

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: PERRYMAN, MARGARET ROSE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: MEDICALLY RETIRED

This statement (consisting of 4 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: M R PERRYMAN

Date: 18/08/2003

I live at the address known to the police.

I qualified as an RGN in September 1983.

Prior to coming to work at the Gosport War Memorial Hospital , Bury Road, Gosport. I was the Sister in charge of the Renal Department of the Intensive Care Unit, Kings College Hospital , London. I was also the Sister in charge of the pain relief research unit at the same hospital.

In 1999 I moved to the Gosport War Memorial Hospital as a SN, E Grade and I worked for four months on the hospital bank. I worked permanent nights and as such would cover in all the wards in the hospital but predominantly on Sultan Ward.

After the first four months I worked on Sultan Ward.

From 1st November 1999 (01/11/1999) until 31st October 2000 (31/10/2000) I worked as a Senior Staff Nurse on a temporary one year contract to Daedalus Ward.

I have been asked to describe the level of general patient care at the hospital.

I would describe the patient care on Mulberry Ward and Dryad ward as excellent. The care given on Sultan Ward was good and the care provided on Daedalus Ward was unacceptable.

By this I mean the culture of nursing care wasn't right.

Signed: M R PERRYMAN
2004(1)

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Continuation of Statement of: PERRYMAN, MARGARET ROSE

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I found that it was the practise of some of the night staff to get the patients ready for the day shift at around 3am (0300) - 4am (0400). Patients who had suffered strokes or who were unconscious would be washed or bed bathed. Some patients would be up and dressed by 6am (0600).

I found that the drugs charts were either not filled in or filled in incorrectly.

Patients would be given their drugs hours before they were due or not at all. This was not a regular occurrence but I felt it shouldn't be happening at all.

I wrote to Phillip BEAD , the Nurse in Charge of the ward about my concerns. I kept a copy of this letter dated 8th May 2000 (08/05/2000), (MRP/1). I received a memo from Phillip in reply (MRP/2) dated 14/05/2000.

I was also spoken to by Phillip who in no uncertain terms 'told me off' for contacting staff at home.

I found that errors were still made and that drugs were left out on lockers in pots. I would come on duty for nights and find that the medication that should have been taken during the day was still there.

I thought that the ward was poor managed. It wasn't kept clean and the whole atmosphere was one of a lack of interest and a lack of care.

I had an occasion to write to Phillip BEAD about staff confidentiality. I was aware that personal information about members of staff was kept in an unlocked filing cabinet by the nurses station and that some members of staff would sit and read documents relating to other members of staff. I have kept the original rough draft of this letter (MRP/3).

I have been asked about the use of syringe drivers and diamorphine .

Signed: M R PERRYMAN
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I considered the pain management on Daedalus Ward to be totally inadequate. The dosage of diamorphine was rarely changed and consideration was not given to the patients build up of tolerance to diamorphine. I am very experienced in pain control due to my previous places of employment and I considered that the doctors were reluctant to prescribe the necessary dosage in order to control some very painful conditions in very elderly patients.

I have been asked about training that I received in the use of syringe drivers.

When I came to the Gosport War Memorial Hospital I was not conversant with the type of syringe driver they used. It seemed to be the type more commonly used for patients who remained in their own homes. I was fully conversant with syringe drivers on the ITU at my previous hospital so in order to make sure I was competent in the GWMH model I obtained the manufacturers instructions and I had a photocopy of the guidelines as set out by the Countess Mountbatten Hospice.

On 21st January 2001 (21/01/2001) I was assaulted by a patient and as a result of my injuries was placed on long term sick. I was medically retired in 2002.

I have been asked about my knowledge of the Police and internal enquires.

I was asked by Phillip BEAD to speak to members of the night shift about a female patient who had been admitted a couple of years before I arrived at the hospital. I cannot remember her name but I think that she had come to our hospital from Haslar Hospital.

I was asked to speak to them because apparently some of them were worried as there was either going to be or there was, an enquiry into this patient.

I read through the patient notes and from memory recall that they were not particularly well kept.

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Continuation of Statement of: PERRYMAN, MARGARET ROSE

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I remember going through the requirements of admission, the checking of pressure areas and the compilation of the Bartell assessment.

I have no other knowledge other than that I remember visiting medical staff as being Dr GARRETT , Dr NORTH , Dr EVANS , Dr HADJANTONIS , Dr GROCOCK and Dr LYNCH

Having read through this statement I think that it is pertinent to add that I have obtained the English National Board 100 which is a qualification in General Intensive Care Nursing and the English National Board 998 which is a qualification in leading and assessing in the clinical area. I also have a Diploma in Nursing from the University of London.

Signed: M R PERRYMAN
2004(1)

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