LYNNE JOYCE BARRETT started work in 1987 firstly Northolt annex then Redcliffe annex where Barton first started work and introduced the syringe drivers. Seems to be a good disciple of Barton.

Statement on Code A relevant in all cases

- LB states that Diamorhine was used at Redcliffe Annex to control pain what date did this start? She states that she does not remember the meetings in1991 even after seeing the minutes dated 11/07/1991. However she does remember the meeting with the Pharmacists from the QA who talked about the Diamorphine and syringe drivers at that time.
- Sister Green showed a brief demonstration regarding syringe drivers and she was also trained by Jill Hamblin in the use of syringe drivers since 1987/1988.
- She is aware of the Analgesic ladder but seems not to have put it into practice.
- Explain what you mean by Tour of Duty?
- You received further training in Palliative/ terminal care in 2003 and further lectures, where were they held? Was this training done in the same way in 1999 as it was in 1987 in the administering of opiates at the Gosport War Memorial?
- States that she writes up all notes in notebook and then transfer them to patient's records. However does not record the increase dosage on a patient Code A and no record of a doctor's visit, even though there was an increase in dosages.
- On Enid SPURGIN records note dia-morphine levels from 20-200mgs but cannot say why Barton prescribed 60mg diamorphine on the 12/4/99 at 0900 and then another 40mg at 1640 the last entry sighed by her, by which the patient had received 90mg diamorphine.
- She states (Enid Spurgin page 10of10) that when parameters are set, they are done so by a doctor. On a scale of 20-200mg nursing staff would always start on 20mg unless told otherwise. What happened regarding my Mother? Why would it be that 20-80mg was written up and 40mg was the administered starting dose?
- States that doctors increase dosages but in another statement states that the doctors write the perimeters and they can increase according to the patients needs? Which is correct?
- This was only weekends when there was no doctor they were able to increase with out the doctor if it was within the perimeters. However in the case of Enid Spurgin the 12th April this was a Monday not a weekend. States that she would speak to Jill Hamblin or Barton if had any concerns.
- She states in Enid SPURGENS case syringe drivers are applied when patients are unable to communicate with staff or unable to take their medication orally, I am totally confused as surely the relatives would have concerns too if they were not able to communicate with there loved ones.
- LB states on Code A file, page on 5 of 6 that a patient showing signs of distress despite being given the prescribed dosage would lead to calling Dr Barton to discuss the problem; and Doctor Barton would give the authority to increase the dosage within the specified range, which had been set by her on the prescription sheet. However this is not true, nurses can increase as you please – is that not correct?
- It is stated that moral was low in Redcliffe Annex they were receiving more acute patients who were very ill and that some did not last a week… I understand myself now reference 1991 document a shocking read.
- It is stated that LB always included relatives in the decision-making and that they were kept fully informed. Why did she fail then in my Mother's case?
- In her statement she feels that Dr Barton is being used as an escape goat so that the relatives who started this vicious campaign can have a name on an official document. I am one of those relatives and if she thinks that I have giving up 10 years of my life to get my name on to an official document she is totally deluded. What document would that be? But her ignorance is

something, which I have become well versed in whilst trying to fight for the right to life for my Mother. I am delighted also to have brought awareness to other families so that they will not suffer at the hands of such mal practice. I know this is probably irrelevant to Tom but this statement I feel strongly about. Has she read the CHI report? That report would not have happened if others and myself had not made formal complaints

My Mother, Elsie Devine

- She states that she is aware of the analgesic ladder can she explain … My mother did not go on an analgesic ladder, that is why I am deeply concerned as she was not in any pain, distressed or agitated
- She states that Diamorphine syringe drivers are use when a patient is no longer able to communicate, how does she explain why it was given to my Mother?
- She states that syringe drivers are used for patients who cannot swallow however that was not the case in My Mother?
- On the 18th November 1999 LB administered a Fentanyl Patch (which is the equivalent to 135mg diamorphine.
- Would LB expect any side effects regarding this patch, especially if the patient is not opioid tolerant?
- Why did LB administer this very strong opiate to my mother who had not received even a paracetamol?
- If my Mother was in so much pain why did they treat her with this patch, which takes up to 24 hours to take effect? Surely LB would titrate a pain relief so that my Mother had 'immediate' relief?
- Fentanyl is an opiate and requires dual signature, this is missing on my Mother's prescription sheet. I need to see full drug chart.
- LB States that my Mother refused her oral medication on the 18th, but at 0600 she took her amiloride? It seems the night nurses had no issue. Did LB not consider that my Mother had complained of a sore mouth? Why on the first refusal did they see fit to administer a fentanyl patch?
- My Mother wasn't in terminal pain, or agitated or aggressive. My Mother told the psychiatrist that the tablets they were giving her made her mouth sore; surely if she was in chronic pain she would have mentioned that. She had two visitors that day, the 18th November 1999, Mrs. Briggs who had tea with her, dried her hair after a bath; My Mother signed her pension book. My brother visited her that evening, chatted and kissed her goodbye, he told her I will see you tomorrow Mum? Not one member of your staff including you notified my brother, family, or Mrs. Briggs that you had administered a Fentanyl Patch 25mg and that my mother was now in the Terminal stages. LB her named nurse!
- That morning after the Fentanyl patch had taken full affect, she woke at 5.30 dress herself she then according to the statement in the IR Report my frail Mother allegedly threw one nurse up against a book case and another nurse across the room and also tried to get a patient out of bed. Seems strange to me that all this that my Mother was accused off is not in the medical notes. (Not the same story as in her statement)
- Did LB not consider this to be an overdose of Diamorphine?
- Is LB aware of the analgesic ladder?
- Is LB aware of the Wessex Protocol?
- Why did LB fail to use either in the care of my Mother?
- Is LB aware that Fentanyl was only licensed in 1999 in the treatment of patients with chronic intractable pain dying from Cancer?
- Temazapan was written up on admission but LB states the chart shows it was never given, oral

