WITNESS STATEMENT

STATEMENT OF **GILLIAN ELIZABETH HAMBLIN**

AGE: OVER 18

This Statement consisting of 13 pages 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 in it anything which I know to be false or do not believe to be true.

DATED this 23rd day of October 2007

Signed .. Code A .....

GILLIAN ELIZABETH HAMBLIN

I am Gillian Elizabeth Hamblin of Code A

I am a Registered General Nurse, having qualified in 1970. I had first become involved in nursing in 1965 as a cadet and commenced a three year qualification course in 1967 at Hackney Hospital, East London, working on all wards until my qualification as a Registered Staff Nurse on a Surgical Ward.

Following my qualification I worked in a variety of hospital posts before taking up an appointment as a nurse at the Gosport War Memorial Hospital in 1976. At that time, the Hospital had a male ward, a female ward, a further ward for children, together with a casualty department, an out-patients department and an operating theatre. Each patient at the Hospital would be looked after by his or her own General Practitioner.

Signed. Code A .....Witnessed... Code A .....

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After about 18 months, I moved away from the Gosport area. My late husband was in the Royal Navy and was posted to other parts of the country. I therefore held various positions at other hospitals, before returning to the Gosport War Memorial Hospital in 1987 and moving to the Redclyffe Annex in February 1988. Initially, I held the post of Staff Nurse on the Redclyffe Annex, which was located a short distance from the main hospital, dealing with palliative care and long stay patients. In due course the structure of the Hospital then changed, with the male ward becoming known as the Daedelus Ward, and taking both male and female patients, and Redclyffe annex moving to the main hospital and becoming Dryad Ward in about 1995. I then became the Nursing Sister on Dryad Ward. Dryad Ward would deal with continuing care patients, palliative and terminal care, post-operation and fracture patients generally of the age of 65.

Over a period of time the bed occupancy rate on the Ward increased. Consultant Geriatrician, Dr Ian Reed decided that the Ward should be taking more patients in order to free beds at the Queen Alexandra Hospital. The nature of the conditions from which the patients suffered also changed over time. This process of change in terms of the nature and dependency of patients changed gradually over a period of time. By the mid 1990s the position was becoming problematic, and it steadily escalated from that point. Patients would be transferred to the Ward with a much greater level of dependency, and indeed patients would come to us when they were more acutely ill, still requiring acute care, when previously they would have been kept in a hospital elsewhere for a longer period of time, and would have been more stable on transfer to us at the Gosport War Memorial Hospital. We had a greater level of orthopaedic cases, and experienced difficulties as we were a continuing care ward, so we were not entitled to occupational therapy and thus physiotherapy.

I recall telling Dr Reed that in order to take such patients we would need other services such as physiotherapy, but this never materialised. I recall that I specifically raised my concerns about resources and the fact that it was not appropriate to transfer patients to the Ward in many instances when Consultant Dr Ian Reed became Medical Director. I met with him and with Barbara Robinson, the Patients Services Manager. I recall that Dr Reed said words to the effect

"We'll sort it out Gill", but in fact no changes were forthcoming. Unfortunately, this appeared to be a standard response on the part of Dr Reed. The Physiotherapy Department did try to help by showing Ward Nurses what to do by way of physiotherapy, but this was on an ad hoc basis, and not satisfactory. We also required input from the Occupational Therapy Department. This too was only provided on an ad hoc basis.

Although there was this increasing demand in terms of numbers of patients and their dependency, there was no increase in staff numbers. This was again a matter which I endeavoured to raise with managers, including Barbara Robinson, but nothing resulted from it, and we were simply told that we had to get on with it.

For much of my time as Sister in Charge of Dryad Ward, medical input was provided by a Consultant and a part-time Clinical Assistant. The Consultants changed regularly over the years. The Consultant would attend once a fortnight to carry out a Ward Round, unless he or she was unavailable, for example, on holiday, when no consultant would then attend for a month. One or two of the Consultants were helpful in giving advice if required at other times. By way of example, Dr Althea Lord, was willing to be contacted at any time. By contrast, however, on the occasions when I endeavoured to telephone Dr Ian Reed, he would simply indicate that the relevant General Practitioner on duty should be contacted, so that ultimately I did not consider that it was worthwhile contacting him.

