Form MG15(T)

RESTRICTED

RECORD OF INTERVIEW

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(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 1055 Time concluded: 1135

Duration of interview: 40 MINUTES Tape reference nos. (→)

Interviewer(s): **Code A**

Other persons present: Mr CHILDS - Solicitor

Police Exhibit No: Number of Pages: 25

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the voluntary interview with Doctor REID. Doctor can you just confirm, I'll just tell you what the time is first, which is 1055, can you just confirm that we stopped for a comfort break...
REID	Yes.
Code A	...and a cup of coffee and we haven't spoken to you about...

REID No.

Code A ...what you're being interviewed for, and the personnel in the room have stayed the same?

REID Yes.

Code A Yeah. I will remind you that you are still under the caution that I gave you earlier.

REID Yes.

Code A We were talking about, just going onto another topic, which is about Clinical Assistants. Why do they have Clinical Assistants?

REID I suppose it's basically to help, um, provide care,...

Code A Yeah.

REID ...um, and I suppose if you like if, um, you are short of Consultants and then it's giving what, it's relieving them of the burden of some of the work they may have to do and various examples I gave in the past like ENT or Dermatology so if it's simple straight forward stuff the Consultant might say: "Well you've had a bit of experience you see these ones." ...

Code A Yeah.

REID

...So it's about, um, providing, if you like, um, often about providing a level of experience it's just a bit more than G.P.'s are confident to deal with because they've had a bit of training and that.

Code A

And did you say 'there were other Clinical Assistants' apart from the one down at Gosport?

REID

I, yes, I mean I'm not quite sure of again whether it was a practice, or whether it was an individual appointment but, um, I think it was near Petersfield, I think his name is Doctor Andrew CAIRNS, I mean Doctor JARRETT would be able to...

Code A

Yeah.

REID

...tell you about that.

Code A

Yeah. And is the Clinical Assistant down at Gosport different from yours in that they were more, you said they were providing the care down there, you know?

REID

From, from, Doctor BARTON was expected to provide twenty-four hour cover to the wards and see new patients that came in and attend to any problems that was basically her role.

Code A Uh-huh, okay. And what we've got here is a Job Description for Doctor BARTON from, – I can't remember where it was taken from now, it was one that was relevant at the time she took the role on.

REID Was that back in the '80's was it?

Code A Yeah, yeah. And it's, we've given it a reference number which is GJQ/HF/14. You obviously had no involvement in that did you?

REID No.

Code A No. And so when…

REID I've never seen it.

Code A No I wouldn't have expected you to have I suppose, but when you took the Consultant's responsibilities on down at Dryad Ward the post was already settled wasn't it,…

REID Yes.

Code A …Doctor BARTON was already…

REID Yes.

Code A …doing it?

REID Yes.

Code A Yeah. What did you expect Doctor BARTON to do on a daily basis?

REID Well as I say, um, I, I felt that Doctor BARTON actually did in some ways more than the role I would have expected in that, you know, as I said she usually came in twice a day and didn't just wait to be called, which was, you know, what might have happened in other places and other G.P.'s would just sort of come in when they were called to do so, but she was actually sort of quite proactive in her approach with the patients she'd come in in the mornings and as I said she usually came in again in the afternoons.

Code A Okay. So when we spoke about your role...

REID Yes.

Code A ...and comparing it with Doctor JARRETT...

REID Yes.

Code A ...right and Doctor JARRETT would decide where you went and where you worked...

REID Yes.

Code A ...and that sort of thing, you know where your sessions would be. Who was taking that similar role for Doctor BARTON?

REID (Pause) Um.

Code A Was there one?

REID Oh, um, I mean I'm not, I'm not really aware that anyone was. Um, I mean I would have thought that, Doctor BARTON and Doctor LORD had worked for a long time very closely together...

Code A Yeah.

REID ...and knew each other very well and, um, I mean Doctor BARTON used to, perhaps I think it was just because she knew her better speak to Doctor LORD probably more than she did to me,...

Code A Yes.

REID ...and I would have thought if she had had issues she would have most certainly probably raised them with Doctor LORD to start with and (pause).

Code A Okay. Look if I ask you to have a look at this, there's a job summary there at the top...

REID — Yeah.

Code A — ...it's the Job Description for the Clinical Assistant.

REID — Yeah. (Long pause)

Code A — The next page is a letter. If you just keep hold of that for us Doctor and we can just go through each, just, how, the first one there is 'to visit units on a regular basis' wasn't it?

REID — Yes.

Code A — And how often would Doctor BARTON see the patients then?

REID — Well I'm told that she came in every morning...

Code A — Yeah.

REID — ...and came in most afternoons too, and sometimes came in in the evenings as well and so I don't, I mean there's no doubt in my mind that Doctor BARTON was fulfilling number one (1), I don't have any question about it.

Code A — That's the whole purpose of this section to go through that and to give us an understanding of how you saw it being performed at the time, so. The next one about 'seeing new patients'...

REID Yeah.

Code A ...and that was...

REID To the best of my recollection she did that.

Code A Yeah?

REID Yeah.

Code A You had no problems...

REID No.

Code A ...in that you can't remember?

REID I don't recollect any problems with her.

Code A Now you came in on your ward round once a week...

REID Yes.

Code A ...on a Monday afternoon?

REID Yeah.

Code A And is it correct to say that she, Doctor BARTON, had the day-to-day medical management responsibility of the patients?

REID — Yes.

Code A — Yeah. And she was doing that?

REID — Oh yes.

Code A — Yeah. And the 'case notes', writing up the case notes?

REID — Yes, um, I think she did that, I mean I think what I said in one of the statements, um, previously was that, um, um, (pause) that 'I felt that any time there was an important sort of change in a patient's condition that that was recorded'. Um, she certainly, um, didn't write up, you know, every, you know, sort of 'slept badly last night therefore, you know, needed a sort of sleeping tablet', no she didn't always do that, but as far as I'm concerned I felt that whether there had been an important change, or an important decision to be made that she made a note to that effect, that's what I felt at the time.

Code A — Okay. 'Discharge summaries'?

REID — Oh yeah she did that.

Code A — Yeah. Does it mention, actually on that form the HRM60?

REID — Yeah I think that's, it's just a bit of paper that, um, um, well it's got several duplicate sheets and one goes off to

records within the hospital, I think one (1) goes off to the Government so that they can compile National statistics,...

Code A — Yeah.

REID — ...that's what that refers to long and superseded by something else.

Code A — And 'death certificates'?

REID — As far as I'm aware yes she did that.

Code A — Did you get involved in those at all, or?

REID — Um I couldn't say that I definitely, I mean there might have been the occasional deaths that I, um, certified say if Doctor BARTON was on holiday, or not immediately available that I might have done the occasional, and again I might have done the occasional Cremation Certificate. In fact I'm sure I did two or three Cremation Certificates but I mean Doctor BARTON did most of it.

Code A — Yeah. Now we obviously know that one of her roles was to take part in your ward rounds,...

REID — Yeah.

Code A — ...and I think you've covered that haven't you, I mean she did...

REID — I mean by circumstance that our timetables that Doctor LORD and I would arrive at the same time and she could not be in two places at once.

Code A — Uh-huh.

MR CHILDS (Sol) — Sorry is it worth pointing out that quite a few of these numbers perhaps from one (1) to six (6), tell me if I'm wrong, but you probably know, you'd know if she was doing this by having looked at the notes rather than physically seeing her doing these tasks, would that be fair to say?

REID — Oh yes I mean...

Code A — Sorry.

Code A — No that's fine.

REID — I mean the 'discharge summary' I mean I didn't have any complaints from G.P.'s that they weren't getting discharge summaries,...

Code A — Yeah.

REID — ...so the presumption is that they've been done.

