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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 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 BARRETT Date: 04/01/2005

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 Hyoscine 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.

Further to my previous statement with reference to the treatment of Code A, DOB Code A whilst a patient on Dryad Ward, Gosport War Memorial Hospital.

The guide lines for obtaining prescribed drugs to be administered to patients whilst on Dryad Ward is rigidly controlled.

Drugs can only be prescribed by a doctor, a record of drugs is written into the patients prescription chart.

Controlled drugs are stored in a locked cupboard within a locked cupboard. The keys to these cupboards are only held by trained nursing staff.

It requires two trained staff firstly to check the prescription chart relating to the patient to ascertain that the controlled drug is still required and that it has been authorised by a doctor.

The next step was to check the time of the previous administration of the drug(s) given to the patient. Then both of the trained nurses would take the drug chart to the drugs cupboard where the drugs are stored. A check would be made to ensure that the correct drug is withdrawn and verify the dosage required.

Once both members of staff were satisfied that the drug and dosage was correct then the drug register was completed but not signed at this stage.

In the case of controlled drugs to be administered through a syringe driver the drug(s) have to be mixed with a measured amount of sterile water. In 1996 the standard amount of sterile water

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mixed with the drug was 10mls.

The quantity of solution containing the drugs has to be sufficient to last over the 24 hours that the syringe driver is delivering the required hourly dose.

When the syringe driver was initially set up the connecting line from the syringe driver to the patient had to be charged, ie, filled with the solution from the driver. This usually takes about ½ ml of the solution.

It therefore follows that the initial dosage takes less than 24 hours to complete. This is because there is a quantity of the solution still left within the plastic line connected to the patient.

Subsequent driver administrations given to the patient will then take the 24 hour period to deliver the required dosage.

At the completion of each syringe driver administration the plastic line will always contain ½ ml of the solution.

The amount of sterile fluid solution mixed in the syringe driver has now been reduced to 8mls which is a set standard.

The subcutaneous needle which is inserted into the patient is usually changed every 72 hours. This is just to make sure that the patient is comfortable with the needle and there is no soreness.

With reference to the mmls (milli mols per hour). The standard delivery rate today is 48mmls which will deliver the dosage through the syringe driver in 24 hours.

In 1996 the normal rate for setting the syringe driver was between 50 and 52 mmls per hour. This was because there was a larger volume of fluid contained within the syringe driver.

Where I have administered syringe driver dosages to the patient **Code A** the sterile

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solution contained within the syringe driver was set at 10mls delivered at the rate shown.

With reference to my entry on page 29 of exhibit BJC/71, dated 23/1/96 (23/01/1996), @ 1545. The delivery rate is shown as 43 mmls per hour. I can only presume that the sub cut needle was changed, therefore a new line had to be primed which meant that the fluid in the syringe was reduced which altered the delivery rate.

Code A at this stage was very poorly, he was being turned on a regular basis to prevent breakdown of pressure sores. On occasions the line and needle would be pulled out. This meant that a new needle and line had to be inserted and then recharged. Consequently the delivery rate would be lowered.

The dosage and delivery rate of drugs prescribed to a patient could only be authorised by a doctor.

In the case of Code A whilst on the Dryad Ward in 1996 the prescribing doctor was Dr BARTON .

On the occasion where it was noted that the patient Code A was still showing signs of pain and distress despite being given the prescribed dosage, then the trained staff would discuss the problem with Dr BARTON on the phone or when she visited the ward.

Dr BARTON would give authority to increase the dosage within the specified range, which had originally been set by her on the prescription chart.

The absolute maximum that the dosage could be increased was 50% of the previous dosage. However it was a very rare occurrence.

The practice of setting a range of the dosage amount of prescribed drugs on the prescription chart is no longer in place.

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Each dosage of prescribed drugs given to the patient Code A were authorised by Dr BARTON.

The standard procedure today to increase or decrease the dosage now requires the physical presence of a doctor to attend the patient on the ward.

A specified amount has to be recorded in the prescription chart.

I have examined entries recorded on the prescription chart for the patient Code A on page 18 of exhibit BJC/71.

I can confirm that on the 16/1/96 (16/01/1996) at 1300 hours I administered 80mg of Diamorphine, 400mg of Hyoscine, 60mg of Midazolam, these entries have been signed/initialled by myself.

I can also confirm that on the 16/1/96 (16/01/1996) at 1300 hrs I recorded on page 20 of exhibit BJC/71 that I administered 5mg of Haliperidol to Code A

The above drugs were prescribed by Dr BARTON who had seen Code A on the 16/1/96 (16/01/1996).