Consultant input did ultimately increase following a complaint about a matter which I think may have arisen at some stage in 2000, and Consultant Ward Rounds were then carried out once a week.

For much of the time I was responsible for Dryad Ward the Clinical Assistant was Dr Jane Barton, a local General Practitioner. In addition, she was Clinical Assistant to Daedelus and Sultan Wards. I believe that she was appointed as Clinical Assistant in October 1988, resigning in 2000.

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Dr Barton's position throughout the time that she was employed as Clinical Assistant was a part-time one. She did, however, carry out a significant amount of work even on that part-time basis. Following Dr Barton's departure in 2000, a full time Clinical Assistant was appointed in her place, Dr Joseph Yikona, to carry out the same work Dr Barton had done on a part time basis.

In my position as Ward Sister I was able to assess the medical and nursing requirements. It was clear to me that Dr Barton had way too much work to do particularly as the demands of patient numbers and dependency increased. I recall Dr Yikona complaining one day about the amount of work he had to do, and I made the response: *"How do you think Dr Barton felt, and she had Sultan Ward as well which you don't have"*.

I do not believe that Dr Barton had adequate consultant backup and support. As an example of the lack of consultant involvement, in my time as a Sister on Dryad Ward, I was not aware of any calls from consultants in order to check on patients under their care.

A once a fortnight Ward Round was, in my view, in no way adequate in dealing with the needs of patients certainly from the mid 1990s onwards, and for the support of the Nursing Staff and Dr Barton.

Throughout my time as sister in charge of Dryad Ward, there was no increase in numbers of nursing staff. The various consultants were aware of the problems in relation to staff numbers, but did not seem to be able to do anything about it. I felt able to raise the issue of nursing staff, expressing my concern, but the culture at the time was not such that this enabled me to raise the question of the lack of medical resources.

I recall that at one stage I arranged for all the Nurses on Dryad Ward to talk to Dr Ian Reed to discuss our concerns about nursing numbers. I cannot now recall precisely when this meeting took place, but I am clear that nothing resulted from it by way of any increase in nursing numbers. Indeed, I recall that at the end of the meeting Dr Reed came to me to indicate that he

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would not be available on the Ward for a period of 6 weeks and that it would be necessary to employ a locum.

I left the Gosport War Memorial Hospital in 2004, having been on sick leave from 2002.

From my years of experience in working with Dr Barton, I can say that she was fantastic with all of our patients. As a part-time Clinical Assistant, she would come to the Hospital at about 7:30 each weekday morning, and carry out a ward round, seeing every patient. The Ward Round would be carried out with me if I was on duty or with one of the senior nurses if I was off. Every patient on the Ward would be seen her, and she would endeavour to speak with each of them. She was concerned to get to know them and their families. On the Ward Round we would report to her about the patient's condition, and what might have happened over night. Dr Barton would not examine each of the patient's records as a routine, but only those we directed, where the patient needed more by way of review, or for example, if results had become available and further assessment of a patient was then needed. Dr Barton would then leave Dryad Ward at about 8:00a.m., in order to carry out a similar Ward Round on Daedelus Ward. Having completed that Ward Round she would then leave the Hospital to attend at her local surgery.

On the Ward Round Dr Barton would examine the patient if there was any particular problem or concern, as needs be. In many instances, given the nature of the patients on the Ward, the nature of the problem more often than not was related to the patient's chest.

Dr Barton would then return to the Ward at lunchtime on at least 3 of the 5 weekdays, in order to clerk in patients who had been admitted, or review patients further if they were ill or deteriorating. She would also be willing to see relatives if they were concerned to meet with her then. Similarly, Dr Barton would return to the Hospital in the evening to see patients, if there were problems and we needed her assistance, and again to see relatives. The need for her to attend in the evenings was generally less than at lunchtimes, but she would certainly be willing to come to the Ward if it was necessary. Indeed, Dr Barton made it perfectly clear that the Nursing

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Staff could call her at any time to review a patient's condition or for advice, and she was entirely happy with this.

In addition, Dr Barton would generally attend the Consultant Ward Round once a fortnight, though on occasions she had to cut this short in order to attend a session at her GP Surgery.

