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RECORD OF INTERVIEW

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Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 14/07/2006

Time commenced: 0959 Time concluded: 1041

Duration of interview: 42 MINUTES Tape reference nos. (→)

Interviewer(s): DC1162 QUADE / DC2479 YATES

Other persons present: MR CHILDS, SOLICITOR

Police Exhibit No:	Number of Pages:
Signature of interviewer producing exhibit	

Person speaking	Text
DC QUADE	The time by my watch is 0959. This is a continuation of the interview of Dr REID. Dr can you confirm that the same people are in the room as before?
REID	Yes.
DC QUADE	And all we've done is just stopped to change the tapes over.
REID	Yes.

DC QUADE Thank you. And we haven't spoken to you.

REID No you haven't.

DC QUADE Thank you very much. I remind you that you're still under caution. We were talking about diamorphine and what I was just asking you was that we know that you've told us how you expect the nurses to start off ...

REID Variable doses

DC QUADE Yeah and your expect ... your expectancy is that they start off at the lower ...

REID Yes.

DC QUADE ... range, the lowest range.

REID Yes.

DC QUADE But what I'm asking about you rely on their experience to do that

REID yes

DC QUADE okay. And previously you've said that it's often safer to allow nurses to do things than it is Dr's.

REID Yeah.

DC QUADE Now you say that the nurse will start off with the lowest dose.

REID Yes.

DC QUADE Let's assume she has yeah or he has. And what stops ... how do you ... are you saying that it's their experience again that allows them to increase the doses as required?

REID It would have to be.

DC QUADE Yeah. And how would you expect them to do that incrementally? In this instance for instance we've got a 20 to 200 milligram dose of diamorphine over 24 hours. So how would you expect the nurses to increase that if necessary?

REID I mean I think the first thing to say is that I would expect that the documentation of the patient was ... pain was controlled otherwise so its regular nursing records of that. If the pain was under control then obviously I would not expect any dose increase to take place. If a patient did appear to be experiencing pain then ... I mean as I remember the sort of ... although I'm not sure sort of why the knowledge would be at that time but to increase by 50 per cent of the previous days dose would be acceptable practice. So if someone was say on 20 milligrams a day

and the pain wasn't controlled then increasing by 50 per cent of the 20 or 10 milligrams to give a total of 30 milligrams would be acceptable.

DC QUADE Thank you. I mean presumably then 45 …

REID Yes that sort of …

DC QUADE That sort of …

REID Yeah that sort of.

DC QUADE Dr BARTON didn't … looking at the records there's no … no checks or fail safes to see how the nurses are going to do that. We've already discussed it, you've … you actually told the nurse to do something.

REID Yes.

DC QUADE Yes. And she's made a record.

REID Yes.

DC QUADE Dr BARTON … there is no record of … there is no record of her actually even prescribing the medicine in the medical records apart from the prescription charts

REID No

DC QUADE yeah. There's non justification as to why it's …

REID No.

DC QUADE And there's nothing … there's no acknowledgement from a nurse …

REID Of any guidance …

DC QUADE … of any guidance or instructions …

REID That's …

DC QUADE … is there?

REID No there isn't.

DC QUADE No. And you've talked about 200 was far too great …

REID Yeah.

DC QUADE … too high an end.

REID Yeah, far too high.

DC QUADE Yeah. The difficulty I have with this is it's alright with hindsight to look at it and see even with your instruction to the nurse …

REID Yes.

DC QUADE ... you've instructed her to go to 60 ...

REID Yes.

DC QUADE ... if necessary ...

REID Yes.

DC QUADE But she's actually put on there 'can be gradually increased as and when necessary'.

REID Yes.

DC QUADE So that is an ongoing ... there's no ... there's no finite on that is there?

REID No.

DC QUADE It's ... she's not ... it doesn't ... that doesn't read as if she's telling the nurses go to 60.

REID No it doesn't.

DC QUADE It looks as if the nurse can look at that and I can increase that as and when.

REID Yes yes. I mean it doesn't reflect what I have written.

DC QUADE No no. So even after you've seen her the patients ...

REID Yeah.

DC QUADE ... and written on there you're not gonna be seeing that patient for another week are you?

REID No.

DC QUADE At best yeah. Within that week what stops that patient from going up to 200 milligrams?

REID There's absolutely nothing ... you mean in terms of this instruction?

DC QUADE Yeah.

REID Nothing.

