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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) BARRETT

Statement of: BARRETT, LYNNE JOYCE

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

This statement (consisting of 5 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 in it anything which I know to be false or do not believe to be true.

Signed: L BARRETT Date: 03/09/2004

Further to my statement dated 7.3.2003 (07/03/2003) I am still employed by the Fareham and Gosport Primary Care Trust as a staff nurse on Dryad Ward at Gosport War Memorial Hospital . I qualified as a SRN in 1972 at the Hull Royal Infirmary. I have 17½ years experience as a Registered General Nurse.

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

I have been asked to detail my involvement in the care and treatment of Elsie DEVINE . From referral to her medical notes (exhibit reference BJC/16PG222&223. I have recorded the following:-

21.10.99 (21/10/1999)

Admitted this pm from F3 QAH, was admitted there with increasing confusion and aggression. The aggression has now resolved. Still seems confused at times. Has CRF.

Needs minimal assistance with ADL's. A very pleasant lady. Her appetite on the whole is not good and can be a little unsteady on her feet.

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Quite cold on admission and both feet swollen.

S/B Dr BARTON. See treatment chart for drug regime.

I have then signed the entry.

I the entry relates to the admission of Elsie DEVINE who was admitted on the 21st October 1999 (21/10/1999) in the afternoon from F3 Ward at the Queen Alexandra Hospital . Was admitted there with increasing confusion and aggression. The aggression has now resolved. Still seems confused at times, has CRF. These three sentences were not not my observation but information I would have obtained either by way of a discharge letter, verbally from other staff members from the QA Hospital or her medical notes. CRF is chronic renal failure.

ADL's are activities of daily living, ie, washing, dressing, eating etc and this sentence would have come from Mrs DEVINE's discharge letter or staff at the QA.

The entry then relates to my personal observations as I would have cared for her on the ward for a couple of hours.

Mrs DEVINE was seen by (S/B) Dr BARTON . Dr BARTON would have seen Mrs DEVINE, examined her, looked her medical notes and her discharge letter. Dr BARTON would have written in Mrs DEVINE's medical notes about what she found on examination and also completed a drug chart (prescription sheet).

From refering to BJC/16PG277and278 I can say that on 21.10.99 (21/10/1999) Dr BARTON prescribed Temazepam 10mg 1on (at night). This was an as required prescription. This is a night sedation drug and would have been given by the nursing staff to Mrs DEVINE if she was having trouble sleeping at night. The chart shows that it was never given. There are two entries relating to this drug one on the 11.11.99 (11/11/1999). The entry ends written in error and one on the 12.11.99 (12/11/1999) which shows refused.

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Oramorph 10mg in 5mls, 2.5 to 5mls four hourly. This is an analgesic (pain killer). These drug was never given. Both of these drugs were to be given orally. Oramorph was to be given as required. It is an opiate.

There were two regular prescriptions:-

Thyroxine 100mcg's 1od (daily) orally, this is a hormone replacement tablet.

Frusemide 40mgs 1od (daily) orally, this is a diuretic, to prevent water retention. This shows that she was being treated for her swollen feet. The charts show that both Thyroxine and Frusemide were given daily apart from the 2.11.99 (02/11/1999) when neither were given.

From my personal recollection of Mrs DEVINE she was a fairly small lady who would rummage around in other peoples lockers and take there sweets, biscuits and then 1 or other members of staff would have to try to persuade Elsie to give the items back. I can remember one morning I had just come on duty, I usually arrived at about 7.05 (0705) to 7.10am (0710). I can remember seeing Elsie in the main corridor just outside the main day room. She had hold of Debbie BARKER by both wrists and she was trying to push Debbie against a rail attached to the wall. I went up to Elsie to try to persuade her to let go of Debbie. She pushed Debbie up against a door frame. After a bit of persuasion Elsie released one wrist of Debbie's and hit me around the face, knocking my glasses off. We were trying to persuade Elsie to go into the day room. Elsie was beyond reason and was shouting loudly. This went on for about ½ an hour or ¾'s 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 a sedative for her. During the incident Elsie also kicked my legs and I ended up with nail marks in my right arm.

I remember that I gave Elsie the injection, at this time she was in the day room, still beyond reasoning and refusing to sit down. After giving her the injection she was still shouting and not

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very happy. So I left leaving Liz BELL and Debbie BARKER with her. I remember that they sat with her the majority of the morning until she had calmed down completely.

From referral to the drug chart BJC/16PG277and278 I can see that Dr BARTON has prescribed Chlopromazine on 19.11.99 (19/11/1999) at 0830 50mg injection. LB are my initials and I gave the injection to Elsie but I did not write the initials myself. Chlopromazine is a sedative and this prescription is in the once only section and was given due to the events I have just described.

Taken by: Code A

Signed: L BARRETT

Signature Witnessed by:

2003(1)