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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: YOUNG, RENA ROSINA

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: HEALTH CARE SUPPORT WORKER

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: R R YOUNG Date: 23/09/2004

I am a Health Care Support worker currently working on Sultan Ward at the Gosport War Memorial Hospital which is under the Fareham and Gosport Primary Care Trust.

I have been so employed in this role since 1994. My role as a health support worker comprised of helping, supporting trained Registered General Nurses (RGN) and State Enrolled Nurses (SEN).

This included the day to day care of patients on the various wards. I would report to the Senior Nurse on duty any concerns I had with regards to the well being of patients, such as deterioration in the patients health. Any concerns that the patient's had would be notified to the senior staff nurse on duty at that time.

I would deal with relatives enquiries relating to a patient's health care. Once I had been informed of the relatives concern I would then refer the enquiry to the staff nurse on duty who would then deal with the enquiry.

As a support worker I would also clean the beds/mattresses after the patient had vacated their bed. One of my responsibilities was feeding the patients where required.

Where a patient had died on the ward that was expected I would prepare the deceased with another member of staff ready to be taken to the mortuary. In the event of a patient who died unexpectedly the deceased would be left in the bed. I would have no involvement in dealing with this patient until the set procedure had been complied with.

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Once the procedure of notifying a doctor had been completed and the deceased had been examined by the doctor and senior staff nurse I would then be detailed to prepare the body for the mortuary.

It was often the case that removal of the body would be completed by a support worker from the next shift.

Death was always and is currently verified by a Registered General Nurse normally with another member of staff present.

I do not remember the patient Code A .

I have no involvement in the administration of prescribed drugs whether orally or intravenous or those given by syringe driver .

I have over the years undertaken mandatory study days and voluntary study days where I have been updating my knowledge as a support worker.

In 1996 I was working night shift on a permanent basis. I would work on Sultan, Dryad or Daedalus Wards which were all elderly care wards.

Sultan Ward at that time was a GP medical ward. Dryad Ward was a continuing care ward. Daedalus was a stroke rehabilitation ward.

I have been shown a photocopy of the microfiche exhibit ref BJC71, page 15.

I can confirm that I was present with Staff Nurse MARTIN on the 24th January 1996 (24/01/1996). I have seen the entry timed at 1.45am (0145) in relation to the patient Code A Code A .

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I recognise Staff Nurse MARTIN's handwriting stating that the patient's death was verified in my presence. Death is verified following a set procedure which is that Staff Nurse MARTIN would have shone a light into the deceased's eyes to ascertain if there was any reaction to the light. She would have checked to see if there was any pulse on the patient's carotid artery. She would have then checked with her stethoscope the patient's/deceased heart.

Once all the vital signs had been checked Staff Nurse MARTIN would ask if I agreed that there were no visible signs of life. Once this was established that there were no signs of life, Staff Nurse MARTIN verified the death of the deceased **Code A**.

As this was an expected death I would remove any excess pillows and lay the patient down.

Approximately ½ to 1 hour later I would then with another member of staff prepare the body to be sent to the mortuary. Where necessary we would wash the body leaving the deceased in their own nightwear. In come cases we would put a white hospital shroud covering the body.

We would then put an identification label on the deceased's foot and one on the stomach area.

Then we would wrap the body in a hospital sheet which also had a label with the deceased's name.

Then at least 2 members of staff would list and bag all the deceased's personal property. A list would be signed by both members of staff and put inside the property bag.

Once all this had been completed the porter would be called to bring the trolley for transferring the deceased to the mortuary.

If this procedure was completed during my night shift I normally would accompany the porter to the mortuary where I would assist the porter to transfer the body into the mortuary cold store. The porter would then write the deceased's name on the door of the cold store.

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The deceased's personal property was then taken to the Patients Affairs Office where they secured and the room locked.

I cannot remember whether this patient, Code A, was transferred to the mortuary during the night shift that I was on duty.

I had no other involvement in dealing with this patient.

On the label identifying the deceased would be included the deceased religion, date, time of death, the ward and whether the body was to be cremated or buried.

It was the responsibility of the Staff Nurse to notify the next of kin of the death.

Taken by:DC Code A

Signed: R R YOUNG
2004(1)

Signature Witnessed by: