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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: DORRINGTON, IRENE MARGARET

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

This statement (consisting of 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: I M DORRINGTON Date: 02/12/2004

Further to my previous statement made to the Police on 16th October 1996, (16/10/1996) I would like to add that I kept up to date with all my Nursing courses with yearly reviews, up until I retired in 1999, having 38 years nursing experience. I am unable to remember my RGN number

I was a Staff Nurse in 1996 working night shift only, on Dryad Ward at the Gosport War Memorial Hospital .

My responsibilities were in the main "patient care" and I was in charge of a team of two or three Auxiliary nurses. Our task on nights were to care for the patients, give medication, make up care plans and hand over to the day shift. My supervisor at that time was either Fiona WALKER on Sultan Ward or Anita TUBBRITT on Dryad Ward.

I don't believe I received any training in the use of I/V drugs except for hand outs

I have never heard the term the Wessex protocols.

I did a day course at the Gosport War Memorial Hospital in the use and setting up of syringe drivers . I must say that I was nervous regarding their use and with others I asked for more training. Usually when we came on to nights the syringe drivers for patients had already been set up by the day team.

The named nurse is something that was used on days mainly, but not nights. This was the nurse

who was responsible for a particular patient and whose name was usually on a board in the nurse's station.

In relation to the time and date of all entries, I would complete these in the notes when I had finished all of my jobs, however if the patient was really poorly I would write in the care plan at the time.

My tour of duty was always night duty, I had never done days. I worked 20 hours per week which was 2 nights. My hours of duty were from 1930 to 0730 the following day.

I have been asked to detail my involvement in the care and treatment of a patient on Daedalus Ward, Elsie Hester LAVENDER . I have no recollection of this patient at all and from working on Dryad Ward, I would only cover another ward in the case of absence through sickness or otherwise. From referral to entries in her medical notes, exhibit reference BJC/30 I can confirm that on page 123 of those notes which is a nursing care plan, dated the 23rd February 1996 (23/02/1996) I have written and signed the entry "Analgesic given before settling, comfortable night. DF118x 2 given at 0630 at her request" DF118 is an analgesic and is also known as dihydrocodeine. I should imagine that the patient was in some discomfort and she may have had a stroke. It is clear that the analgesic worked because I have written that she had a comfortable night. After referral to the drug charts of page 141 of the notes I see that I gave her the tablets at 2300 and 0630.

I can also confirm that also on page 123 of the notes dated the 24th February 1996 (24/02/1996) I have written and signed the entry" Comfortable, appeared to have picked a spot on forehead. It bled copiously forming clots. Managed to stop it by pressure. No further episodes"

I can also confirm that also on page 123 of the notes dated the 1st March 1996 (01/03/1996) I have written and signed the entry"Refused medication at 2200 hours, took a while but I persuaded her to take them. Eventually took them at at 2300 hours. Leaking faeces. Nursed on alt sides." The medication refused was DF118 dihydrocodeine. I have no recollection of this patient as I have said but it was a fairly usual occurrence for deteriorating patients to refuse

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medication. It was however always worth persevering and they usually took the medication later, as in this case. The term nursed on alt sides meant the patient was moved from side to side in an attempt to prevent pressure sores. Alt means alternate.

I can also confirm that again on page 123 of the notes dated the 2nd March 1996 (02/03/1996) I have written and signed the entry "Took medication well, nursed on alt sides. Still leaking faeces PR."

The term took medication well simply means that the medication was taken without incident, such as refusal.

PR means Per Rectum.

I can finally confirm that on page 151 of the notes, which is a nursing summary regarding the patient Elsie LAVENDER dated, Night 24th February 1996 (24/02/1996) I have written and signed the entry" Comfortable night. At 0300 appeared to have picked a spot on forehead which bled copiously. Managed to stop it by pressure. MST 10Mg given 0615. BS high at 24.2. Insulin given earlier." The part of the entry regarding the picking of the spot on the forehead I had mentioned previously on the nursing care plan.

The part of the entry regarding the picking of the spot on the forehead I had mentioned previously on the nursing care plan of the same date. MST is Morphine Sulphate Tablets 10Mgs given. BS means Blood sugar which was high and her Mixtard insulin was given at 0700 hrs.

Taken by:D WILLIAMSON