DC QUADE And you replied earlier on just a couple of moments ago on this tape about when I asked you how you would expect the nurses to go ahead with the increases etc, and I think ... did you say that you would expect some documentation as well?

REID Yes.

DC QUADE And the thing I'll say about that Dr is that there's a lack of documentation from the Dr's.

REID Yes.

DC QUADE And then the Dr who prescribed the drug in the first place hasn't even bothered to write down why she prescribed it and yet you're still expecting ... you've still got an expectancy of the nursing staff to record when they increase it.

REID Can you say this again?

DC QUADE Well I'm saying that Dr BARTON the prescribing Dr ...

REID Yeah.

DC QUADE ... hasn't bothered ...

REID To give any instruction.

DC QUADE ... to write down why she prescribed it.

REID No.

DC QUADE There's no examination of the patient according the records yeah.

REID That's right.

DC QUADE And there's no ... so there's no justification for the drug and there's no instructions or guidelines for the nurses.

REID Nursing staff yeah.

DC QUADE Yes?

REID Yeah.

DC QUADE You come along the same day you change the dose ...

REID Yes.

DC QUADE ... yes, and instruct the nurse ...

REID Yes.

DC QUADE ... yes, and knowing your answers now you're ... you would expect that the nurses if they increase the dose you'd expect some documentation, some justification why they're increasing the dose.

REID Yes.

DC QUADE Yeah, some change in the patient.

REID Yes.

DC QUADE Presumably etc etc etc.

REID Yes.

DC QUADE But they can see from the Dr's records that the Dr's aren't bothered or the Dr in this case isn't ...

REID Can't be bothered.

DC QUADE ... can't be bothered to write yes?

REID Yeah.

DC QUADE And there's certainly ... you've already said looking at these records that there is inconsistency in the nursing notes.

REID Yes.

DC QUADE Yeah.

REID What was that in relation to?

DC QUADE We were just talking about the nursing notes the other day and we were talking about the records, you were saying how sparse the records were and sporadic.

REID The nursing or the medical?

DC QUADE The medical records.

REID Medical records yeah.

DC QUADE And that brought us on to the nursing notes.

REID Yes.

DC QUADE And we were trying to make a comparison between the two and you then agreed that the nursing notes were inconsistent as well, although it looks as if there's a lot of notes down there when you actually analyse it there really aren't are there about the patient. We're talking about ...

REID No there's not. I mean there are days when there doesn't seem to be anything recorded on some notes.

DC QUADE This is it, that's the point ... that's the point yes. But you're still expecting ... you're still happy for that 200 milligrams to remain on there.

REID I mean ... as I say I don't remember, I would certainly say that you know I should have crossed the prescription off but what ... I mean that may not have crossed my mind at the time because I think I felt this lady was going to die in the next 24 hours and therefore it was unlikely she was gonna need any more diamorphine beyond the 60 milligrams. But I accept that I should have crossed it out.

DC QUADE And ...

REID I didn't think the situation would arise in other words of having to increase it beyond 60 milligrams.

DC QUADE Okay. But certainly in your view on the 12th you feel that she was in the terminal phase?

REID Oh yes.

DC QUADE Yeah.

REID Well I mean from ... from the records in ...

DC QUADE Yeah and we covered that just now. We can't say how she was diagnosed as being in need of the diamorphine can you?

REID There's no indication in the medical records as to why diamorphine was started.

DC QUADE Yeah.

REID Or the syringe driver diamorphine was started. Why she's switching from MST to diamorphine.

DC QUADE And we talked about the role of the BNF just now and you've already said that you would use the BNF to convert certainly from morphine to diamorphine.

REID Yeah.

DC QUADE So how would you have converted in this case Dr, we know that she was on 40 …

REID Yeah.

DC QUADE … 40 milligrams …

REID Yes.

DC QUADE … over the 24 hours of the … it was MST by then wasn't it?

REID Yeah.

DC QUADE Yeah. And …

REID There's the conversion chart

DC QUADE Yeah there it is. What's the reference there Chris?

DC YATES It's … sorry, CSY/HF/9.

REID Mrs SPURGIN was having a total dose of 40 milligrams …

DC QUADE Yeah.

REID … a day. So that would put her between 20 and … well let's say 25 but it said that … I mean the nursing records stated that Mrs … what's her name.

DC QUADE SPURGIN.

