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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: SHAW, FREDA VAUGHAN

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

This statement (consisting of 5 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: F V SHAW Date: 06/08/2004

I am the above named person and I reside at an address known to the Hampshire Police.

I am a registered general nurse. My Nursing Midwifery Council Number is Code A

I qualified as a registered nurse for mentally handicapped nurse in 1975. This was in Lennox Castle Hospital, Lennox Town, near Glasgow.

I then qualified as a registered general nurse in 1977 at the Argyle and Bute College of Nursing and Midwifery in Greenock. To obtain this qualification I undertook an 18 month post registration course.

I worked for a further year in Broadfield Hospital Port Glasgow, Scotland, I finished working at this hospital in July 1978.

I then left the nursing profession in 1978 and then had a variety of nursing jobs until March 1992.

In March 1992 I started work as a staff nurse at the Redcliffe Annex, The Avenue, Gosport which was part of the Gosport War Memorial Hospital.

I believe it was in 1995 the Annex was closed down and all our patients were transferred to the Dryad Ward as were the staff.

RESTRICTED

I have been working at the Gosport War Memorial Hospital since 1992. I commenced as a D Grade Staff Nurse. In 1994 I then qualified as an E Grade Staff Nurse.

I am currently working on the Dryad Ward as an E Grade Staff Nurse.

My role responsibilities on the ward in the absence of senior staff. I then take charge of the ward. I supervise health care support workers and junior staff. I am also responsible for the training of student nurses who are on placement at the ward.

Dryad Ward consists of 20 beds. The ward primarily consists of elderly patients over the age of 65. The majority are fully dependent on nursing care. The patients are initially in the ward for a 4-6 week period.

I have received on the job training from other trained senior staff with regards to the usage of syringe drivers . I believe I first starting using these drivers in or around 1992. I have also attended study days in connection with the manufacturers requirements relating to syringe drivers.

A syringe driver is a small battery operated motorised syringe pump which has been designed to deliver a constant dosage of medication over a set period of time. It is primarily used for continuous pain relief to patients. It can also be used on patients who are very ill to prevent nausea.

The only person who can authorise the usage of drugs administered through a syringe driver is a doctor. As far as I can recollect it was policy in the early years to allow up to 3 different drugs to be administered via the syringe driver in one dosage over a set period of time.

The policy has been changed since the (CHI) Commission for Health Improvement enquiry which was conducted around 2000.

It is now standard practice to only mix 2 different drugs in the one syringe driver. If more than

RESTRICTED

2 drugs are required to be administered then either another syringe driver is set up for the patient or the drug is administered directly by injection by a trained nursing member of staff.

I have been asked to detail my involvement in the care and treatment of Code A dob Code A who was a patient on Dryad Ward in 1996. Firstly I cannot remember anything about this patient. From memory and referral to entries in his medical notes.

I have been shown a printed copy of a microfiche exhibit reference BJC71.

I can confirm that I have made an entry on page 24 of this exhibit commencing as follows.

Past History - long term psychiatric problems (depression). Has been in Hazledene Rest Home for past 7 months as wife unable to cope with decreasing mobility.

Has had recent falls due to decreasing mobility.

Reluctant at times to eat and drink.

Catheterised on the 23/12/95 (23/12/1995) due to fluid retention.

This observation has been written on the rear of the admission notes for the patient, Code A Code A

In relation to this entry 'catheterised', this means that patient has had a tube inserted through the penis into the bladder in order that urine can be drained from the bladder.

I can confirm that I have written an entry on page 25 dated 5/1/96 (05/01/1996) as follows:-

Transferred from Mulberry Ward at lunchtime. Appears to have settled well. Wife and daughter visited this afternoon. Les has a sore on (R) buttock which has granuflex on - same left intact. (L) buttock dressing removed and granuflex applied. Scrotum sore and broken, left

RESTRICTED

dry. Has taken a small amount of puree as reluctant to eat sandwiches, needs to be encouraged with diet and fluids. Catheter bag changed and dated.

Where I have written (R) this means right. Granuflex is the name of a type of dressing used on the ward for the treatment of pressure sores. (L) = left.

With regards to the entry commencing 'Scrotum', I have noted that the skin on the scrotum is very dry and the skin is cracked. 'Left dry' means I have not given any treatment.

I can confirm that I have written the following entry on page 35 of Code A s nursing care plan as follows

'Bed bath' given, liquid paraffin to penis, scrotum and sacrum (small of the back). This entry is dated 15/1/96 (15/01/1996). The next entry is dated 19/1/96 (19/01/1996) commencing

'Bed bath - navel cleaned and mouth care given.

Liquid paraffin to scrotum and penis given.

Navel relates to the belly button.

I can confirm that the patient, Code A (after reading his notes) had the following care plans administered to him after examination on his initial admission to Dryad Ward. They were as follows

Hygiene care plan - ie, the patient's washing personal hygiene.

Catheter care plan - ie, the care of the patient's fluid output.

Pressure or wound care plan - this would be the monitoring of the patient's skin condition and any sores, specifically this related to Code A 's scrotum, his sacrial area (small of

RESTRICTED

back).

There was also a diet and fluid intake care plan. The patient was monitored with regards to what he eats and drinks.

There was a sleep care plan. The patient was monitored during sleep time. They would be asked how they like to be settled during the night.

The above care plans would be adhered to by all the nursing staff treating the patient Code A

Code A

I have checked the drugs chart for this patient. I can confirm that I did not administer any drugs.

The care plans as shown above detail what treatment Code A received whilst on Dryad Ward.

Taken by: DC Code A

Signed: F V SHAW

Signature Witnessed by:

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