If we needed to contact Dr Barton on the telephone, we would generally do this up until about 7:00p.m. In my experience it was rarely necessary to contact the Doctor after that time, although there were occasions when we called her beyond 7:00p.m., for example, if we had concerns about a particular patient or were dealing with a particular family. The only time when we tried to leave her was in peace when she had a weekend off, not being on-call as a GP over the weekend. When Dr Barton was not due to be on-call at a weekend she would come in on the Friday and go through absolutely everything with us to make sure that all that needed to be done was done with us and for the patients, and I would describe her as fantastic in this regard.

As some measure of the way in which we found her assistance to be of a very high order, we felt lost when she was off on holiday or away ill. Her GP partners who stood in for her did not achieve the same standard in her place.

When a patient was admitted to Dryad Ward, a member of the Nursing Staff would carry out routine observations including blood pressure, temperature, pulse and testing the patient's urine. A nurse would always be present when clerking in by Dr Barton took place so I was present on many occasions when Dr Barton then proceeded with her review. In my experience, the nature of the patient's medical notes which were available on transfer varied. Sometimes all the notes were available, sometimes a limited selection, and on occasions nothing at all. Dr Barton would, if the material was available, scan the history in relation to the admission, and would then carry out a full assessment as I would expect on a full clerking in by the Doctor. Although she would not re-do the basic observations already carried out by a member of the Nursing Staff, she would review the relevant body systems, including chest and abdomen, and of course paying attention to any relevant area or condition from the patient's history.

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I am conscious that Dr Barton's entries in the medical records were brief. This was so both for her initial assessment or clerking in, and her subsequent reviews of patients. Her notes did not reflect all of the various things which were actually undertaken for the patient. The initial assessment would be a full one, even if not noted in a comprehensive fashion. In my view, the important points in relation to the patient's were written down, but Dr Barton would not repeat what was already contained in nursing notes or list a whole series of negative findings. From my experience over the years in working with Dr Barton, it was quite clear to me that her notes were necessarily brief, resulting from the considerable demands on her time. Quite simply, she had so much to do that it was not possible for her to attend to all of her clinical duties in seeing and assessing, and indeed caring for the patients, and then making comprehensive notes about her reviews. In my view, the quality of her care was not compromised or limited, but given the constraints on time, she had no alternative but to keep her notes more limited in order for her to cope.

I am conscious at the same time that the nursing records were not as extensive as might be found elsewhere, and similarly these deficiencies were attributable to pressure of time. The choice was one of limited care and the completion of paperwork, or proper provision of care, with paperwork suffering on occasion. This was essentially the same choice facing Dr Barton.

Dr Yikona's hours were generally 9:00a.m. to 5:00p.m., although I recall that there was occasions when he was there until 7:00p.m. catching up with her paperwork. In my view, the actual amount of medical care delivered by Dr Barton was no less than that provided by Dr Yikona. The difference between them was that Dr Yikona would have the opportunity to write- up medical records due to the greater amount of time available to him. The only difference in terms of delivery of care was that it was possible for Dr Yikona to take bloods and arrange x-rays rather than waiting for another team member to do this.

I recall that over time a practice of prescribing medication on an advance basis arose at the Redclyffe Annex. We would find that it was necessary to ring a GP at a weekend in order to

commence a small dose of medication or if it was necessary to increase medication in the context of providing palliative care to patients where there could be a developing level of pain and distress, and an increase in tolerance of medication. The practice developed with patients who were perceived to be terminally ill and an increase in medication might be required, anticipating that it might not be easy to contact a doctor to enable the medication to be given, for example, at weekends. I recall that when Dr Barton originally took up her post in 1988, some General Practitioners when on duty at weekends would not be willing to come in when requested, but would delay for a period until it was convenient for them, with the result that patients might be in pain for a long time. The situation therefore developed whereby Dr Barton would write up medication with a range of dose specified which might then be given if the circumstances merited it. This was a practice which arose at a point at which Dr Barton had come to know the Nursing Staff well, and similarly, we had come to know her well, so that there was significant and appropriate mutual trust between us all. Accordingly, it came to be the position that if Dr Barton on admission or indeed subsequently, perceived that a patient might become terminally ill, she would be prepared to prescribe medication which might be appropriate by way of palliative care on an advance basis, with a dose range. On occasion, it was not actually necessary to administer medication prescribed in this way. It was, however, available if necessary.

