to a lady called Sylvia , I do not know her last name. When I started work at the Redcliffe Annex Sylvia was already on a driver giving her diamorphine. I was surprised at the levels of diamorphine being given, Sylvia had had a stroke and was on 1.2gms of diamorphine per 24 hours. I had not previously seen such a high dose in a patient

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with that sort of condition.

I did address my concerns to senior nursing staff, however nothing seemed to happen. I don't recall when Sylvia died but it was not immediate. I don't know who the doctor who prescribed the drug was but the doctor on the ward as I recall was Dr BARTON . The Sylvia incident was in 1994.

I then moved to the QA hospital , returning in 1995 as an F Grade on Dryad Ward under sister Gill HAMBLIN . Gill was very good at basic nursing care, however I feel that on reflection she lacked some aspects of nursing knowledge and experience. Her management style left much to be desired. Gill would, in my opinion, belittle and bully staff. It was very much her word and what she said went. It was difficult to implement up to date practice and to challenge current practice was not encouraged.

Dr BARTON was the doctor on the ward. She and Gill HAMBLIN had a close working relationship, Dr BARTON respected Gill HAMBLIN as a nurse. Drugs were prescribed to patients more or less on their arrival. This included diamorphine a Midazolan and meant that it became a nurses decision as to when a patient would start on a particular drug. I had never seen this practice before. It created a grey area of when a patient should go on a certain type of medication, based on the individual opinion, at that time.

I recall one particular case on Dryad Ward of a lady called Bernice WHITE . Mrs WHITE was elderly, in her late 70's, 80's, I don't however recall her medical condition but she had the shakes. It was discovered that she had developed the shakes as a side effect of the increase in her morphine. The morphine was reduced and Mrs WHITE continued to live for some time.

On another occasion I recall a patient named Diana WHITE . She was elderly and suffered from dementia, she would squeal and Dr BARTON prescribed, diamorphine and Fentanyl patch, she was already on aromorph. I did not think Mrs WHITE should be on all three drugs. I phoned Dr BARTON at home and told her this. Dr BARTON was reasonable but said that in her opinion she should be on these drugs. From what I can recall we didn't give all the drugs

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and monitored the patient.

Since the start of investigations at the GWMH I have been spoken to by CHI but not the police. Syringe drivers are now used a lot les than they once were. I think that some staff lacked the full knowledge of the analgesic ladder . People went onto Morphine without starting at the bottom the ladder. There have been efforts to improve this.

At no stage did I ever witness or feel that any member of staff did anything to harm a patient. In 1995 I undertook a palliative care course to help increase my knowledge and to pass this onto members of staff. Gill HAMBLIN said this would help staff to overcome the 'myths of morphine'.

At the GWMH there remains a small hospital culture, in that there is a resistance to change and a lack of turnover of staff meaning that poor practice could continue. As far as I am aware there is still no use of pain charts.

I feel quite sad that all this has happened and hope that something positive comes out of it for the patients. I do know that the morale of all the nursing staff has been effected by this.

I wish to add that I did not share my concerns with CHI because I wasn't asked. The questioned they asked were quite direct.