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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: 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: L J BARRETT Date: 07/03/2003

I live at the address shown overleaf. I am an RGN Grade E. I am currently employed by the Fareham and Gosport Primary Care Trust as a Staff Nurse on Dryad Ward, Gosport War Memorial Hospital (GWMH), Bury Rd, Gosport.

I qualified as a SRN in 1972 and worked within the Ear, Nose and Throat Department in Hull.

In 1974, I moved to the Portsmouth Royal Hospital, Portsmouth. I left there to have my family. I then moved to the Plymouth area, where I joined a nursing bank and worked in various places. I returned to Gosport in 1979.

In November 1980, I began working for the Thalassa Nursing Homes Group.

In 1987, I began working for the South East Area Health Authority. I worked at the Northcott Annex, which was an annex of the GWMH for continuing care for the elderly. The annex closed shortly afterwards and I moved to the Redcliffe Annex.

The Redcliffe Annex was part of the GWMH. It was not part of the main hospital site and was set on two floors. I believe there were 23 beds, but they were not always taken. There were normally around 17 - 18 patients at any one time.

The Redcliffe Annex was not like a hospital. We would have strawberry teas in the garden for the patients and B-B-Q's in the grounds for patients, staff and relatives.

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The vast majority of patients were dependant on staff for their daily care. They were not able to participate and needed help with their feeding and their toileting.

Some patients would stay with us until their death. This could range from weeks to months to years.

I have been asked about medication in the unit.

Patients would bring their own medication with them and they would receive all of their medical treatment from their own GP's, who would come into the hospital. If a patient required a doctor, then we would summon their own GP.

The system then changed and Dr BARTON became the doctor for the annex, the Clinical Assistant. This system was better because Dr BARTON saw the patient much quicker.

Dr BARTON worked under the consultant at the time. The consultants were Dr LORD , Dr LOGAN and Dr Chandra KUMA .

When I began working at Redcliffe Annex, I was full time, working 37½ hours per week on the day shifts. These would be earlies, which were 7.30 (0730) - 4.15 p.m, (1615) half day which was 7.30 (0730) - 1.00 p.m, (1300) and lates which were 12.15 (1215) - 8.30 p.m (2030). I worked with Sharon LOOM , Sarah RITCHIES , Gill RYDER , Bet WILLIAMS , Chris EVANS , who were the trained staff, untrained were Code A

Code A

I can remember that Anita TUBBRITT , Beverly TURNBULL , Maggie WIGFALL and Mary FIELDS worked on the night shift. The sister in charge when I first arrived was Sister GREEN . She was off sick for a lot of the time and then Gill HAMBLIN . The sister was in charge of the annex and worked days. The sister at the main hospital would cover the night shift at the annex.

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I have been asked about the use of Diamorphine at the Redcliffe Annex. Diamorphine was used if necessary, to control the pain level of patients. It was given through subcutaneous injection. Other medication would be used and administered rectally or if the patient could swallow, orally.

I have been asked if syringe drives were used. They were. They were used regularly to deliver Cyclizine, which suppresses nausea, and Midazolam, which is a tranquilliser.

I have been asked about the administration of prescriptions. All drugs were given as per the prescription. The doctor on the prescription, dictated the amount, and method of administration. Trained nurses would have an input with the doctor as to the method of administering the drug, but they could not deviate from the prescribed method of delivery.

Diamorphine and syringe drives were in use at the Redcliffe Annex prior to my arrival. I believe there was one or possibly two at the annex. I think that they were expensive to buy.

I have been asked for my definition of Palliative Care. I would describe this as the sympathetic care of a patient with a debilitating and terminal disease, for example cancer, the end stages of dementia, Parkinson's disease and rheumatoid arthritis.

I have been asked if I had any concerns about the use of syringe drivers whilst I was working at the Redcliffe Annex. I did not. I felt that they were being used for the good of the patient. If I felt that I had any concerns, then I would have gone to Sister HAMBLIN or Dr BARTON, whom I found to be very approachable. I would have spoken up and said something. I remember that I was nervous when I first used a syringe driver, but I had someone with me and I felt confident in using it.

I have been shown a copy of minutes of a meeting dated 11/07/1991, (JEP/GWMH/1/KMR/COPY/5.) I remember that I did attend a meeting, but I cannot remember its content. Therefore I am unable to say if it was this meeting. Having read through the minutes, I am still unable to recall this meeting, but I know that I didn't have any concerns as

outlined in the minutes.

I do remember that we had a meeting with a Pharmacist from the Q.A. Hospital who talked about syringe drivers and Diamorphine.

I have been asked what training I received in the use of the syringe driver. Sister GREEN showed me in a brief demonstration and I was told of the drugs that didn't mix. I received further training some six - seven months ago in Palliative and Terminal Care. I attended lectures in Palliative and Terminal Care if I had the opportunity to do so.

I have been asked about the mortalities in the Annex. Of course, people died there due to the nature of the establishment, but I remember a period when we received more acute patients who were very ill. Some of them didn't last a week and I remember on one occasion, two patients died on the same day that they were admitted. Staff moral at this point was very low. We weren't getting to know the patients or their families.

The unit then moved up to the main hospital site. I didn't like this. I felt the unit lost its 'personal touch'. It moved into Dryad Ward and became a Continuing Care Ward.

We would also carry out long-term assessments of patients and provide slow stream rehabilitation with a view to them returning home if possible or being discharged to a nursing home.

We still have patients who require Palliative and Terminal care and syringe drivers are used on the ward where appropriate.

I have always included relatives in the decision-making concerning patient's treatments and have kept them fully informed. I believe the medical staff have done so as well.

I would like to add the following. I have been a nurse for thirty years. I came into nursing to help people. It is my opinion that patients are now dying in pain, because doctors are too scared

to prescribe pain relief and relations won't allow us to help patients with their pain, because of what they have read in the papers.

Moral at the hospital is not good. I know of staff that will not wear their uniforms home, so as not to attract attention from the public. We are trying to do our best for the patients we have here.

I would also like to add the following:

I feel that Dr BARTON is being used as a scapegoat so that the relatives who first started this vicious campaign can have a name on an official document. We are losing good nurses because of what is being said about the hospital. They would rather work somewhere else and who can blame them.

I feel that not enough is being said in the press to support the staff. The articles I have seen have been very bland and certainly not as forthcoming as the relatives have been allowed to be.

I have been working within elderly care for 23 years now and I have never felt as bad about being a nurse as I do now. I am proud of the uniform I wear but I don't know how much more I or my colleagues can take. The amount of verbal abuse we take from relatives is becoming worse and I personally don't see why that just because I wear a nurses uniform I have to take it and do nothing. We are supposed to have a policy of zero tolerance to violence whether it be verbal or physical, well I feel that it's not really working.