Code A — Yeah.

REID — Um I mean the notes we've talked to, um, I mean the day-to-day measure of management with the patients, I mean the nurses had, you know, felt very well supported by Doctor BARTON and so, and again my, my view in that was by my discussions with the nursing staff who were sort of, um, always sort of knew what's happening with the patients, um, and were very clear that whenever they had a problem they rang Doctor BARTON and Doctor BARTON sorted it out.

Code A — Okay. Yeah thank you. 'Prescription of drugs'.

REID — Yes well she prescribed as required yeah.

Code A — Yeah. And would she…

REID — Participate in multi disciplinary case conferences, I mean again I, I think because of time constraint she probably (pause), I just can't remember whether she did, um, or not but I would not have seen that as being the most important part of her role because I'd generally be, I'd generally be involved in that so there wasn't any need for both of us to be, to be there.

Code A — But did you go to those?

REID — They must have had them but I can't, I don't remember them.

Code A — Perhaps it would be helpful if you explain what one is?

REID — Basically what we get, we get together with, uh, a senior member of the nursing staff, Occupational Therapist, Physio Therapist and discuss the patients and what the plans are.

Code A — Yeah.

REID — Oh I think what it was, I'm not sure whether the wards had a regular case conference on Dryad Ward at that time because of its role as largely a continuing care ward because there was really very little physio and occupational therapy input, it was more nursing and medical and so there may well not have been a, at that time a case conference on Dryad Ward. I think there was one on Daedalus Ward.

Code A — Now the next one, I think is the next one 'providing advice and professional support'?

REID — Well I mean from, from, for the nursing staff absolutely no question that she did that.

Code A — Yeah. And you were quite happy?

REID — Absolutely.

Code A — Yeah. The next one is 'opportunities to improve services', was that apparent or?

REID — I think it's very difficult, um, um, you know given the sort of very limited sort of time that, uh, that, um, Doctor BARTON sort of, you know, had available.

Code A — Okay.

REID — I mean certainly, I mean I, I had no (inaudible) to improve services, it's difficult to comment on really.

Code A — Okay. What about the...

REID — Advising and counselling relatives?

Code A — Yeah. I know you've, but you've touched on that haven't you by saying that 'you would do that when you were down there'?

REID — Oh yeah, and Doctor, Doctor BARTON did a lot of that. ...

Code A — Yeah.

REID — ...I mean she often came in, um, in her own time to speak to relatives and come in in an evening after she had sort of, you know, finished surgery just to do that I am told, you

know, I mean I didn't see that for myself but that's what the nursing staff reported to me.

Code A — Who would tell you that Doctor, anyone in particular, or?

REID — Oh the nursing staff would, you know, on a ward round.

Code A — And I think the last one there is 'liaison with the G.P's'.

REID — Well it's a sort of a vague sort of, I mean I suppose it meant sort of, you know, there's a patient being discharged home and there was some problems and she'd give the G.P. a ring to let him know , if it was particular issues...

Code A — Yeah, yeah.

REID — ...like it wasn't, what I meant I wouldn't say that as being a sort of, not a major role, or a major point of her role.

Code A — Chris have you got any questions on that Job Description?

Code A — If it's only on the job description no but you touched on one or two things I'd like to ask questions on.

Code A — Yeah go on yeah, yeah.

Code A — In fact one is part of the Job Description the notes. You said 'if there were important changes...

REID Yeah.

Code A ...in a patient...

REID Yeah.

Code A ...then that would be written up'.

REID I'd always felt that was done yes.

Code A And what would you say is an important change?

REID Well if there had been a, say a marked deterioration in a patient's, um, condition, um, if, you know, patients had say developed heart failure, or, um, you know, a chest infection or whatever that, that sort of thing so, um, for example I mean if someone had a headache you wouldn't expect...

Code A No.

REID ...that to be written in the notes.

Code A So the marked change in the deterioration,...

REID Yes.