I felt that the Nursing Staff had adequate training and information concerning palliative care and treatment. Dr Beewee, Consultant on Oncology at the Countess Mountbatten Hospital, would come to give us lectures in palliative care and, for example, use of syringe drivers. In addition, it was possible for us to contact doctors at the Countess Mountbatten Hospital, and the Rowens, a local hospice, if further advice was needed. With this knowledge and access to advice, and from the experience of working together, there was an appropriate level of trust between Dr Barton and the Nursing Staff, that the Nursing Staff were in a position to evaluate the needs of a patient in terms of relief from pain and distress, and consider what would be appropriate by way of a starting dose of medication to relieve these, or indeed by way of increase in such medication.

In my direct experience, the vast majority of initiations of such medication, and increases in it, took place during the day. Indeed, increases in or initiation of such medication might take place

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in consequence of the Ward Round conducted with Dr Barton even if the actual administration of medication or its increase was commenced later on. Similarly, such increase or initiation might take place after a discussion at lunchtime or in the evening, directly with Dr Barton. If, however, such liaison with Dr Barton being present was not possible, Dr Barton would be phoned when the initiation or increase in medication took place.

On occasion liaison with Dr Barton took place after the increase in medication – had been initiated, but in those circumstances it would very shortly after, and Dr Barton would at that point have the opportunity to review the position.

In the event that Dr Barton was on duty at a weekend, she would be contacted in this way in the event that it became necessary to consider an increase in or initiation of medication. If, however, she was not on duty at a weekend we would tend not to phone her, but would contact the Duty GP. In my experience, the Duty GP would generally review the position over the telephone with the benefit of the prescription already made by Dr Barton.

In my experience Dr Peters was the only GP who did not like authorising the administration of medication with an advance prescription in this way. Accordingly, the Nursing Staff would tend to ring Dr Althea Lord in the event that Dr Peters was on duty. Dr Lord was herself entirely contact to consider initiations and increases of medication on the basis of such advance prescriptions.

From my own knowledge, every consultant responsible for Dryad Ward was aware of this practice of advance prescribing. It would have been readily apparent to the Consultants when carrying out a Ward Round, simply from reviewing the Drug Charts of patients where such prescriptions had been recorded. Each consultant reviewed drug charts with such prescriptions in my presence on ward rounds. From my knowledge, through discussion with all the various Consultants, all were aware of how this system of prescribing operated. I am aware that Dr Lord would write such prescriptions herself when she considered it appropriate, had it not already been done by Dr Barton. Dr Jane Tandy too adopted this practice. Although aware of it, no consultant

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ever raised any concern about this prescribing practice with me, neither was I aware of any expression of concern by Consultants to anyone else. No restriction on this arrangement was indicated to the Nursing Staff by any of the Consultants, and there was never any indication that the arrangement should not be applied.

When reviewing matters with Dr Barton, or when she was on holiday or not on duty at a weekend, with other doctors, there would be a substantive discussion about the patient's condition and the nature and extent of any pain and distress, and the circumstances in which that was presenting at the time. In reviewing a patient's pain and distress, in my experience the Nursing Staff were always concerned to consider the cause of the pain, for example, if it might put you through repositioning of the patient, in which the increase in medication was potentially not required.

I am aware that from time to time Dr Barton recorded in the records a phrase to the effect: *"I am happy for the Nursing Staff to confirm death"*. I understood from this that Dr Barton would necessarily need to be contacted, for example if a patient died at night or when Dr Barton was conducting a GP Surgery session, simply for her to confirm death. Formal certification of death was of course another matter entirely. The nature of the patients admitted to the Ward, and the nature of their conditions was such that a not insignificant number of patients admitted would die on the Ward. The understanding Dr Barton and I had from this phrase was that she recognised the potential of the patient to die, not that she believed the patient necessarily would die.

Sadly it was the case that patients were transferred to Dryad Ward in a state in which they were dying. Indeed, we had patients admitted who died within 2 hours of admission as their transfer had clearly been inappropriate given their condition at the time. As I understood the position, such transfers would take place in order to free beds elsewhere. Towards the end of my time as Sister on Dryad Ward it became standard practice for one of the Mangers to ring the ward to ask how many beds were available, and if any patient had died overnight. If a patient had died, the Manager would then ring the Queen Alexandra Hospital in order to advise them, and a patient could then be admitted. I became disgusted by the way in which patients were admitted to the

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Ward in a condition which clearly indicated such a transfer should not have taken place, but unfortunately there was nothing I could do in this regard. It was simply something which was way beyond nursing control, and as nurses all we could do was care for the patients as best we could.

