RESTRICTED

STATEMENT

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Signed Name	[S GIFFIN]
Telephone No	Code A
Postcode	
Date Of Birth	
Occupation	[RETIRED NURSE]
Address	Code A
Forename 1	[SYLVIA]
Surname	[GIFFIN]

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

I am a trained nurse and was until recently employed by the Portsmouth Health Trust at Gosport War Memorial Hospital < span class="holmesRecord" id="E1">/C35 .

I commenced training as a nurse in 1956 and after I completed training I began working as a State Registered Nurse at the St M ary's Hospital, Portsmouth /cat /L6 .

In 1973 I commenced work at the Gosport War Memorial Hospital in Gosport.

I worked at the Redcliffe Annexe which was a unit based approximately half a mile from the main hospital site. The Redcliffe Annexe was a unit of about 17 b eds used for the elderly patients, who were coming to the end of their lives. I worked happily at the unit and felt that we treated the patients well and that we made them comfortable as they approached the end of their life. This wa s based on a 'tender, loving care' type of treatment.

However this all changed when Gill HAMBLIN /N131 took over as the sister for the unit in the early nineties. It seemed that she had a vendetta against people she did not like. She made it obvious that she did not like the night staff and she targeted me in particular.

I remember on one occasion that Isobel EVANS /N136 , the senior nurse in charge of the unit, visited us early one morning stating that HAMBLIN had complained about our work.

However, EVANS congratulated us because she could not find any problems.

The other problems with HAMBLIN was that she encouraged the use of syringe drivers.</p>

A syringe driver is a syringe attached to the patient that injects them over a 24 hour period to give constant pain relief.

Prior to HAMBLIN coming to the unit we rarely used the syringe drivers. However when she arrived their use escalated, although this was at the time when they were initially introduced. I felt this was wrong, because it seemed that most patients were going on drivers even when they were not in pain and their use was a matter of course rather than need. Therefore they were going to meet their 'maker' full of drugs. I felt that in the right circumstances the syringe drivers were the correct method to ease pain. But I did not agree with their 'blanket' use on patients.

The other problem with the syringe drivers was the fact that when they were first introduced we did not receive any formal training on their usage.

Another problem was the fact that on nights there was only one trained nurse and two untrained healthcare workers. Which meant that when I was on duty at night , I was the only trained nurse in the unit.

There was no medical care at night therefore if there was any problems with the patients and the drivers, I had to contact the main hospital unit.

The decision to place patients on the syringe drivers was entirely down to the doctor responsible for the ward. This was Doctor BARTON /N34 , she was the unit doctor for several years.

I got on well with Doctor BARTON and felt she was a competent doctor.

However what usually happened was that Doctor BARTON would 'sign up' that a patient was suitable to be placed on a syringe driver then HAMBLIN or one of the duty staff would decide if and when it was necessary to place the patient on it This meant that if the drivers were required in HAMBLIN's opinion, the authority was already signed.

Eventually I spoke to my colleagues at the unit about my concerns over the drivers. I remember we had a meeting and it seemed that they shared my concerns. Howe ver when I complained to the management they did not support me because they were frightened of losing their jobs.

It was not until Anita TUBBRITT /N7 , another nurse, became involved that I got any real support. Though I did approach Sister GOLDSMITH /N123 who was based at the main hospital building and she was also supportive.

Finally I contacted my union rep, Keith MURRAY /N135 , who wrote to Isobel EVANS, the general manager for the nursing staff and conveyed my concerns.

Various meetings between staff and management were arranged but these were mainly aimed at pacifying our fears and make us feel that something was being done.

We also had a meeting with the 'pain control people' in order to train us in the use of the syringe drivers.

I remember at one meeting Doctor BARTON stated that she felt we were accusing her of euthanasia. Despite these meetings and my protestations the use of syri nge drivers continued to increase.

I cannot remember the names of any patients that I felt suffered or died because of the syringe drivers but I do recall on one occasion that Doctor BARTON asked my advice in regard to a patient that was on Valium, that HAMBLIN wanted to place on a syringe driver.

I told her that I thought it was unfair to do this and that she should be placed back on Valium/Diazepam. She was placed back on Valium and lived for a fur ther ten years.

Another problem with the drivers that continued after the meetings was although the correct dosage of say Diamorphine was given to them, the dosage would automatically increase once they got used to it. This would also upset me a great deal.

I also recall that a check at the pharmacy revealed that the Redcliffe Annexe was using more painkillers than other similar units, which tends to support the above claim.

Eventually I gave up complaining despite the fact I was not happy with what was occurring.</p>

After a few years we moved to the new hospital building and we worked in different wards. Until after sometime we were once again 'ward based' and I ended up on Daedalus Ward.

In September 2002 I left the nursing profession after being on sick leave for a year with stress brought about by the problems I was having at the hospital.

A few weeks ago I became aware that there was an enquiry into work procedures at the hospital. Therefore I sent Anita TUBBRITT copies of paperwork I had sa ved from the 1991 episode. This consisted of letters, reports and minutes of meetings.

I would like to add that I worked on nights at the Redcliffe Annexe for ten years before someone died on nights.

However once HAMBLIN arrived it became a regular occurrence, I can even remember one of the ambulance drivers joking about it.

On Thursday 12th December 20 02 (12/12/2002) I gave Code A several documents I have retained relating to the incidents I have mention ed in this statement.

These documents have given identification reference SG/GWMH/1. /X146