REID … SPURGIN, was irritable which suggests to me that she still had pain, still had not been adequately controlled so I think it would have been reasonable to say she was on 40 milligrams of … this is MST, let's add another 50 per cent onto that if we're going to try and control this lady's … if … this is assuming this lady's in a lot of pain, add 20 milligrams to that, that makes a total of 60 milligrams of oral morphine, which equates to 45 milligrams over 24 hours in a syringe driver, if I've got that right.

DC QUADE Yeah I'm … the fact was though she … she'd received 40 … she'd only received 40 milligrams hadn't she?

REID Yes.

DC QUADE That was what was controlling her pain.

REID Well I don't think … I don't think it was.

DC QUADE That's what she was receiving.

REID Yes. So if it's a straight conversion ...

DC QUADE Yeah.

REID ... then according to this you'd be talking about 25 milligrams.

DC QUADE Yeah.

REID If her pain wasn't controlled we're talking about 45 milligrams. So I'd have thought that a starting dose within the minimum of 25 would have been appropriate.

DC QUADE And what does Dr BARTON actually ...

REID Well she wrote 20 to 200 I think didn't she.

DC QUADE Yeah that's right. And what did you ... what did you do you went down to what?

REID Well Dr BARTON gave 80 milligrams and I understand what you said before that she said this was a mistake. I felt clearly that 80 milligrams was far too much and reduced the dose to 40 milligrams.

DC QUADE Yeah. And even that looks on the high side now doesn't it?

REID Not ... well if one said ... there were sort of indications in the nursing records that this lady was still distressed so I think that a starting dose of between 25 and 45 would be appropriate, 45 if she was in pain. And the nursing records

do tend to suggest that this lady's symptoms were not under control.

DC QUADE — We're probably slightly at odds with our figures because I worked … when I looked at this before …

REID — Yeah it's important.

DC QUADE — Yeah … yeah. I looked at this and thought that the dose …

REID — You're right.

DC QUADE — Yeah.

REID — Yeah I think you're right. Because what it says every 12 hours.

DC QUADE — Yes.

REID — Yeah sorry.

DC QUADE — Okay, you … do you want recalculate or do you want to … or listed, let's do it your way

REID — (Inaudible). So …

DC QUADE — I think you are slightly higher on your diamorphine.

REID — Yes I am sorry it's my mistake. If the patient was on 20 milligrams ... if the patient ... she was on 20 milligrams, pain was controlled on that so 15 milligrams would have been the dose according to this.

DC QUADE — Then I would agree with that, I'd say between 15 and 20 would have been ...

REID — Now what I've said if this lady was in pain and pain wasn't controlled by 20 it would be permissible to give her the equivalent of 30 milligrams.

DC QUADE — Hmm, mmm.

REID — Which according to this is 20 milligrams.

DC QUADE — Okay.

REID — Now as ... as I ... I'm not sure that the BNF guidance said this in 1999 and the reason I say it is I've a recollection of the correction as being between half and a third.

DC QUADE — Yeah.

REID — Of the dose. And I know there is ... there's ... I'm thinking ...

DC QUADE — I know there is ... I know what you're saying and there is ... there are schools of thought.

REID Yeah.

DC QUADE And even now I think there are ... there are schools of thought within the medical profession ...

REID Yeah ... as to the exact ...

DC QUADE ... the conditions.

REID Yes there is.

DC QUADE Yeah. But we have to go on what we ... what our limited knowledge, and what I would say to you is that agreeing with what you've just said that from Dr BARTON's initial administration of it right that she'd caused, she actually ... it represents somewhere between a four and six fold increase in the drug.

REID Yes.

DC QUADE And ie what she was getting now in diamorphine was the equivalent of between 160 and 240 in a 24 hour period of ...

REID It's completely...

DC QUADE Now when you altered it to the 40 ...

REID Yes.

DC QUADE ... and it seems like quite a drop in the ... but that was still two or three fold increase.

REID Yes.

DC QUADE In the oramorph ... in the morphine she was getting before. I don't know whether you agree with this or.

REID Well it depends what you use as a conversion factor doesn't it.

DC QUADE Yeah.

REID So the 40 milligrams you know may still have been ... may still have been ... I mean looking back at things now the 40 milligrams may still have beenlooking back on things now the 40 milligrammes may still have been on the high side certainly compared to this. But I think that ... I mean I can't remember but this time I feel that this was a lady who had been suffering and in pain for you know three weeks we hadn't successfully got on top of that pain. I thought when she saw she was dying and I'm sure that my overriding sort of priority was ... as far as possibly making sure this lady wasn't over sedated but the same time that she wasn't going to suffer, cause I think she'd suffered enough.