morph written up on admission but shows not given. Drawn from the pharmacy against my mother's name. On the 11th November 99 on the nursing notes it states ref. my Mother out to the toilet in the night not wandering or disruptive yet at 0115 hours my Mother was given Temazapan sleeping drug (it states written in error) she refuse this drug on the 12th at 2140hrs. On the 11th my Mother was given a urine check and at 0800 Trimethoprim was commenced for treatment of a presumed urinary tract infection. There is no record on the nursing notes of who gave my mother the urine check and why after 4 weeks they suddenly decide to do a urine check on my mother. The results were returned after the full course of antibiotic had been given on the 15th – this result was normal.

- Is LB aware of the effect Trimethoprim has on the kidneys and the creatinine level? It causes a **false reading of increased creatinine**, which does not affect the GFR and is reversible. This is clearly researched and written as part of the patient drug information.
- On the same day, the 11th you commenced my Mother on Thirodazine. Why was this?
- Are you aware of the side affects of Thirodazine (spelling not correct)? You gave my Mother this as a calming medicine… correct. In what way did she need calming?
- If my Mother's behaviour was not controlled or worsening, why did you reduce the dosage on the 16th and 17th? It has been stated that my Mother's aggression was a sign of her terminal pain, but I fail to understand then why you did not administer the Thirodazine twice daily on the 16th/17th. This can only show that she was less agitated/aggressive.
- My Mother was bathed on the 15th/16th and 18th November, 18th being the very day you bathed her at PM when you had already administered the Fentanyl patch at 0830 to this confused, agitated and allegedly dying elderly lady.
- My Mother was bathed and her hair washed (pm) being as she was in allegedly in the terminal stage, Mrs. Briggs dried her hair, mum signed her pension book (Ex daughter-in-law)?
- 5 years later LB remembered my Mother to be a fairly small lady who would rummage through peoples lockers and then you or other members of staff would have to persuade her to give them back. Extraordinary her cupboard was filled with chocolates and biscuits that she could not possibly finish.
- LB states that she remembers one morning that she had just come on duty around 0705 and my Mother was in the main corridor outside the main room. She had hold off Debbie Barker by both wrists and was trying to push Debbie against a rail attached to the wall;
- I went up to Elise to try to persuade her to let go of Debbie, she pushed Debbie up against the door frame. After a bit of persuasion, she release one wrist of Debbie's and then hit me around the face and knocked off my glasses. They all tried to persuade Elsie to go into the Day room but she was beyond reasoning and was shouting loudly and this went on for about half an hour to three quarters of an hour, this incident also included Gill Hamblin and Liz Bell. Dr Barton came in to do her early morning ward round – saw what was going on and prescribed 50mg Chlorpromazine (IM).
- (Gill Hamblin states that she called Barton over the telephone and on her advice she withdrew it from the pharmacy) she wrote the time 0830. Someone put LB initials against the administering of this drug; she did not sign this yourself, correct? Dr Barton signed it off later as Jill Hamblin states.?
- **The Independent Review** I had in 2001 tells a completely different story? The Independent Review states my mother this frail 88year old who was unsteady on her feet and was registered partially disable, woke that morning at 5.30am dress herself and proceeded to get a patient out of bed, she threw one nurse across the room and another up against a bookcase, so quite honestly I don't know what to believe the IR or LB.
- LB administered the 50mg chlorpromazine IM injection to my mother in the day room. (But
- She fail to say that 4 nurses held her on the floor whilst this was given.) LB states that my

Mother was still shouting and not happy, this is extremely upsetting to hear this in the statement . Through all these alleged attacks that my Mother committed, there is not one entry made in the nursing notes or the accident book to protect them for accident liability.

- All morning this incident going on and you never saw no urgency to call the family. LB states that she sat with her the majority of the morning until she had calmed down completely. LB states that she left Liz Bell and Debbie Barker with Elsie for the rest of the morning, while my family was getting on with their lives not knowing what was happening.
- As stated in the I.R. After LB administered the IM Chlorpromazine 50mg, this extremely painful injection to my frail 88year old Mother. Some 55 minutes later a syringe driver was administered into my Mother's back with 40mg Diamorphine and 40mg midazolam. On the drug chart it was written up by Dr Barton first administered by Jill Hamblin, however need explained why the pharmacy section was not filled in as per all the other drugs administered to my Mother? After the administration of the Morphine/ midazolam with already 50mg Chlorpromazine, and the Fentanyl equivalent of 135mg Diamorphine all within 24hrs.
- Liz Bell and Debbie Barker walked my Mother for 3 hours and by 12.30pm she had relaxed enough to be settled into an armchair and then transferred to a bed and my mother was able to take some fluids. (ref I.R.)My Brother visited at 1pm to an appointment with Jane Barton and no idea his Mother was unconscious and dying.
- LB states that she is aware of the use of drivers and the analgesic ladder that is to start on paracetamol. In the case of my mother, she had never received any painkillers or opiates before hand. LB states that the dosage and delivery date of drugs to a patient can only be authorised by a doctor.
- Would LB agree all her nursing notes were updated on all patient's needs and changed?
- However I cannot see any assessment on my mothers notes that was done over a 24 hour period