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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: BARRETT, LYNNE JOYCE

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

This statement (consisting of 8 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: L J BARRETT Date: 11/08/2004

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

I qualified as a SRN in 1972 at the Hull Royal Infirmary.

I have 17½ years experience as a Registered General Nurse (RGN).

In 1987 I was working at the Redcliffe Annexe as an RGN.

I believe it was in 1994 that the Annexe was closed and the patients and staff were transferred to the Dryad Ward at the Gosport War Memorial Hospital (GWMH). At this time I was an E Grade RGN.

I am currently an E Grade staff nurse on the Dryad Ward at the GWMH.

My nursing Midwifery Council Pin No is Code A

My current responsibilities on the Dryad Ward are tending to the day to day running of the ward. This includes supervision of junior staff, caring for the patients, administration of prescribed medicines.

I have been using syringe drivers since 1987 or 1988. I was given on the job training by the Clinical Manager on the ward at the Redcliffe Annex by Sister Gill HAMBLIN . I was shown how the syringe driver worked, how to book the prescribed drugs out from the drugs register

which were to be used in the syringe driver. I can recollect that we were also informed which prescribed drugs could be mixed in the syringe driver and which drugs were not suitable for mixing.

The only prescribed drug that I would not put together in a syringe driver are Haloperidol and Cyclazine. This is because when these two drugs are mixed the solution turns a milky colour. Nursing staff also received tutorials from pharmacists who came on to the ward.

We were advised which drugs were not to be mixed, especially when administering large doses. For example Hyacine was pointed out as being toxic and had to be diluted more thoroughly. It would be administered in another syringe driver.

I work a 37½ week on the ward. The shift pattern consists of early which either starts 0730 to 1530 or 0730 to 1300. Lates are 1215 to 2030. Nights commence 2015 to 0745.

Dryad Ward consists of 20 beds. The majority of the patients are aged over 75. Currently the Dryad Ward is closed as a continuing care assessment ward.

I should mention that with regards to syringe drivers it is policy that two trained nurses are present when the driver is set up with the required prescribed drugs.

I am aware of the Analgesic ladder, ie, the pain ladder. Basically this refers to the strength and type of drug given to a patient. This starts from the simple paracetamol through to drugs containing codeine, then onto weak opiods then onto the opiates, ie Oromorph and Diamorphine

Drugs and dosages given to patients are sometimes based on the 24 hour observations of nursing staff. These observations are passed onto the doctor when he or she are doing their ward round. Or if necessary if in more urgent cases the Doctor may well be phoned.

From 5pm (1700) to 7am (0700) the hospital is covered by Primecare deputising Doctors

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Service.

Syringe drivers are used when patients cannot swallow that is take oral medication. The driver is an effective way of delivering pain and or sedation relief over a 24 hour period without the peaks or troughs.

I have been asked to detail my involvement with the patient **Code A** who was admitted to the Dryad Ward on the 5th January 1996 (05/01/1996).

Firstly I do not remember this patient.

I have been shown a printed record from a microfiche exhibit BJC71.

I can confirm that on page 25 I made the following entry.

9/1/96 (09/01/1996) small amount of diet taken, very sweaty this evening but is apyrexial, has stated that he has generalised pain, to be seen by Dr BARTON in the morning.

With reference to the above entry apyrexial means 'The patient's temperature is within normal limits.

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

16/1/96 (16/01/1996) - 2000 hrs - condition remains very poor, some agitation was noticed when being attended to S/B Dr BARTON Haliperidol 5mg - 10mg to be added to the driver.

The next entry is timed at 1300 hrs that day.

Previous driver dose discarded driver recharged with diamorphine 80mg Medazalam 60mg, Hyacine 400mcg and Haliperidol 5mg given at a rate of 52 mmol/hly. Visited by daughter (not Sister WILES) who is now aware of poorly condition. All nursing care cont'd. (R) ear found to

be blistered along upper edge, please nurse only on back and (L) side, marking very easily please turn 1½ - 2 hry.

S/B means seen by.

Where I have referred to 52 mmol/hly this relates to the rate that syringe driver dosage is to be set over the 24 hour period, ie the hourly rate.

(R) = right. (L) = Left.

At this stage I should point out that it was my practice to record all my notes concerning patients on a little note book which I carried in my pocket. I would then write up the Nursing notes from pocket note book at the end of my tour of duty.

Where I have stated 'Previous driver dose discarded'. This means that Dr BARTON had requested a change to the constituents in the driver. Therefore the previous dosage was discharged in the presence of two nurses.

Then a new dosage (in this instance) containing the additional Haliperidol was then set up and administered to the patient.

I have been shown the ward controlled drugs record book for the Dryad Ward.

On page 7, dated 16/1/96 (16/01/1996), timed 1300 there is an entry showing 20mgs (This is 2 x 10mg ampoules) of diamorphine that I have taken out from the drug cupboard. The entry is signed by me and witnessed by staff nurse Freda SHAW . The entry relates to Code A Code A .

On page 11 on the same date in the drugs register there is an entry dated 16/1/96 (16/01/1996), 1300, showing 60mgs (this is 2 x 30mg ampoules) of diamorphine that I have taken out from the drug cupboard. The entry relates to the patient Code A , which is signed by me and

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witnessed by staff nurse Freda SHAW.

