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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: MORGAN, DAVID VICTOR

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

This statement (consisting of 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: D V MORGAN Date: 09/09/2004

I live at an address known to the Police.

I am a Registered Mental Nurse (RMN); my General Medical Council number is Code A I qualified in 1991 at Southampton University. I did my training at Knowle Hospital, Wickham, Southampton .

My qualification is the same as a Registered General Nurse, but is specialised in mental health. I am not qualified to work on a general ward.

Upon qualifying in 1991, I worked at Knowle hospital on GALBRAITH ward. This was an acute ward.

In 1995 I moved to ALVERSTOKE ward within the same hospital and when ALVERSTOKE ward moved location to the GOSPORT WAR MEMORIAL HOSPITAL (GWMH) and became MULBERRY ward, I moved with it. This ward is an elderly mental health ward, its patients are aged 65 and over. The ward was divided into three sections, these were 'A' which contained patients who were 'functionally ill'. By this I mean were suffering from something like depression or grief, they were expected to be treated and then discharged. Section 'B' which contained patients who were suffering from the early stages of dementia but would have periods of lucidness and Section 'C'. These patients were suffering from dementia; they would be incontinent, not eating and regressed. They were highly dependant. At this time I would have been involved with the everyday care of the patients, I would have been a 'named nurse' for some of them. By this I mean that I would have been responsible for identifying that individual

patient's problems in relation to their care needs, as apposed to their medical needs. Determining the over all goal in relation to the problem and devising the action plan, the method by which that goal would be attained. I would also be more available for the patient by that I mean I would spend time chatting with them and being the person who they recognised as being 'their' nurse.

As a trained member of staff I would have been responsible for the dispensing of medication to the patients. If the medication was a controlled drug then two members of trained staff would check a patient's prescription and then take the drug out of the controlled drug cupboard, enter the amount taken in the controlled drug book and make an entry on the patient's drug card. Both members of staff would then witness the patient taking their medication.

If the drugs required were not controlled drugs then I would dispense them by myself.
Whilst working on MULBERRY ward I worked an 'in house' shift system. I worked a 0700 - 2100 shift three days a week and then had four days off. I always worked days.

In June 1996, due to disability, I was unable to continue working on the ward and upon my return to work in December 1996, I took up my current post.

I am currently working as a RMN E grade, at Lee Grove House, Gosport. This is an eight bed adult mental health rehabilitation ward. My responsibilities are to teach everyday living skills to people who have become institutionalised, in order to determine the most appropriate environment for them to live in.

I have been asked if I can recall a patient by the name of Code A
I do recall this gentleman, I first met him when I was working on ALVERSTOKE ward as a student. It would have been between July and September 1990, I was 21 in the September and this is why I can place the time. I also recall him because he was the father of a lady who worked within the mental health field, a I Code A . I had worked with her at HEWITT HOUSE, where she ran the day hospital.

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I remember Les as being a stocky, strong man with grey hair and a beard. I remember him as being chatty but I can not recall anything about his illness. I do remember that he was well known to the team I worked with and was admitted on a regular basis.

I next met Les some 5 to 6 years later when he was admitted to MULBERRY ward from a nursing home. . I cannot remember if I was his named nurse or the nature of his illness at that time.

I recall that he had lost a lot of weight and seemed to be frail and thin in comparison to when I had last met him.

I have been shown a copy of a document identified as BJC/71/pg11. This is the front page of a transfer details form. I can identify the handwriting as mine. This document is filled in when a patient is moved from one ward to another location. This could be another ward in the same hospital or to another hospital or to a care or nursing home
This transfer form relates to Code A and I have written the following under Section One, Personal Details. MULBERRY ward area A, DRYAD ward. This means that the patient was moved from Mulberry ward 'A' section to Dryad ward at the GWMH.

I have noted his pre-admission address as Redacted Redacted

P. means Phone.

I have noted the date and time of transfer as being FRI-5-1-96 (05/01/1996), the patients name as Code A his forename as Code A and that he likes to be known as Code A

Under reason for admission I have put LOW IN MOOD-VERBAL AND PHYSICAL AGGRESSION.

I cannot remember the actual circumstances of Les's admission but from this entry I assume this

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relates to his behaviour in the nursing home. Under date of admission to hospital, I have written 13-12-95 (13/12/1995). This would have been the date that Les came to Mulberry Ward.

