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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: MARTIN, MARY ELIZABETH

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

This statement (consisting of 5 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: M E MARTIN Date: 18/08/2004

I am the above named person and reside at an address known to the Hampshire Police.

I retired as a RGN (E Grade) in 2000. My Nursing Midwifery Council No. was **Code A**

I qualified as a RGN in 1978 after completing 3 years of training at the Queen Alexander Hospital in Portsmouth.

I believe it was towards the end of 1979 that I went to work at the GWMH . At that time I was working on the male ward. I worked on the male ward for approximately 6 months.

I then went to work at the Northcott Annex (which was part of the GWMH) situated in Bury Hall Lane, Gosport. I worked at the Annex for about 4-5 years.

I believe it was in 1985 that I went to work at St Christophers Hospital in Fareham as a staff nurse working permanent nights. I worked at this hospital for approximately 3 years.

In 1988 I then returned to work as a staff nurse at the Redcliffe Annex.

I believe it was in 1994 that the Redcliffe Annex was closed and the patients and staff were transferred to Dryad Ward.

I was permanent nights duty staff nurse at the Annex and also when I transferred to Dryad Ward.

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Dryad Ward consists of 20-21 beds for elderly long term patients. There were also some patients who were admitted for respite care.

My night shift commenced at 2045 and finished at 0745 hours. There was a hand over period at the beginning of the shift from the day shift and again when we were finishing our night shift. There were 3 staff on nights, one trained, ie RGN and two auxiliaries. On occasions there would be an (SEN) State Enrolled Nurse.

My responsibilities on the ward consisted of the management of the ward, caring of the patients, administering drugs where applicable. I was responsible for contacting the Doctor of a patient where necessary.

At that time I would contact the patients own GP up to 10pm (2200). After 10pm (2200) it would be a locum Doctor. I will add that it was on very rare occasions that a Doctor was called out.

With regards to the use of syringe drivers I can recollect that I first starting using these whilst I was at the Redcliffe Annex in 1988. All the trained nurses were given a half day's training in the use and preparation of a syringe driver.

A syringe driver can only be set up by two trained nurses. One of the reasons for this was because controlled drugs were administered in the syringe driver. A record of these controlled drugs was strictly recorded in the ward drugs register.

I have been asked to detail my involvement with the patient **Code A** . Firstly I cannot recollect anything about this patient.

I have been shown a printed copy from a microfiche bearing the reference BJC71.

I can confirm that I have written the following entry on page 15 as follows.

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'24.1.96 (24/01/1996) Death verified at 1.45am (0145) by S/N M E MARTIN in the presence of N A YOUNG (and then signed by me)'.

The procedure for verifying death was first to check the patient's vital signs, lack of radial pulse, pupils fixed and dilated and no lung or heart sounds when tested with a stethoscope.

If it was an expected death which in the case of this patient Code A it was, I would contact the family immediately to inform them of the death.

The patient's GP would be contacted in the morning by the day staff.

If the death was unexpected we would not verify death. A doctor would be called out to attend to the patient.

With reference to the entry I have made above on page 15. This entry has been written in the clinical notes. It is the only time that a nurse will write an entry in the clinical notes. That is to confirm that the death of a patient has been verified.

Death could only be verified by a trained nurse.

Death of a patient is verified by a trained nurse which has to be witnessed by another member of staff, normally an auxiliary. This was the policy on the ward at the time.

I can confirm that I signed for and withdrew Oramorph on the 10/1/96 (10/01/1996) at 1020pm (2220). This entry had been written by Dr BARTON . This is recorded on page 17 as follows.

Oramorph 10mg/5mls route given was to be oral - 2.5mls 4 hourly.

This drug was administered to the patient after the consultant's round who in this case was Dr TANDY accompanied by Dr BARTON. Oramorph was prescribed by Dr BARTON and

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recorded in the drugs chart on page 17.

The reason for administering the drug at this time is simply that the drug round was usually at 10pm (2200). This drug was kept in a locked cupboard which was within another locked cupboard.

I can confirm that I withdrew 10mg in 5mls (This Oramorph is a standard doseage delivered in a bottle from the pharmacy) at 1020pm (2220) for the patient Code A. This entry is signed by me and witnessed by Fiona WALKER . This is recorded in the drug register for Dryad Ward.

I can confirm that I wrote the following entry on page 26 as follows.

Night - condition remains poorly, all care continued, syringe driver running satisfactorily. Signed by me.

Any involvement that I had with the patient Code A will be recorded on the patients notes.

I can confirm that I have written the following entry on page 27 as follows.

Night - Little change in poor conditions, appears more peaceful. Turned frequently and suction given when necessary.

Suction is given to a patient when they have excess fluid on their lungs. The excess fluid is extracted using an electric machine.

I can confirm that I have written the following entry on page 29.

Night - Patients condition deteriorated suddenly at 1.40am (0140) and Code A died at 1.45am (0145). Code A (daughter) informed at 1.50am (0150). Death verified by S/N M E MARTIN in the presence of N A YOUNG. For cremation.

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I cannot remember the patient Code A After reading this entry concerning his death I still cannot remember anything about this patient.

I will add that I worked on Dryad Ward for 18 months approximately. I then moved, moved to work on the Sultan Ward as night duty staff nurse later in 1996.

I can also confirm that I withdrew Oramorph at 0610 on the 11/1/96 (11/01/1996) for the patient Code A. The doseage was 5mg per 2.5mls as previously administered and recorded in the Dryad drug register book.

Taken by: Code A

Signed: M E MARTIN

Signature Witnessed by:

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