Code A ...the marked deterioration in the patient. What about a marked change in the drugs prescribed or anything like that?

REID — Um I mean in general terms, uh, if there's a marked change in drugs it's usually because of a change in the patient's condition,...

Code A — Yeah.

REID — ...so I'd expect that to be noted.

Code A — Yeah. I accept that obviously with the medical notes you've got your drug charts...

REID — Yes.

Code A — ...wherever they've been written in as required and etcetera. Would you also expect to see an entry within the clinical notes as well?

REID — It was certainly good practice, um, everyone, everyone at some stage may forget to make an entry in the notes because they're distracted by something else, but in general terms if someone developed a chest infection, urine infection, heart attack, stroke, whatever I'd expect there to be an entry in their notes.

Code A — So this would be in real layman's terms, if somebody, for instance, developed a chest infection or whatever would you expect to see in their clinical notes some sort of...

REID — Well I...

Code A … 'query chest infection prescribed whatever drugs'.

REID Well the minimum I would expect to see is, you know, 'chest infection and treat with penicillin' or something like that.

Code A Yeah if it was some form of antibiotics…

REID Yeah.

Code A …and then you should be able to turn to the…

REID The drug chart…

Code A …drug chart…

REID …and see that.

Code A And see yeah.

REID Or the other way round look at the drug chart and…

Code A And see the entry yes.

REID …see the entry in the notes, you'd expect that yes.

Code A Right so they should cross refer?

REID — In general yeah.

Code A — Okay. And just one more thing about a Clinical Assistant. The Clinical Assistant, as we've said, you've said several times now are G.P.'s.

REID — Usually.

Code A — Usually.

REID — They're not always.

Code A — No, but usually. And certainly in the case of the Clinical Assistant at the Gosport War Memorial Hospital, Doctor BARTON was a G.P.,...

REID — Yes.

Code A — ...and quite an experienced G.P. and part of a practice.

REID — Yes.

Code A — Would it be normal, I'm trying to think how to phrase this, a G.P. working in a practice, and they are very busy people,...

REID — Yes.

Code A — ...and they have x amount of patients allotted to them,...

REID Yeah.

Code A ...if somebody was going to take on the extra responsibility, the extra job...

REID Yes.

Code A ...as Clinical Assistant...

REID Yeah.

Code A ...would they be expected to lesson their workload at the surgery, the practice,...

REID I think that would be a matter for...

Code A It's a matter of choice...

REID Yeah.

Code A ...but...

REID I mean within...

Code A ...it's to fit it all in I'm thinking.

REID Yes. Um we're all, we're all different, um, some of us can cope with lesser or greater workloads than others, um, and I

think that what will, I mean I don't think you can generalise, I think you would have to look at what the Clinical Assistant's role actually was. I mean I think if it's say just doing two Dermatology Clinics well you can't be in the practice. But on the other hand covering a hospital, you know, where the cover is twenty-four hours, um, that does, you know, put, you know, additional sort of strains, sort of considerations on the person who is undertaking that role, particularly if they've got a very busy general practice.

Code A Okay. That's fine Geoff.

Code A You said that you 'don't think you had ever seen this before' Doctor?

REID No I haven't.

Code A So with regards to, um, her job summary and her duties, who was responsible for ensuring that she had completed those then satisfactorily to that? We'll touch on it again later on I think.

REID Yes well I mean I suppose it will be, um, the Consultant for whom she working with.

Code A Okay, all right. Simple as that then?

REID Yeah.

Code A

Okay. Now how many sessions a week was Doctor BARTON contracted to there?

REID

Well I see it says there five,...

Code A

Yeah.

REID

...I thought it might have been six but I don't, I mean I just don't know.

Code A

And I think you said that 'she normally worked longer than she needed to'?

REID

Oh yeah.

Code A

Yeah. Over the hours?

REID

Um well I mean the thing we'll have to remember is that it's a nominal number of, if you multiply by five or six times, you know, by 3½, and there's no question to me she's putting in the, you know,...