The above amended and addition on dosage for the syringe driver was authorised by Dr BARTON.

The discarded dosage from the syringe driver is then disposed of down the sink, witnessed by two members of staff.

I can confirm that I wrote the following entry on page 27.

18/1/96 (18/01/1996) 2000 - poorly condition continues to deteriorate. All nursing care cond.

Cond is an abbreviation for continued.

1500 driver recharged with Diamorphine 120mgs. Midazolan 80mg, Hyoscine 1200mcg, Haliperidol 20mgs and Nozinan 50mg. Wife has visited for most of the day. Appears comfortable in between attention. Oral suction given with some effect.

Oral suction relates to where the patient has had chest secretions removed from the back of the throat using a suction machine. This procedure is done to alleviate distress of the patient.

The above entry would have been written at the end of the late shift by me from my note book.

I have been shown the drug register page 7 dated the 18/1/96 (18/01/1996), 1500 patient Code A Code A. The entry confirms that 20mg of Diamorphine (2 x 10mg ampoules) were taken out from the drug cupboard by Gill HAMBLIN witnessed by myself.

On page 16 of the register for the same day and time there is an entry showing 100mg of Diamorphine signed by Gill HAMBLIN and witnessed by myself.

I will also add that I have made a mistake with regards to an entry on page 7 which shows

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another entry dated 18/1/96 (18/01/1996), 1500 against Code A 20mg signed by me and witnessed by Bridgette SPENCER .

This entry should be dated the 19/1/96 (19/01/1996) 1500 and not the 18/1/96 (18/01/1996) 1500.

I wish to add that under no circumstances would I alter, add or change prescribed drugs to a patient without the authorisation of a Doctor.

I have noted that there is no record on the nursing notes for the 18th January 1996 (18/01/1996) showing there was a visit on the ward by a Doctor which would have led to the changes, ie increase in doseage of prescribed drugs to the syringe driver of Code A at 1500 hrs that day.

There is no written note showing that a Doctor has visited. It is my opinion that an entry for the early turn/shift for the 18th January 1996 (18/01/1996) has been omitted.

I cannot give any other reason as to why there is no record of the reason requesting an increase in the doseage to the patient of Code A on 18/1/96 (18/01/1996) at 1500.

I can confirm that I wrote the following entry on page 28.

1505 19.1.96 (19/01/1996) marked deterioration in already poorly condition all nursing care cond, position change strictly 2 hly. All pressure areas intact except for a small discoloured area at the base of big toe. Mouth care performed at each position change, breathing very intermittent, colour poor.

1500 syringe driver recharged with Diamorphine 120mg, Midazlam 80mg, Nonzine 50mg, Haliperidol 20mg, Hyscine 1200 mcg at a rate of 48 mmols/hly.

Mrs Code A has phoned and will visit later.

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I have checked the drugs chart record for the 18th January 1996 (18/01/1996) and I recognise the signature and handwriting as that of Jane BARTON. She was on duty Monday to Friday.

With regards to the way I wrote my nurses notes. I complete the notes at the end of the shift as previously stated. Firstly I record a general overview of the patient during the shift. I then record any significant events such as Doctors visits and recharging syringe drivers. As a rule I normally time and date my entries.

I can confirm that I wrote the following entry on page 29 commencing.

22.1.96 (22/01/1996), poorly but very peaceful, all care given today, Daughters have visited and spoken to Sister HAMBLIN.

1515 Driver recharged with Diamorphine 120mgs, Midazalam 80mgs, Hyoscine 1200mcg. Nozinon 100mgs at a rate 43/mmols/hly.

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

23/1.96 (23/01/1996), poorly condition remains unchanged has remained peaceful all care has contd, Pastor Mary has visited.

(Pastor Mary would have been called as the patient Code A was believed to be near to death).

1545 Driver recharged with Diamorphine 120mg, Midazalon 80mgs, Hyoscine 1200mcg, Nozinan at a rate of 43 mmols/hly, signed by myself.

The Haliperidol was stopped by Dr BARTON on the 20/1/96 (20/01/1996) which is recorded on the drugs chart.

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There is no record made on the nursing notes relating to a visit by Dr BARTON (The Dryad Clinical Practitioner) on the 19/1/96 (19/01/1996). This does not mean that Dr BARTON did not visit the patient. An entry would only be made if Dr BARTON had made alterations to the patients drug regime.

With regards to the entry dated 16/1/96 (16/01/1996), 2000 this is the time the entry was written not the time Dr BARTON visited the ward.

As a general rule Dr BARTON would conduct visits in the morning usually between 0730 - 0800 Monday to Friday or when specifically called in by Nursing staff.

With regards to my clinical manager at the Redcliffe Annex initially it was Sister C GREEN , she however went on long term sickness and subsequently left. Her position was then taken over by sister HAMBLIN.

I would add that when a patient is unable to communicate to staff that he or she was in pain Nursing staff would use non verbal indicators such as facial expression, body language and position. Insomnia (not sleeping), lack of appetite and obvious distress. These non verbal indicators would be indicators to nursing staff that a review of the treatment/medication for the patient may be required.

Therefore nursing staff would refer this for the attention of Dr BARTON.

Taken by: DC Code A