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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: WALKER, FIONA LORRAINE

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

This statement (consisting of 12 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 L WALKER Date: 01/12/2004

I am Fiona Lorraine WALKER and I live at the address shown on the attached form.

I am currently employed as a Nurse Practitioner with Laser Care Clinics based at Haslar Hospital, Gosport. I am also employed by 'Prime Care' as a custody nurse for the Hampshire Constabulary.

I have been a nurse for 36 years and qualified as a Registered General Nurse for 32 years.

In 1982 I began working at Gosport War Memorial Hospital . I was employed as a 'Night Sister'.

I was employed at Gosport War Memorial Hospital until 2003, at that stage I was employed as a Senior Staff Nurse (nights) based on Sultan Ward of the Hospital.

I was one of three 'Night Sisters' employed at the Hospital. Only one Night Sister usually being on duty at one time.

During the 'Night Shift' which was from 2015 hours to 0745 hours my responsibilities were for the whole hospital and members of staff and patients. This included a Minor Injuries Department of the hospital which was open 24 hours a day.

During the night shift I would be in charge of the whole hospital and available to be called to any part or ward of the hospital that required the presence of a senior member of the Nursing

Staff to provide advice and assistance.

This responsibility was for the whole of the Night Duty period.
There was no on-site Doctor available 24 hours a day at Gosport War Memorial Hospital. Therefore if there was a need to call a Doctor for advice and to discuss a patients condition then this responsibility would often fall to me.

The doctor called would then decide whether it was a matter that could be dealt with by the Nursing Staff or if it was necessary for the doctor to attend the hospital.

If it became necessary for me to have this kind of involvement in the care of a particular patient then I would usually make a note on the patients medical record in the nursing section if it had not already been noted by a trained member of staff.

During the course of a Night Duty I would try if possible to visit each ward of the hospital to ensure that there were no problems with either patients or staff.

I have previously made statements to the Police regarding Gosport War Memorial Hospital on 23rd January 2004 (23/01/2004) and also on 19th October 2004 (19/10/2004).

Signed F WALKER

I have been asked if I recall anything about a patient called Code A born Code A who was at Gosport War Memorial Hospital from 13th December 1995 (13/12/1995) where he was originally on 'Mulberry Ward'. He was then transferred to 'Dryad Ward' on 5th January 1996 (05/01/1996) and died on Dryad Ward Gosport War Memorial Hospital on 24th January 1996 (24/01/1996). I have no personal recollection of this patient.

I have been shown copies of Medical Records bearing the name Code A bearing the exhibit reference of BJC/71 which consists of 49 pages. I have examined each page in turn and can find no entry on these records that I have been the author of or have countersigned.

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I have also been shown two Controlled Drug Record books, exhibit reference JP/CDRB/20 and exhibit reference JP/CDRB/21.

On my examination of these Record Books for the period of Code A 's stay at Gosport War Memorial Hospital I can say that with regard to Code A I have made no entries in the Controlled Drug Record Book, exhibit JP/CDRB/21.

From my examination of the Controlled Drug Record Book exhibit JP/CDRB/20 I note that on 3 occasions I have acted as 'witness' to controlled drugs being administered to Code A

The entries appear on pages 76 and 77 of exhibit JP/CDRB/20 and are dated as follows:-

i 10th January 1996 (10/01/1996)
ii 11th January 1996 (11/01/1996)
iii 12th January 1996 (12/01/1996)

On each of the above occasions the controlled drug was 'Oramorph ' - 'oral solution'. On each occasion I acted as 'witness' to the administering of the drug to Code A by staff nurse Mary MARTIN .

The full details of these entries should be read as follows:

On 10th January 1996 (10/01/1996) a dose of 'Oramorph' 10mgs in 5mls solution was checked against prescription at 2220 hours. The medication was given to the patient Code A by staff nurse Mary MARTIN and the whole procedure was witnessed by me.

On 11th January 1996 (11/01/1996) a dose of 'Oramorph', 5mgs in 2.5mls solution was checked against prescription at 0610 hours. The medication was given to the patient Code A by staff nurse Mary MARTIN and the whole procedure was witnessed by me.

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On 12th January 1996 (1/01/1996) a dose of 'Oramorph', 5mgs in 2.5mls solution was checked against prescription at 0615 hours. The medication was given to the patient Code A by staff nurse Mary MARTIN and the whole procedure was witnessed by me.

I have checked a copy of the medical records of Code A exhibit BJC/71.

I note that at page 17 of 49 and at page 19 of 49 a prescription of 'Oramorph', 5mgs in 2.5mls solution to be given 4 hourly at 0600 hrs, 1000 hrs, 1400 hours and 1800 hrs appears. It was normal practise for 10mgs in 5mls solution to be given at 2200 hours in order that the patient need not be disturbed at 0200 hours to be given a dose of medication. It was normal practise for the prescribing doctor to write up the prescription chart in order to allow this to be done.

On my examination of the prescription charts I note that the doses shown in the controlled drugs record book correspond with the prescription charts.

The procedure for administering controlled drugs at Gosport War Memorial Hospital was as follows:-

All controlled drugs are stored in a locked cupboard within a locked cupboard on the ward.

Details of the movements of 'Controlled Drugs' are recorded in the 'Controlled Drug Record Books'.

Before ANY drug can be administered to a patient it must first be prescribed by a doctor.

ALL 'Controlled Drugs' are required to be checked and witnessed by TWO nurses. One of whom must be a 'Registered Nurse'.

The two nurses check the prescription chart of a patient. Then take the prescription chart to the drug store where the drug in question is checked against the prescription chart.

The drug is then checked to ensure that the correct dose is available and is in date. The drug is then taken with the prescription chart to the patient.

A further check is then made that the patient is the correct patient to administer the drug to.

This is done by checking the patients identification band against the prescription chart.

This check is usually done by the witnessing nurse, who may have come from another ward and may not be familiar with the patient.

Both nurses will then 'witness' the patient taking the medication or one nurse will 'witness' the medication being administered to the patient by the other 'nurse'.

Both nurses then return to the drug cupboard where the register is then completed and signed by the nurse giving the medication and the nurse who acted as 'witness'.

At the same time the prescription chart is completed and initialled by the nurse who administered the medication.

The Controlled Drugs Record Book records the following information.

1. Date (Drug checked against prescription)
2. Time (Drug checked against prescription and withdrawn from store)
3. Name of patient (To whom drug to be given)
4. Amount given (Dose of medication as per prescription chart)
5. Given by (Signature of trained nurse giving drug to patient)
6. Witnessed by (Signature of nurse who 'witnessed' the full procedure)
7. Stock balance (Running total of remaining doses of drug/medication)

All the above headings 1-7 are under the heading of the drug/medication and its dose.

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All of the above sections are required to be completed by the nurses administering the drug/drug.

It was part of my responsibilities to be available to 'witness' or administer controlled drugs to patients during the period of my duty. However this was not one of my main priorities, therefore if I was engaged in other duties then another member of nursing staff could be called to 'witness' this procedure.

Before withdrawing from store any prescribed medication I would ensure that the prescription was completely legible and clear. I would also satisfy myself that the prescription was in my opinion appropriate for the patient in the circumstances. If I had any concerns regarding any of the above points then I would not administer or allow to be administered the medication until I had discussed the matter with a doctor.

In my experience this has only occurred on a few occasions when I have been unable to read the writing of the prescribing doctor.

Taken by:DC **Code A**