RESTRICTED

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: O.18 (if over 18 insert 'over 18') Occupation: STAFF NURSE

This statement (consisting of 9 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 SHAW Date: 11/07/2005

I am Freda Vaughan SHAW and I reside at an address known to Hampshire Police. I am a registered general nurse and my nursing and midwifery council number is Code A.

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

In 1977 I completed an 18 month post registration course in order to qualify as a registered general nurse at Argyle and Bute College of Nursing and Midwifery in Greenock.

I worked for a further year at Broadfield Hospital Port Glasgow, completing that in July 1978.

I left the nursing profession in that year and worked in a variety of other positions.

In March 1992 I began work as a D Grade Staff Nurse at the Redcliffe Annexe which formed part of the Gosport War Memorial Hospital.

In 1994 I qualified as an E Grade Staff nursing which is my current grade.

Around 1995 Redclyffe Annexe was closed and all the patients were moved to Dryad Ward. I moved to Dryad Ward at this time. Both Redclyffe Annexe and Dryad Ward were for patients that required continuing care, palliative care, rehabilitation or for the terminally ill.

I have remained as a Grade E Staff Nurse on Dryad Ward ever since, until my moved to

Daedalus Ward in Sept 1998. As an E Grade Staff Nurse my role responsibilities are to supervise health care support workers and junior staff and to take charge of the ward in the absence of more senior staff. I am also responsible for the training of student nurses who are on placement at the ward.

Dryad Ward has 20 beds and the patients are primarily elderly over the age of 65 years. The majority of these are full dependent on nursing care and are usually in the ward for a 4 to 6 week period.

. have received on the job training in the use of syringe drivers .. I believe I first used these in or around 1992. I have also attended study days in connection with the manufacturers requirements relating to their use.

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

The only person who can authorise the use of drugs administered through a syringe driver is a doctor. In the early years it was policy to allow up to three different drugs to be administered via the syringe driver in one dosage over a set period. That policy has since changed.

My understanding of the terms the named nurse is that this is the person who is responsible for the nursing care of the patient. The nurses were usually allocated a four bedded bay and split into teams A and B. These were responsible for putting care plans in respect of those patients in place and keeping them up to date. The named nurse would be the person whom the patients family could speak to if that nurse was actually on duty at the time. If there were not then another member of staff would speak to them.

The time and date of all entries in the notes would usually be completed at the time, if the patient was seriously ill, but in other cases it would be completed when there was time to do so,

but in any case at the end of the tour of duty.

My tour of duty has always been from 0730 hrs to 1330 hrs (days) and 1415 hrs to 2030 hrs (lates).

I have been asked to detail my involvement in the care and treatment of Sheila GREGORY who was a patient on Dryad Ward at Gosport War Memorial Hospital and who died on 22.11.99.

At that time I was an E Grade staff nurse and my roles and responsibilities were as previously stated. My supervisor at that time was Sister Gill HAMBLIN . From memory and referral to entries made in Sheila GREGORY's medical records (identification reference BJC/21), I can state the following:

On page 237 I have recorded.

13.9.99 Seen by Dr REID on round - continue - inhalers changed to nebulisers.
I have then signed the entry.

I entry relates to a ward round that Dr REID conducted on 13.9.99 and is recorded in the clinical notes on page 67 and 68 written by Dr REID. Continue, means to continue with the care as before of Mrs GREGORY the only change being to commence a nebuliser instead of an inhaler. That would have been a change in the drug regime and the way that they were taken. Prior to 13.9.99 Mrs GREGORY was using an Atrovent Inhaler and a Becloforte Inhaler (Page 159). This was change to Iprtropium nebuliser and Budesonide nebuliser. I am unable to say why these drugs were prescribed. An inhaler requires you to breath in the medicine in a particular manner, to be able to do this the patient has to be able to understand instructions, also the patients requires to be able to breath quite deeply. A nebuliser is given via a mask and the drug to vaporised by a machine allowing the patient to breath naturally.

My next entry read:

20.9.99 seen by Dr REID for FBC-U&ES manç ? rehab
I have then signed this entry.