Code A

The hours.

REID

...the hours during the day and then was being paid in terms of hours for the out of hours cover.

Code A

And is her 'session' the same as your session?

REID — Yes it was at that, yes, yes it was 3½ hours, yes.

Code A — So was she effectively, she wasn't getting paid for all the hours that she worked there?

REID — No, no. She was being paid, I mean, I mean she was being paid in the sense partly for being on the premises and doing work and part was also recognised as being for the out of hours,...

Code A — Yeah.

REID — ...but it was not, you know, defined that say like say two of the five are for coming in and actually being on the premises and the other three are to recognise the on call, it wasn't like that it was just all bundled together. I don't think that would be different, that's not different from anywhere else.

Code A — I was just about to say.

REID — I mean St. Christopher's you know the contract, although it was with the practice it was for providing, um, twenty-four hour care but also coming in to do ward, coming in to do ward rounds and attending to patients as they needed and so it wasn't any different from anywhere else.

Code A — And it's presumably no different to your role at the moment as well when you're saying that 'you do eleven sessions',...

REID — Yeah.

Code A — ...but you actually do more than that.

REID — Um yes, I mean I don't know (pause), yeah I put in more hours than ten / eleven sessions.

Code A — Yeah that's what I meant,...

REID — Yeah.

Code A — ...perhaps clumsily said but that's what I meant, yeah. What happened out of hours, presumably Doctor BARTON wasn't responsible all the time for cover?

REID — Well she, I mean she was in the sense that she had a contract...

Code A — Yes.

REID — ...to do that. But if you like she had I suppose a, but I don't know what the agreement was within the practice but effectively she sub-contracted, if you like, with her partners to cover when she wasn't available...

Code A — Yeah.

REID — ...that was, as I understand it, the arrangement.

Code A — And on a daily basis who, I think we touched on this just now as well, she was accountable to you was she on a daily basis?

REID — She was accountable to me for the patients on Dryad Ward.

Code A — Yeah, yeah. And presumably so she was responsible to you overall as well then with regard to the patients, but that is the same question isn't it really?

Code A — It is, yeah.

Code A — Yeah. And what were the patient levels on Dryad Ward? I think you said, was it twenty you said earlier?

REID — Yes, yeah. It was invariable full.

Code A — Yeah. And was that similar on Daedalus?

REID — Daedalus Ward had a higher turnover because it was a rehabilitation ward...

Code A — Right.

REID ...and so patients weren't anticipated, it was anticipated that the patients would go home and not spend the rest of their life...

Code A Yeah.

REID ...in hospital. Um and in general when you get increased turnover the beds, I mean you don't get what we call '100% bed occupancy', they're on less than that because there are gaps between patients...

Code A Yeah.

REID ...going out and some are coming in.

Code A Yeah. Did Doctor BARTON spend, to your knowledge did she spend much time on Daedalus?

REID I don't, I don't know, um, but my supposition would be that she probably spent more time in Daedalus Ward than Dryad Ward because there were more patients, you know, coming through the doors and the patients on Dryad Ward I would guess would be relatively more medical stable than the ones on (pause).

Code A Daedalus.

REID — Daedalus. That was my impression that she probably spent more time in Daedalus Ward because that's where there were more problems.

Code A — Yeah. Well while we're talking about both wards, what type of patient was on, so Daedalus you're saying was for 'rehabilitation'?

REID — Yes.

Code A — Yeah. And Dryad...

REID — Was continuing care...

Code A — Continuing care.

REID — ...at the beginning of 1999 yes.

Code A — Yeah. Perhaps if you can just give us a layman's rundown on the difference between rehab and continuing care?

REID — Right, um, well rehabilitation is, the patients are sent to a rehabilitation ward if you think they've got potential to, um, improve and get home, or at least get out of hospital. Um who go to a continuing care ward are patients who are usually just very frail, um, and who don't look as if they are likely to walk again, um, or to be unable to even do very much themselves, um, probably say need help from two nurses, you know, to wash, dress etcetera, so very

dependant patients and you felt there's no prospect of them getting any better, that's how it was at the start.

