

RESTRICTED

Form MG11(T)

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of:

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

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:

Date: 12/05/2006

I am and I live at an address known to Hampshire Police.

Further to my previous statement made on 21/2/06 I would like to clarify the entries regarding the administration of controlled drugs to the patient Enid SPURGIN.

I refer to the nursing notes (Exhibit Reference BJC/45) and the Controlled Drugs Record Book (Exhibit Reference JP/CDRB/47).

On page 9 of the Controlled Drugs Record Book, at 2010 hrs on 1/4/99 I and at 0845 on 2/4/99 I have witnessed the administration of 10 mgs of Morphine Sulphate SR Tabs by Staff Nurse

Also on page 9 of JP/CDRB/47 at 0810 hrs on 3/4/99 I have witnessed the administration of 10mgs of MST by Staff Nurse Lynne BARRETT.

Again on the same page at 0845 on 11/4/99 I have also witnessed the administration of 20mgs of MST by Staff Nurse

On page 69 of the Controlled Drugs Record Book (JP/CDRB/47) at 0900 hrs 12/4/99, I have witnessed the administration of 60 mgs of Diamorphine in 2x 30mgs doses by Staff Nurse Freda SHAW.

Signed:

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On page 87 of the Controlled Drugs Record Book (JP/CDRB/47) at 0900 12/4/99, I have witnessed the administration of 20 mgs of Diamorphine by Staff Nurse Freda SHAW.

This accounts for the 80mgs of Diamorphine as prescribed by Dr BARTON.

Also on page 69 at 1640 hrs on 12/4/99, it is stated I have witnessed the administration of 40mgs of Diamorphine administered by Staff Nurse Lynne BARRETT. This is a mistake, it is written 40 mgs but on a 30mg ampule. So another 10mgs of Diamorphine was needed to make it up to the 40 mgs.

On page 88 of the Controlled Drugs Record Book (JP/CDRB/47) at 1640 hrs on 12/4/99 I have witnessed the administration of 10mgs of Diamorphine (entered after 40mgs had been crossed out and error entered) by Staff Nurse Lynne BARRETT. This is the dose as indicated in the previous paragraph.

On page 131 of the notes I see that at 0800 hrs on 12/4/99 at the Syringe Driver containing 80mgs of Diamorphine and 20mgs of Midazolam was commenced. Although there is an arrow and, dose discarded is written.

Dr BARTON has prescribed and written up both entries, plus one for Hyoscine, which does not appear to have been administered.

Dr BARTON is likely to have authorised the starting dose of Diamorphine used in a range of between 20 to 200 mgs in 24 hours. She is also likely to have authorised the starting dose of Midazolam used in a range of between 20 to 80 mgs in 24 hours, as she used to do her ward round at 0730 am. But I don't recall if she did after all this time,

I cannot recall whether it was Dr BARTON's calculations or if the dosage rate was worked out by Staff Nurse Freda SHAW or I. This calculation would have been based on the previous Morphine Tablets (MST) that the patient had been given in the preceding days. It would be worked out as follows; the total daily dose of MST is divided by (3) three to give the correct

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Continuation of Statement of:

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dose of Diamorphine to be administered by subcutaneous injection.

Having looked at the notes and my previous statement, I can state that I did not work this conversion out, the 80 mgs administered was four times too much. I would not have worked it out to be so high a dose.

I always argued with Dr BARTON over things like this but I was always given short shrift by her. I was basically ignored by her.

I am unable to find in the notes where these decisions are recorded.

I see that on page 108 of the notes that there is an entry in a summary, dated 12/4/99 as follows, "S/B Dr REID , Diamorphine to be reduced to 40mgs over 24hrs. If pain reoccurs the dose can be gradually increased as and when necessary. Enid's nephew has been spoken to and is aware of the situation." This entry is signed by Staff Nurse Lynne BARRETT.

My opinion on this entry would be that Dr REID felt that too much Diamorphine had been prescribed for the patient's needs.

Code A

Code A

Statement taken by:

Code A

Signed: Code A

2004(1)

Signature Witnessed by:

Code A

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