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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: RING, SHARON BARBARA

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: TEAM LEADER SOCIAL SERVICES

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: S RING Date: 25/10/2004

I am currently employed as a team leader for home care for the elderly (over 65's) by the Social Services Department. This is the Fareham and Gosport home service. I run the rapid response team for both areas.

Between May 1976 and May 1979 I trained as a student nurse, I qualified as a State Registered Nurse in May 1979. During this period I worked for the Portsmouth and South East Health Authority. I worked at St Mary's and the Royal Hospital.

My Nursing Midwifery Council PIN number is Code A From May 1979 I worked on B3 the female geriatric ward at St Mary's Hospital as a junior staff nurse.

In 1981 I commenced by midwifery training (which was an 18 month course). I did not complete this course due to falling pregnant. I left in either November or December of 1982.

During the period between 1983 to 1986 I worked part time as a staff nurse on night duty at the Thalassa and Bury Lodge both nursing homes for the elderly, situated in Gosport. At this time I only worked 2 night duties per week.

Around June 1986 I left nursing to start up my own business running a shop for the sale of baby goods and clothes called Bambino's in the Precinct, Gosport.

I ran this business until the beginning of 1990.

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From the beginning of 1990 until September 1991 I was employed by the Ministry of Defence as a clerical officer at HMS Centurion which was the pay and pensions department for the armed services.

From September 1991 I then re applied to work as a nurse with the Portsmouth Health Care Trust. I started work at Redcliffe Annex in The Avenue, Gosport . This unit was a long stay unit for the elderly, ie, patients over the age of 65 years.

Initially I was only working part time as a D Grade registered general nurse (RGN).

Prior to restarting as a nurse I was required to re register with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

At this time whilst working at Redcliffe Annex I was working with Sue DONNE the Senior Staff Nurse F Grade RGN, Lynn BARRAT E Grade RGN and Gill HAMBLIN G Grade RGN who was the Ward Manager.

As a D Grade RGN I was a junior staff nurse. I always worked with a Senior Staff Nurse.

During this initial period that I was working at the Redcliffe Annex I updated my knowledge concerning nursing and healthcare by reading the Nursing Standard and Nursing Times.

Although I know I received training in connection with the use of syringe drivers I cannot remember the dates or where this training took place. However I would not have been allowed to use or set up a syringe driver without the appropriate training.

I cannot specifically remember using syringe drivers at the Redcliffe Annex.

With regards to the use of a syringe driver I am aware that it can only be used on the authority of a prescribed prescription written by a Doctor.

The use of a syringe driver is only authorised after discussions amongst the medical team and nursing staff have reviewed the patient's pain relief/control and the analgesic ladder had been followed re starting with simple paracetamol, distalgesics, then co-dyramol, a codeine based analgesics and when the ladder had been followed then morphiates would then be the next consideration.

Once the authority for a syringe driver was given ie, when it was written in the prescription chart, normally also written in the clinical notes. There should be an entry in the nursing notes which would state what controlled drugs were to be administered to a patient, what the quantity/dosage. The period of time the dosage was to be administered (normally over 24 hours).

The procedure for setting up a syringe driver was that it required two qualified nurses.

The controlled drugs were taken from a secure drugs cupboard the amount/doseage of the controlled drug was checked against the prescription sheet.

The appropriate amount of drug withdrawn was then recorded in the controlled drugs book which was recorded and witnessed by the same two trained nurses that had withdrawn the drugs.

The drug solution containing the prescribed drug(s) was made up in sterilised water.

In the case where it was a mixture of drugs then the compatibility of the drugs would be checked in the British National Formulary (BNF). On occasions the pharmacist would be contacted for advice.

Once satisfied that the drugs mixture compatibility were correct then the syringe driver would together with the prescription chart and drug controlled book be taken to the patient.

At the patient's bedside a check was made to confirm it was the right patient for the prescribed

drugs.

A small butterfly needle was inserted below skin level (sub-cutaneous) and the syringe driver applied which delivered a set quantity over a 24 hour period.

I cannot remember which year that the Redcliffe Annex closed down. All the patients and staff transferred to the new ward, Dryad, at Gosport War Memorial Hospital. At the time of transfer I was an E Grade Staff Nurse.

My responsibilities at this time were deputising in the absence of the senior staff nurse or ward manager, supervising staff and delegating work loads.

Assessing, implementing and evaluating individual patient's care.

Accompanying doctors, consultants on their ward rounds and passing on new treatments and information ordered by the doctors. That is informing, documenting other staff and patients/relatives.

Ordering and safe storage of drugs and dispensing safely drugs to the patients.

I have been asked to detail my involvement in the case and treatment of the patient Code A Code A. From referral to an entry on page 29, a photocopy of Mr Code A 's nursing notes, exhibit ref BJC/71, I can state the following.

I can confirm that I have written the following entry for the 21/1/96 (21/01/1996).

Condition remains unchanged, Mrs Code A phoned, driver recharged at 1745 Diamorphine 120mgs, Midazalom 80mgs, Hyoscine 1200 micro grams, Nozihan 100mgs, one syringe running at 50mms per 24 hours the other at 58 mms, appears comfortable.

This entry has been signed by me.

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Firstly I do not recollect this patient Mr Code A or remember the subsequent care given.

With regards to the above entry the patient's condition has not changed during my shift. Mrs Code A has phoned because she is obviously aware that Mr Code A is very poorly, ie, prognosis is poor.

The syringe driver has been set up and commenced prior to my shift. I have recharged the syringe driver as per the prescription chart written by Doctor BARTON clearly shows that this doseage and mixture of drugs can be administered to the patient.

However if as trained nurses we felt that the amount of drugs was no longer required, ie, there were signs of improvement then I would not administer these drugs. I would firstly phone the doctor on duty for advice.

In my experience contacting a doctor for advice in these circumstances was a rare experience.

With reference to the different rates that I have recorded - both syringe drivers were set to run over a 24 hour period.

With reference to where I have written 'appears comfortable' I understand this to mean that there were no obvious signs of pain or discomfort.

I have written under the initial entry on page 29 of BJC/71 the following:-

2015 no change in condition - which is self explanatory.

To summarise the patient Mr Code A at this stage was obviously very poorly, the family were aware of his condition. That during my shift the patient's condition had not changed.

I have been shown the drug controlled record book relating to Dryad Ward exhibit

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JP/CDRB/21.

I can confirm that on page 7 on the 16.1.96 (16/01/1996) at 0830 hrs I witnessed and recorded 20mgs 2x10mg ampoules being withdrawn by Staff Nurse T DOUGLAS for the patient Leslie Code A.

Again on page 16 on the 16.1.96 (16/01/1996) at 0830 hrs I witnessed and recorded 100mg 1x100mg ampoule of diamorphine withdrawn by Staff Nurse T DOUGLAS for Mr Code A.

On the 21.1.96 (21/01/1996) at 1745 hrs I can confirm that I have recorded 20mgs 2x10mg ampoules of diamorphine which was witnessed by Staff Nurse Rena PEARCE .

Also on page 16 on the 21.1.96 (21/01/1996) at 1745 hrs I have recorded that 100mgs 1x100mg ampoule of diamorphine has been withdrawn for the patient Code A this record was witnessed by Staff Nurse Rena PEARCE.

As far as I am aware I had no further dealings with this patient.

Taken by:DC Code A