Code A — The start of when you went there?

REID — Well certainly before I went there, and that was what was happening and at the time I arrived there that's what the role of the ward was, or the roles of the wards were.

Code A — Okay. And so if you go to Daedalus on rehab you're...

REID — There was an expectation you'd go...

Code A — ...looking to...

REID — To go, to go...

Code A — ...get that patient home?

REID — Yes, yeah.

Code A — Or back to a home or wherever they lived?

REID — Yeah.

Code A — Yeah. But on Dryad for continuing care...

REID — The expectation was that you, you would, um, either be there or perhaps go into a nursing home.

Code A — Yeah where they'd get, like you were saying two nurses...

REID — Where the best sort of level care would be offered.

Code A — Yeah. And these are the patients with very low Barthel scores?

REID — Yes, yes, yes.

Code A — What about 'palliative care' then?

REID — Yeah, um.

Code A — I know it's a difficult subject isn't it...

REID — Yes.

Code A — ...within that respect?

REID — Well, um, obviously on a continuing care ward a number of patients are going to, to die on that ward, um, some of them may, um, (pause). I mean it depends exactly what you mean by sort of, um, palliative care, um,...

Code A — Well what do you understand 'palliative care' to mean?

REID — Right. Well palliative care to me is about sort of, um, relieving symptoms of people who are distressed in some

way. Um, now that may be because of general cancer, maybe because they've got severe heart failure, which isn't treatable, um, and, yeah so it's about relieving sort of symptoms in people who, people to whom it appears their life expectancy is limited.

Code A — Right, so, yeah relieving...

REID — Symptoms.

Code A — ... the symptoms of almost certainly terminally ill people.

REID — Prob, yes. Uh what, um, I mean the reason I'm hesitating is that, um, for example palliative care wards and in particular, you know, patients with cancer, the patients might come if they're in a lot of, you know, pain but the aim would be to relieve their pain and then get them home again. So it's primarily about sort of sympton control in people who have a, an illness that is likely to be terminal but they may not be terminal at that point.

Code A — Yeah I'm with you.

REID — Yeah.

Code A — Within the department what was the arrangement facility for palliative care treatment then?

REID — Right well if I remember at that time Charles Ward at Queen Alexandra,...

Code A — Q.A. yeah.

REID — ... at Q.A. was a palliative care ward,...

Code A — Yeah.

REID — ...um, its specific role was to take patients whose symptoms needed palliating and look after them. Some of them might go home, but probably most of them ended their life in Charles Ward.

Code A — So presumably to go into Charles Ward the decision has already been made that...

REID — This patient is in a...

Code A — Palliative care stage.

REID — No the decision would be that 'this patient has symptoms from an illness which is likely to be terminal, it may not be or it could be terminal'.

Code A — Right. Would they get into Charles Ward from other hospitals then, or?

REID — Um only if they'd been seen by, it would be from Queen Alexandra or St. Mary's.

Code A — Other...

REID — Non elderly medicine wards.

Code A — Yeah.

REID — And would have, one of us would have seen them.

Code A — Yeah. In...

REID — Possible if I could...

Code A — Sorry.

REID — ...just add just sort of clarity. Um you wouldn't always send someone to a palliative care ward to relieve the symptoms, you know you might, through force of circumstance, have to do it on, um, an acute ward, you know, if someone's got severe heart failure and was clearly not getting better, um, likewise on a rehabilitation ward if someone develops another illness or condition,...

Code A — Yeah.

REID — ...um, you might be engaged in sort of palliative care, um, so it's not, we don't just carry out palliative care on palliative care wards.