The inappropriate transfer of patients in this way was something which developed over time. As there appeared to be a greater developing pressure on the Queen Alexandra Hospital, so there was a corresponding increase in pressure on us through the admission of such patients.

I am not aware that any of the Consultants raised concerns with Dr Barton, or with members of the Nursing Staff about her general standard of care of patients, her note keeping, the extent of her initial and subsequent assessment of patients, or her prescribing practice. Similarly, I am not aware of anyone else expressing any such concerns. No such concerns were ever expressed to me directly at any time. For my own part, I had no such concerns about Dr Barton's practice.

In my experience, Dr Barton had a gift for assessing patients, being able to review their condition and know what was right for them. I have not encountered a General Practitioner in my practice who had that quality. As a reflection of my view, I would be entirely happy to have Dr Barton as my own GP.

In my view, Dr Barton was a very caring person, and I was unable to fault her at all. I believe that my nursing colleagues were of the same opinion. It was possible for us to make contact with her at any time, even when she was not on duty. Her attitude towards patients was brilliant, and our patients idolised her. I do not recall any patient having a bad word for her. Dr Barton was always professional, and she would go the extra mile to get anything which a patient might require. She was by some very considerable distance the most caring doctor with whom I have worked.

As nurses we found that she was always willing to listen to us. If on a very rare occasion I was concerned about a dose of a drug, I was able to say so to Dr Barton. A starting dose might have

been recorded as 20mgs of Diamorphine, for example, and we might have considered that 10mgs was appropriate. I found that Dr Barton was entirely willing to discuss such issues and to agree when appropriate. In fact, my recollection is that on occasions when I considered that a smaller starting dose might be appropriate, and that was then initiated, it then became apparent that an increase to the starting dose previously prescribed by Dr Barton was in fact necessary. In my experience, Dr Barton never had any concern about a nurse raising a prescribing issue with her, and she was more than willing to discuss such matters with us.

I found Dr Barton to be extremely hard working. Dr Barton was also compassionate, listening to patients and relatives. At the same time, she would 'call a spade a spade'. This was not a lack of compassion on her part. She was, for example, anxious to know that relatives should know where they stood, and that she did not dress up matters in order to make them more palatable.

I am aware from direct discussion with all of my nursing colleagues on the Ward that we all felt highly of her. I never doubted her ability, or indeed had any cause to, and no member of the Nursing Staff suggested otherwise to me.

All of us were profoundly concerned when Dr Barton came under investigation. We went to Dr Lord, asking her what we could do to help her, but were told: *"Nothing – keep quiet!"*.

In the course of police investigation in relation to the treatment of patients at the Gosport War Memorial Hospital, I made a statement on 16 March 2005. In that statement, on page 2 the following observation was recorded: *"On their visits Dr Barton would prescribe the drugs that were required by each patient. This was a new concept to staff at this time."*

I do not know quite what I had been asked by the Police to produce this observation. I believe I may have been referring to the fact that syringe drivers were a new development on the Ward at one stage, and that Dr Barton would write up the drugs for that as required.

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In discussing matters with relatives, including use of syringe drivers, both the Nursing Staff and Dr Barton would take time with relatives to explain what they involved, and why they were necessary. Sometimes relatives would be concerned that a relative might need an increase in medication because of pain which was apparent to them on a visit, and we would ensure then that the patient was reviewed and the issue discussed with the relatives. In my experience, we spent hours with relatives, and Dr Barton gave them as much time as she physically could.

In a further statement to the Police dated 30 September 2005 it is recorded that I stated the following: *"The practice of increasing the dosage to alleviate and pain and anxiety was not always recorded as it was evident that the patient needed the increase."*

By this I meant that the reasons for the increase in medication were not always recorded – not the actual fact of the increase itself. As I have indicated, the pressures of time, with the increase in numbers and dependency of patients, but without a corresponding increase in staff, meant that we were not in a position to make as detailed records as we might have wished.

Signed. Code A ..... Witnessed..... Code A .....