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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: Code A

Age if under 18: O 18 (if over 18 insert 'over 18') Occupation: STAFF 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: Code A Date: 19/10/2005

Further to my statement dated 29/06/2005 in which I have referred to the Dryad Ward Controlled Drugs Record book (exhibit reference No. JP/CDRB/24) with regard to administering 10mgs in 0.5mls of Oramorph at 1955hrs on 15/10/1998 and again at 1005hrs on 16/10/1998, both of these entries are recorded on page 53 of the Dryad Ward Controlled Drugs Record book (JP/CDRB/24).

From referring to page 261 of BJC/55 , the medical notes for Mr Robert WILSON , the Oramorph that I administered was a regular prescription to be given four times a day at 0600hrs, 1000hrs, 1400hrs and 1800hrs. There is then another prescription for Oramorph that is 20mgs in I believe 10mls. This prescription is for 2200hrs and is a double dose to enable the patient to get a more settled night's sleep. I believe that both of those prescriptions were written by Doctor BARTON.

I can clarify that the entry for the 15/10/1998 is 10mgs in 0.5mls and not 5mls as in page 5 of my original statement.

As it was a regular prescription it would have to have been given, as a nurse I could not have omitted the dose, neither could I have increased it. The time of the dose could vary slightly as the nursing staff may be delayed administering the dose and there had to be a four hour gap between administering the drug.

The prescription is dated 15/10/1998. As I have already stated Oramorph is a opium pain controlled drug and, as such, I would expect to see an entry from the doctor prescribing it as to

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the reason why they had prescribed it. I have been shown page 179 of Mr WILSON's medical notes and can find no record or reason in the clinical notes. Although on page 265 the nursing notes it is recorded on 15/10/1998 that Mr WILSON had pain in his left arm although I did not make that entry for the entry on 14/10/1998.

If the Oramorph did not hold the patient's pain, i.e. break through pain, the patient would be observed over a period of time, a matter of hours, if the patient was still in pain the prescription would still be administered. If that didn't hold the patient's pain, the doctor would be informed. This could either be when the doctor did their morning ward round, or if the pain was particularly bad the doctor would be called out and a verbal prescription could be given over the telephone. The doctor would sign the prescription sheet the following day. The length of time a patient would be observed or assessed for pain would differ from patient to patient depending on their size, medical condition.

All nursing care is a term used by healthcare professionals and means that the patient is terminally ill and that they are too poorly to do anything for themselves. That means that the nursing do everything for them. Tender loving care (TLC) means the same the patient is terminally ill.

I have stated that I am familiar with the analgesic ladder and I can say that there is a large jump in the ladder from Paracetamol, 1gr four times a day, as in Mr WILSON's referral letter page 81 and 10mgs in 0.5mls of Oramorph, although as I did not assess the patient I can't comment on why this may be.