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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: JOICE, CHRISTINE

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

This statement (consisting of 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: C JOICE Date: 10/11/2004

I am Christine JOICE; formerly Christine Carraher and I live at an address known to the Police.

I am a Community Registered Nurse presently employed at the Queen Alexandra Hospital Cosham as an Intermediate Care In-Reach Nurse.

I qualified as an RGN at the Portsmouth School of Nursing in 1988, my Pin Number is Code A

Between 1988 and 1999 I worked at Gosport War Memorial Hospital as a Staff Nurse on General Medical and Surgical Wards and also on the Continuing Care and Stroke Rehabilitation unit on Daedalus Ward. I was the Team Leader of the Stroke Rehabilitation Team. I was responsible for multi-disciplinary team planning, implementing and evaluating care with the aim of discharge, either to home or other care. I supervised junior staff and managed the ward and on occasions I was "Duty" Nurse in charge of the hospital.

In 1995 I was Acting Senior Staff Nurse for 6 months on Daedalus Ward where I assisted and managed a 24 bed ward. I was also responsible for security and advising members of staff on any problems (nursing, medical and social).

In 1996 during a spell of illness from the Gosport War Memorial Hospital I commenced voluntary work at the Rowans Hospice at Purbrook.

Between October 1999 and November 2003 I worked as a Community Registered Nurse for

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Gosport and Fareham Primary Care Trust. In that role I provided nursing care for a wide range of clients with varying needs. Including terminal care, general nursing care, specific nursing care (e.g. dressings) and post operative care. I was responsible for the caseload planning in the absence of senior staff. I assessed the needs of clients and implemented care plans together with evaluation. I was also the Continence Team link nurse and the Community Health representative for Age Concern.

From 2003 to the present I am employed as an In-Reach nurse at the Queen Alexandra Hospital Cosham. My role there includes identifying patients who are suitable for transfer to appropriate care services in the community. I liaise with social services, multi-disciplinary teams within the hospital wards, medical assessment unit and accident and emergency in order to secure the best care service for residents via supported discharges and promotion of independent living. I attend discharge planning meetings and liaise with district nurses. I respond to requests from discharge planners to assess patients who may be suitable for intermediate care and I monitor delayed discharges for NHS and social services to identify patients who can be discharged into the community with support.

I am an extremely experienced nurse and have recent qualifications in rehabilitation and intermediate care, continence care, pressure sore, leg ulcer and wound management. I have also attained the module in facilitating learning in clinical practice. I have attended a recruitment and selection workshop, and also qualified in the care of the elderly ENB.

In 1996 I was a staff Nurse on Daedalus Ward at the Gosport War Memorial Hospital. My primary role was that of patient care, and where on occasions I was the duty manger for the hospital.

I have received training in the use of IV drugs but I have never administered them at Gosport War Memorial.

I do not know the term, the Wessex Protocols.

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I have received mandatory training in the setting up of syringe drivers . The models of such drivers are "Graysby" and there have been two such models.

I am not sure about what training was offered to nurses regarding syringe drivers.

My understanding of the term, Named Nurse is that it is the person in charge of the patient who is the patients and relatives contact. The named nurse may not be the person however who has day to day care of the patient.

Entries in the medical notes are usually made at the time, but in certain circumstances these may be made up later or indeed at the end of duty.

My hours of duty in 1996 were between 30-37 per week. From memory my shifts were days, 0730 - 1230, lates, 1315 - 2030. The long day was 0730 - 2045. The weekly shifts were 2 x early, a long day and 2 x lates.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I have no recollection of this patient, but after reference to her medical notes (Exhibit BJC/30) pages 97,133,139,153and 155, I can confirm that on the 4th March 1996 (04/03/1996), The following is written in the Nursing Care plan, "S/B physio-exercises: - 3 turns of head to right & 5 neck retractions every 2 hours. Elsie needs Analgesia increased" This entry is both written and signed by me as C. CARRAHER .

S/B Physio means, seen by Physiotherapist.

The entry "Analgesia increased" may have been included because the exercises were painful.