Under name of Patient's Advocate, I have written Code A

Code A

Under Section Two, Medical Details I have written the following.

Consultant, DR BANKS , Named Nurse, DAVID MORGAN S/N.

From this I can see that I was Les's named nurse but I have no recollection of this.

The S/N stands for Staff Nurse.

I have noted Les's GP as DR ASBRIDGE , telephone number 511541.

Under Relevant Medical History, I have written PARKINSON'S DISEASE. This means that Les was suffering from Parkinson's disease.

Under Current Medication I have written the following, SERTRALINE 100MG NOCTE. This drug is an anti-depressant and was given at night (nocte) LITHIUM CARBONATE 400MG NOCTE. This drug is a mood stabilizer, it would be given for manic depression and mood swings and was again given at night. DIAZAPAM 2MG, T.D.S(8AM 5PM 10PM) (0800 1700 2200). This is a muscle relaxant and sedative and was given three times a day at 8am (0800), 5pm (1700) and 10pm (2200). THYROXINE 15MCG AM ONLY. This is given to people with a thyroid problem and was given in the morning. CEFACLOR 250mg- T.D.S. This is an anti-biotic and was given three times daily. SUBY G- BLADDER WASHOUT-TWICE WEEKLY. This is a brand name for a solution used to clean a patient's bladder.

I have been shown a copy of a document BJC/71/pg12. This is the continuation of the transfer

details form and the handwriting is mine.

This page is headed Section Three, Nursing Needs.

Under Physical I have written, POOR PHYSICAL CONDITION-BROKEN PRESSURE AREAS TO BUTTOCKS AND HIP. This means that Les had open wounds on his bottom and his hip. FULLY CATHERTERIZED SINCE FLUID RETENTION ON 23-12-95 (23/12/1995). This means that he had been fitted with a catheter on 23-12-05 because he had difficulty passing urine. BROKEN SKIN ON SCROTUM. This means that he had open sores on his scrotum. NURSED ON A PEGASIS MATTRESS. This means that Les had a special pressure relieving mattress. WEIGHT BEARING TO A VERY MINIMAL DEGREE. This means that Les could stand and bear his own weight to a small degree.

From this entire entry I get the impression that Les would only get out of bed to stand next to it with support and that he was nursed in bed most of the time. There is no mention of him requiring a sheep skin in a wheelchair.

Under Psychological I have written, LOW IN MOOD FOR MANY YEARS-ON ANTI-DEPRESSANTS. VERY SETTLED IN BEHAVIOUR DUE TO POOR PHYSICAL CONDITION.

By this I mean that Les had been depressed for many years and that he was prescribed antidepressants for this and that He remained constant in what he did due to his poor physical state.

Under Nutritional I have written, POOR FLUID + DIET INTAKE ALTHOUGH FLUTTUATES AT TIMES AND SOMETIMES BECOMES QUITE GOOD. NEED TO PUSH 'FORTISIPS' DRINK-LES LIKES STRAWBERRY FLAVOUR. LES NEEDS FULL HELP WITH FEEDING/DRINKING. LES SOMETIMES REQUIRES/USES A STRAW TO DRINK.

By this I mean that Les was not eating and drinking much, but this could change and he would improve his intake. Where I have written 'need to push Fortisips drinks.' I mean that Les was to

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be encouraged to drink these milkshake type drinks as they contained vitamins and nutrients.

Where I have written Les needs full help with feeding/drinking I mean that he required help with his meals. This may just take the form of sitting with him and encouraging him to eat or it could mean that he needed to be physically fed.

Where I have written Les sometimes requires/uses a straw to drink. By this I mean that Les would sometimes use a straw to drink with. The ' requires/ uses' would indicate to me that sometimes he may need physical help to drink using the straw and sometimes he would drink by himself using the straw.

Under Social Domestic I have written ALWAYS HAS BEEN A BIT OF A LONER BUT SOMETIMES ASKS STAFF TO SIT WITH HIM. By this I mean that Les didn't mix with the other patients but occasionally would request the company of a member of staff.

I have signed and dated this form 5/1/96 (05/01/1996). I would have completed it on the day of his transfer to Dryad ward.

Taken by: Code A