This again relates to a ward round by Dr REID on 20.9.99 and corresponds to his clinical note on page 68. Dr REID has requested, FBC-U&ES, full blood count and urea and electrolytes in the morning. I have no idea why Dr REID asked for the blood count for Mrs GREGORY, they can be used to monitor or indicator all manner of things, ie, infections, illness or organ impairment.

On 8th October 1999 page 238 I have recorded:

8.10.99 Continues to feel nauseas at times, small amount of diet taken, remains in bed of own choice.
I have then signed this entry.

Nauseaus - means to feel sick. Mrs GREGORY would have been encouraged by the nursing staff to mobilise, although she remained in bed of her own choice.

On 18th October 1999 page 238 I have recorded:

8.10.99 seen by Dr REID to discuss N/H with family.

I have again signed this entry. This entry corresponds with Dr REID's clinical note on 18.10.99, page 69.

This entry relates to the fact that Dr REID at that time thought that a nursing home placement would be suitable and that the nursing staff should discuss this with the family. When this would have been done the patient would have been referred to social services. At that time the plan was for Mrs GREGORY to be discharged to a nursing home.

On 20th October 1999 I have recorded (page 238):

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20.10.99 Spoke to Pauline (N.O.K) re RH/NH, she is happy to discuss with social worker, can be contacted at night or weekends.
I have then signed this entry.

I social worker/social services would have to get involved in Mrs GREGORY placement as they would be aware of the availability of the homes, they would also be of help in the financial aspect of the care.

On 19th November 1999 I have given Mrs GREGORY a 40mgs dose of Frusemide at 1530 hrs intramuscularly. This prescription had been verbally prescribed by Dr BARTON , written out by Sister HAMBLIN. Dr BARTON had subsequently signed the prescription.

From looking at an entry on page 239 dated 19.11.99 I presume that the frusemide was prescribed for shortness of breath but this entry is written by Sister HAMBLIN.

On 22.11.99 I have recorded:

1720 Died peacefully
Property slip No.82060

I have signed this entry then continued.

No carotid pulse
No radial pulse
No heart beat when listening with stethoscope
No visible respiration
No inspiratory sounds of breathing when using stethoscope
No pupil reaction to light
Verified by S/N F SHAW & Sis HAMBLIN

Both Sister HAMBLIN and I have signed this entry.

This entry corresponds with an entry that I made in the clinical notes page 76 and is written under an entry made by Dr REID dated 22.11.99.

1720 Died peacefully
Verified by
S/N F SHAW Sis G HAMBLIN
Both Sister HAMBLIN and myself have signed the entry.

No carotid artery pulse
No radial pulse
No heart beat when listening with stethoscope
No visible respiration
No inspiratory sounds of breathing when using stethoscope
No pupil reaction to light

Both entries are the same and verify the death of Mrs GREGORY. All the tests mentioned are set policy used to verify death.

It would be normal for the nursing staff to verify death if it was expected and the doctor had written words to the effect of 'I am happy for nursing staff to confirm death'.

This was normal practice during periods when there was no medical cover for the ward and the hospital. Medical cover was only available during Dr BARTON's or the consultants ward rounds or during surgery hours when you could phone Dr BARTON's practise for her or the duty doctor. They would either advise on the phone or come to the ward.

Dr REID would conduct ward rounds either weekly or every fortnight. He would conduct them with Dr BARTON and the senior nursing staff on duty. He would visit every patient discuss there care and treatment, any problems with those present, examine the patients, notes,

prescription charts, the patient and then treat them if necessary, ie, prescribe drugs or other treatment.

He would also make an entry in the clinical notes . His round would last at least a couple of hours but would vary every week.

Dr BARTON would conduct her ward rounds each morning. She would walk around, say good morning to all the patients. Any problems for any patient would be highlighted by the nursing staff to Dr BARTON who would then deal with the problem. Dr BARTON got in between 7.45am (0745) and 8am (0800) and was gone for her morning surgery. She could be in for only five minutes if there were no problems brought to her attention. She also did a ward round on Daedalus Ward at that time.