It appears from the previous days entries that she was in slight pain then.

The MST (Morphine Sulphate Tablets) which is slow release Morphine was increased from 20Mgs on 3rd March 1996 (03/03/1996), to 30Mgs the following day 4th March 1996

(04/03/1996). This was because of the increased pain the patient was suffering.

I can confirm that also on page 97 of the notes dated 27th February 1996 (27/02/1996) the following is written in the nursing care plan," Analgesia administered. Fairly effective. Able to help when dressing this a.m" This entry is written and signed by me as C.CARRAHER.

The patient had been given 10Mgs of MST up until 26th February 1996 (26/02/1996) but it had only been fairly effective, and the analgesic was increased to 20Mgs of MST on 27th March 1996 (27/03/1996). I gave her the increased analgesia and then helped her to get washed and dressed. My involvement with Mrs LAVENDER appears to have been on a day to day basis.

I can confirm that again on page 97 of the notes dated the 28th February 1996 (28/02/1996) the following is written, "R Arm less painful able to lift it above head height. L arm less improved" this entry is both written and signed by me as C. CARRAHER.

As I have previously stated the patient had been on 10Mgs of MST taken both AM and at night, from admission to 26th February 1996 (26/02/1996) and increased to 20Mgs on 27th February 1996 (27/02/1996) to be taken both AM and at night. She was also prescribed de-hydrocodeine as required.

All of these drugs had been prescribed by Dr BARTON .

I can confirm that on page 133 of the notes dated the 5th March 1996 (05/03/1996) the following is written in an Exceptions to Prescribed Orders form,

First entry
Date 5/3/96, (05/03/1996)
Time - Alltimes,
Drug Name and Dose - Oramorph S.R. 30mg,
Reason - Pt.on s/c analgesia
This is written and signed by me as C. CARRAHER.

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Second Entry

Date 5/3/96 (05/03/1996)

Time - 1730

Drug Name and Dose - Human Mixtard

Reason - Dose not required

This is written and signed by me as C. CARRAHER

Third Entry

Date dittoed as 5.3.96 (05/03/1996)

Time - 1800

Drug Name and Dose - Ferrous Sulphate 20mgs (Iron Tablets)

Reason - Pt unable to swallow

This is written and signed by me as C. CARRAHER.

Pt means patient

s/c means Sub Cutaneous, (under the skin)

These entries are written on a new chart for the date to which they refer and therefore are not included on page 131 which is dated 23.2.96 (23/02/1996).

Oramorph was not administered to the patient. This is an exception to a prescribed order and shows what the patient was NOT given, not what they were.

The patient was on Sub Cutaneous analgesia, and she either didn't require the drug, or she was unable to swallow. I wouldn't necessarily give Morphine on top of what the patient was previously prescribed as it may have had a detrimental effect. This is also shown on page 139 on the regular prescription sheet with crosses in the Oramorph column on 5th March 1996 (05/03/1996).

Oramorph is the trade name for MST.

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I cannot recall why on the first entry on page 133 I have written, Alltimes in the time column next to Oramorph. This may be because she had not been given it all that day.
The other entries are as follows

Human Mixtard is Insulin; Dose not required is self explanatory.
Ferrous Sulphate is Iron Tablets; Pt is unable to swallow is also self explanatory.
These drugs were also NOT given.

I can confirm that on page 153 of the notes dated 4th March 1996, (04/03/1996) the following is written, "Patient complaining of pain, and having extra analgesia PRN. Oramorph Sustained Release Tablets dose increased to 30mg BD by Dr BARTON" This entry is written and signed by me as C.CARRAHER.

PRN means, "As and when required"
BD means, "Twice a day"
This means that the patient was complaining of pain and was given MST analgesia which had been increased from 20 to 30Mgs as and when required, and prescribed by Dr BARTON. This is shown on prescription chart on pages 139 and 145 dated 4/3/96 (04/03/1996) the entries of which are signed by Dr BARTON.

Page 133 refers to drugs NOT given rather than those that were.

Taken by: D WILLIAMSON