Code A	I'm with you yeah, yeah I'm with you. So if circumstances take over a patient...
REID	Yes that's right. I mean they may be too ill to be moved to the palliative care ward.
Code A	Yeah. But the palliative care ward is there for that one purpose...
REID	Yes.
Code A	...basically?
REID	Yes.
Code A	Yeah. So it's fair then to say that not everybody that was on Dryad Ward was suffering from an illness or disease that would necessitate palliative care then?
REID	Absolutely, you're absolutely right.
Code A	How do you feel, what do you feel the level of care and treatment was that was offered to the patients at the time on Dryad when you were there?
REID	Sorry what did I?
Code A	What did you feel about the level of care and treatment that was being offered to the patients?

REID — I mean I felt the patients got very good, I felt the patients got very good nursing care,...

Code A — Yeah.

REID — ...um, on, um, Dryad Ward...

Code A — Yeah.

REID — ...and I mean I'd no concerns about the medical care either.

Code A — Okay. What about equipment levels down at the hospital, what would you say about those that were at your disposal?

REID — Um, I can't think really what you mean by that. I mean because most of the equipment we needed would be, you know, nursing equipment, you know,...

Code A — Yeah.

REID — ...for looking after patients who can't, who are not mobile. I mean you wouldn't expect, you know, there to be lots and lots of medical equipment at somewhere like the War Memorial, I mean we'd have an ECG machine,...

Code A — Yeah.

REID ...a Cardiograph, but we wouldn't expect to have anything more than that and it still doesn't have anything more than that today, so. I'm not sure what...

Code A So it wasn't...

REID ...is behind the question...

Code A So it wasn't wanting for...

REID Oh no, no, no.

Code A No.

REID No not for medical equipment, no.

Code A No okay.

REID Not that I, not that I recollect.

Code A I think we've touched on (pause). Somebody in your department would decide who would go to those wards wouldn't they?

REID Yes. Well I mean essentially it was us as Consultants...

Code A Yeah, yeah.

REID ...who decided.

Code A — From the various sources that you would...

REID — Yes.

Code A — Yeah.

REID — Yes.

Code A — Yeah. We just talked about a patient say in a rehab ward or maybe in a continuing care ward who slipped into a palliative stage, you know,...

REID — Yes.

Code A — ...and they could stay there. Was there any system about transferring a patient from one of those wards to an emergency hospital?

REID — Um.

Code A — How would that have worked?

REID — If a patient becomes very unwell a decision has to be made: "Well how active are we going to be?" Um, if it was felt that it was right to treat this patient what we call 'aggressively', you know, by that I mean 'actively'...

Code A — Yeah.

REID — ...then you would ship them back to Q.A. Um on the other hand, uh, if you felt that this patient was sort of, maybe in a situation where the patient was not likely to recover, or they might have been too ill to transfer up the road and then you make a decision: "Well the most important thing here is a palliation of symptoms," but that doesn't necessarily mean not treating other things at the same time.

Code A — No no, no, no. And who made those decisions then doctor?

REID — Doctor BARTON would usually make that decision.

Code A — Yeah, okay. Was there any guidance, or protocols regarding that, or?

REID — Not that I'm aware of.

Code A — No.

REID — So it would be her clinical judgement.

Code A — Okay. Now when Doctor BARTON originally took her post in 1988, now we understood it was for one year, so how does that get renewed each year. Are you aware of that at all?

REID — No.

Code A No?

REID The Personnel Department would be able to tell you that sort of thing.

Code A And presumably from what you've told us in your answers earlier, it's a career...

REID Post.

Code A ...post. Is there any training involved for her in that or not?

REID No.

Code A No. What about pharmacy and drugs prescribing, is there any ongoing training in that, or?

REID No.

Code A Is that down to individual doctors to...

REID Yes, yes. I mean you are expected to be competent to prescribe after registration, so.

Code A It's one of your responsibilities is it not?

REID Yes it is.

Code A — Yeah. And was there any training that Doctor BARTON, or any other Clinical Assistants, was there anything they could have done like go training wise, or?

