

RESTRICTED

Form MG11(T)

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: WIGFALL, MARGARET

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

This statement (consisting of 3 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: Margaret WIGFALL

Date: 30/11/2004

Further to my previous statements made to the Police, on 11th October 2002 (11/10/2002) and 9th July 2004, (09/07/2004) I would like to add that since 1981 I have worked one night a week at the Gosport War Memorial Hospital . At first at Redcliffe Annexe and then on Dryad Ward where I am still working. Very occasionally I would cover other wards in the event of absence or sickness on those wards.

My role would be that of general patient care.

I am unsure who my line manager was in 1996.

I have not received training at all in the use of I/V drugs

I have heard recently of the term 'Wessex Protocols' but I do not know what they are.

The term Named Nurse means that this person is the patient's main nurse who is responsible for their care.

The entries in the medical notes, including Nurse's Care Plans would usually be written up towards the end of night duty heading towards handover, unless a patient was really poorly when the notes would be made at the time.

My weekly hours are 10 hours per week and my tour of duty is from 2015 until 0745 the next day.

Signed: Margaret WIGFALL
2004(1)

Signature Witnessed by: D WILLIAMSON

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Continuation of Statement of: WIGFALL, MARGARET

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I have previously mentioned about my training in the use of syringe drivers.

I have been asked to detail my involvement in the care and treatment of Elsie Hestor LAVENDER . I have no recollection at all of this patient, but from referral to her medical notes BJC/30 I can confirm that on page 123 of the Nursing Care Plan dated 22nd February 1996 (22/02/1996) where I have written and signed the following entry, "Settled and slept well C/O sore shoulders, analgesia given"

C/O means complaining of.

The entry is self explanatory really, it is clear the patient was in some pain with a sore shoulder and I have given her analgesia.

I have referred to the prescription charts on page 141 and I have given the patient two tablets of Dihydrocodeine (DF118) at 2300hrs and 0500 hrs. I am unsure what the exact dosage was because the copy BJC/30 is not clear enough.

That is the only entry I have made in this patient's notes. I do not recall the night in question and for that reason I do not know why I was covering Daedalus ward that night from Dryad Ward.

Taken by: D WILLIAMSON

Signed: Margaret WIGFALL
2004(1)

Signature Witnessed by: D WILLIAMSON