RESTRICTED

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 STAFF NURSE

This statement (consisting of 6 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: 15/02/2006

I am Irene Margaret DORRINGTON and I live at an address known to the Police.

I retired from the NHS in 1999, after 38 years nursing experience.

I retired as a Staff Nurse at Gosport War Memorial Hospital ; I cannot recall my RCN number.

In 1997 I was a Staff Nurse working night duty 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 I believe to be Fiona WALKER .

I don't believe I received any training in the use of I/V drugs. I may have received hand outs.

I have never heard the term the Wessex protocols.

I attended a day course at GWMH in the use and setting up of syringe drivers. I recall I was nervous regarding their use and along with others I requested more training.

Usually, by the time we came on to nights the syringe drivers for patients had already been set up for us by the day team.

The title named nurse is something used on days, but not on 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 notes at the time.

As I have said I only worked a night duty. I worked 20 hours per week which consisted of two nights. My hours were from 1930 until 0730 the following day.

I have heard the term All Nursing Care, this means that we were providing all the care that patient required, in that they were unable to do anything for themselves. Their Bartel score would be low. We would provide care in relation to washing, dressing, feeding, repositioning, bathing and toileting.

The term TLC means Tender Loving Care and would indicate to me that the patient was poorly and not expected to live very long.

The term, "I am happy for Staff to verify death" Indicates that a patient is terminally ill and not expected to live very long and that the Doctor is happy for staff to verify the death of a patient in her absence

I have been asked to detail my involvement in the care and treatment of a patient named Geoffrey PACKMAN ; I have some recollection of this patient and from referral to his medical records (Exhibit Reference BJC/34) I can state that on page 63 of his notes which is a Summary dated 29/8/99 I have written

"Slept for long periods. Oramorph given as prescribed. This morning c/o left abdominal pain" I have signed this entry I DORRINGTON

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Nocte means night

c/o means complained of

On the same page of the notes dated 31/8/99 am I have written;

"Appeared to have a comfortable and peaceful night. This morning passed a large amount of black faeces" I have signed that entry I DORRINGTON

On page 172 of the notes which is a prescription sheet in relation to this patient.

I have initialled that I have administered 20mgs of Oramorph at 2200 on 26/8/99

I have initialled that I have administered 10mgs of Oramorph at 0600 on 27/8/99

I have initialled that I have administered 20mgs of Oramorph at 2200 on 29/8/99

I have initialled that I have administered 10mgs of Oramorph at 0600 on 30/8/99

This is cross referenced to the Dryad Ward Controlled Drugs Record Book (Exhibit Reference JP/CDRB/24)

On page 54 dated 26/8/99 at 2225hrs I have signed that I administered 20mgs of Oramorph in 1ml to the patient, witnessed by Staff Nurse Anita TUBBRITT

On page 59 dated 27/8/99 at 0700 hrs I have signed that I administered 10mgs of Oramorph in 5 ml to the patient, witnessed by Staff nurse Anita TUBBRITT

On page 55 dated 29/8/99 at 2220 hrs I have signed that I administered 20 mgs of Oramorph in I ml to the patient, witnessed by ME FIELDS

Also on page 55 dated 30/8/99 at 0610 hrs I have signed that I administered 10mgs of Oramorph

in 0.5 ml to the patient, witnessed by ME FIELDS

The Oramorph was written up on 26/8/99 for 10mgs in 5ml, 10-20mgs range 4 hourly during the day and 20mgs in 5ml at night (nocte) and signed by Dr BARTON and that was my authorisation on night duty to administer the Oramorph to the patient. The 20mgs of Oramorph is the night time dose given so as not to disturb the patient when they are asleep at night.

The patient passing the large amount of black faeces (excretions from the bowel) indicates that he may have been suffering from a bleed in the stomach. If he were on iron tablets then that may have been partially responsible and black faeces may be expected.

This matter would not have been reported to a Dr immediately, because there was not one on duty overnight. However this fact would have been passed to the Day Sister on changeover and the Dr would have been informed by her. As far as I can see this fact is not recorded in the notes. I am unsure about what action was taken in respect of this, there appears to be no entry as such within the notes referring to this.

I see from the notes that on the following day 1/9/99 that Dr REID was on the ward.

On page 79 of the notes dated 25/8/99 on a Nursing Care Plan for sleep, I have written,

"Small watery faecal leak before settling. Only marking afterwards. Slept fairly well. Repositioned am, used hoist and glide sheet" I have signed that entry I DORRINGTON.

This indicated that he was leaking from his rectum, before he settled down for the night, but not too much afterwards. He was repositioned after midnight but due to his size he was hoisted up to do so and a glide sheet used to turn him

Also on page 79 of the notes dated 26/8/99 on the Nursing Care Plan for sleep, I have written,

"Appeared to have a comfortable night. Oramorph given as boarded. All care given" I have

signed that entry I DORRINGTON. The Oramorph I have given as previously mentioned in this statement. All care given indicates that there was little that the patient could do for himself in relation to Activities of Daily Living i.e. washing toileting etc.

Also on page 79 of the notes dated 29/8/99 on the Nursing care Plan for sleep, I have written,

"Quite sleepy. Medication given as prescribed. C/O left abdominal pain ?bowels or?" I have signed that entry I DORRINGTON.

The medication given as prescribed is the Oramorph I have previously mentioned.
C/O means complained of
Left abdominal pain may have been the bowels
? ? Means unsure.

Also on page 79 of the notes dated 30/8/99 on the Nursing Care Plan for sleep, I have written,

"Appeared to have a peaceful and comfortable night. No faecal movement until mani & then it was a large amount of black soft faeces". I have signed that entry I DORRINGTON

Mani means morning.

On page 83 of the notes dated 31/8/99, early am, on a Nursing Care Plan for toileting, I have written,

"A large amount of soft black faeces passed" I have signed that entry I DORRINGTON.

In relation to calling a Dr, when the patient passed the black faeces on 31/8/99. This was noticed in the morning and a Dr would be available shortly. If this had occurred at night and it was felt serious enough then we would have called a Dr out. IM DORRINGTON