REID — Well yeah I mean there are, um, well there's lots of courses and different things available and particularly there's lots of training courses available on things like palliative, palliative care.

Code A — Okay. The ward didn't change in roles at all while you were down there?

REID — Oh it did.

Code A — Explain that then.

REID — Right . Well, um, I think what happened was, and I don't, well I don't know why it happened but, um, Dryad Ward started running with empty beds, so in other words there weren't, um, there didn't seem to be, um, enough patients coming through with continuing care problems to, to fill the beds.

Code A — Is this when it first opened?

REID — No I'm talking about when I, when I, when I, when I was there.

Code A — Sorry yeah.

REID — This seemed to start around the time I was there.

Code A — Yeah.

REID — Um (pause) and, oh believe it or not I mean at that time, you know, Q.A. hospital was under, was still, at that time was under huge pressure for beds, so there were always these sort of tensions: "Well you've got empty beds down in Gosport, why aren't you sort of filling them up and helping us out up in Q.A.?" Um and so what happened, I mean it wasn't a conscious decision made, it was almost: "Well let's send the least unsuitable patients there." So it might have been, so instead of it definitely being continue patients who went down it might have been someone who looks: "Well there might be a chance that they might get back on their feet, but it doesn't really look very likely so we'll send them," and that sort of eases the bed pressures up at Q.A. I think it would be, it's difficult to understate just how much pressure there is from Q.A. to fill beds in community hospitals.

Code A — Yeah, uh-huh. So in the ideal world when you describe those sort of patients as they're unsuitable, like the most unsuitable patients...

REID — The least unsuitable yes,...

Code A — The least unsuitable...

REID ...or the next most suitable.

Code A Yeah, uh-huh. But in the ideal world where would they have gone?

REID They would probably have gone to Daedalus Ward.

Code A And how did that impact on your role at all, or did it?

REID Well it meant there was probably more patients coming through the ward and the turnover would gradually start to increase because some of these patients would get better...

Code A Yeah.

REID ...and would go home,...

Code A Yeah.

REID ...or back to a residential home, or nursing home...

Code A Yeah.

REID ...so the turnover increased. I mean I couldn't, I haven't got the figures but that was, that was the fearing that the turnover increased because of that.

Code A — I think I've read somewhere about sort of patients being admitted for four to six weeks of respite care. Was that a...

REID — Yes I had forgotten about that. Yeah we used to, we used to do that, um, my recollection is for two weeks, the patients received two weeks in hospital and then six weeks at home and then two weeks in hospital again in order to give relatives a break. So there was a bit of that going on in Dryad Ward I think when I first came there,...

Code A — Yeah.

REID — ...I'd forgotten about that,...

Code A — Yeah.

REID — ...we don't do it any longer.

Code A — How did you feel about your levels of responsibilities towards Dryad Ward?

REID — Um, well I mean as the turnover increased it obviously meant there was a bit more, a bit more work for me,...

Code A — Yeah.

REID — ...um, uh, I mean as I said I went down on a Monday afternoon but it wasn't uncommon to go down sort of other evenings in the weeks particularly if there's relatives who,

you know, wanted to speak to me, so I'd go down there sort of Wednesday evening and speak to relatives. Um or I might decide I'd, you know, to pop in and see someone who I might have been a bit concerned about.

Code A

Yeah. What did you think the hospital expected of you, were you happy with the way they sort of responded to you or (TAPE MACHINE BUZZES) accepted your role, that sort of thing?

REID

Yeah. Um well I mean there was no such discussion, I mean there was no sort of, there was no management, um, system in the hospital with which we were involved. It's all, I mean that if (laughs), I mean the manager at the hospital managed the nurses and the beds, but the medical staff, the medical input was managed from Q.A.

Code A

Right, yeah. That's telling us that that tape is just about to come to an end again. The time now is 1135 and I am turning the machine off to change the tapes.

INTERVIEW CONCLUDES – TAPE MACHINE SWITCHED OFF