DC QUADE Okay. Going back to your prescription charts Dr ...

REID Yes.

DC QUADE ... when you caused that change in the diamorphine ...

REID Yes.

DC QUADE ... on page 130 ...

REID Is it the one with diamorphine at the top?

DC QUADE That's the one yeah. And the third one down is the medazalam isn't it?

REID Yes.

DC QUADE Can you talk us through the history of what happened ... do you want to have a look at this copy cause it's clearer?

REID Talk us through?

DC QUADE The history of that medazalam during that day.

REID Well it looks as though it was in ... well it was increased in dose.

DC QUADE Do you know why that was?

REID No I don't.

DC QUADE Was that your instruction?

REID No. I can't think it would be my instruction if I'd just reduced the dose of diamorphine at the end of the day.

DC QUADE Again 20 ... 20 milligrams of medazalam to a 92 year old lady is likely and from what I feel to have quite a high sedative effect on an old lady isn't it, and a particularly frail 92 year old lady?

REID Yes it will be likely to yeah.

DC QUADE Who's not very well at the moment.

REID Yeah.

DC QUADE Was that a consideration when you ... when you reviewed her and reduced her diamorphine?

REID I mean I can't remember ... I can't remember whether I thought about medazalam or not. I mean I think my most immediate concern was that the dose of diamorphine was far too high and that was the important issue to address.

DC QUADE Looking back on it now do you think that 20 milligrams of medazalam was a bit high for her as well?

REID — Well that's the dose that's in the BNF.

DC QUADE — Hmm, mmm. But the prescription ... the prescribing of medazalam is it not affected by the ... by the actual patient?

REID — Usually in the BNF it says no just reduce the dose in the elderly and it doesn't. Whether you think it is appropriate to reduce the dose in the elderly.

DC QUADE — So can we work out why the ... if you look at it now can you think why the medazalam was increased to 40 milligrams then?

REID — Well there's nothing in the records that I see that can substantiate that there was a reason for doing it. And one can only presume this lady was very distressed but there's nothing to indicate that that was the case.

DC QUADE — So that looks to have been a nursing decision?

REID — As far as ... well I can't ... I can't tell, there's nothing from Dr BARTON to say that you know she sanctioned it.

DC QUADE — Could it have been a mistake?

REID — I suppose it could be but I mean it seems to be quite clearly written immediately above it 20 milligrams.

DC QUADE Hmm, mmm. Yeah but it's a variable range isn't it?

REID Yes. I mean the reasons are that it's a mistake or someone's felt that it's been necessary but there's no documentation to support it.

DC QUADE Your note says now very drowsy.

REID Yes.

DC QUADE Since diamorphine infusion established so reduce to 40.

REID Yes.

DC QUADE And then if pain increase ... if pain increases increase dose.

REID Yeah.

DC QUADE How ... what ... how would they have ... how would a nurse have known from looking at the patient that she needed, at that stage, that she needed more medazalam?

REID Well by observation if the patient was thrashing ... irritable thrashing around the bed etc and that would be ... and at that stage one would be relying on certain ... non verbal assessment.

DC QUADE But again there's no ... there's no record in there that says as to why the medazalam was increased is there?

REID No there isn't.

DC QUADE What would you have considered to be excessive dose of diamorphine in this instance from Mrs SPURGIN?

REID Well 80 milligrams is an excessive dose. I'd say 60 milligrams would have been an excessive dose too.

DC QUADE At that time?

REID When I saw her that ... that morning yeah whenever it was yeah.

DC QUADE And what would have ... what would you have seen the justification of increasing it to the 60 that you advise the nurses?

REID Well documentation that the patient was in pain or distressed.

DC QUADE Was you ... did anybody seek your advice in regard to Mrs SPURGIN about the prescribing regimes at all?

REID Not that I can recollect.

DC QUADE No. And yet we can clearly see that Dr BARTON for one reason or another has prescribed the wrong dose yeah. Had she ever contacted you for advice on prescribing?

REID — I don't recollect having done so.

DC QUADE — Are you confident in your replies that you've given us so far today, are you confident in that the prescribing didn't lead to a worsening of her condition?

REID — No.

DC QUADE — And why is that?

REID — I was concerned that the dose of 80 milligrams may have caused over-sedation.

DC QUADE — And she'd been on the various forms of morphine up until then.

REID — Hmm, mmm.

DC QUADE — The oramorph, the MST. And going through the notes there really doesn't appear to be ... I know and you know that one of the important things about administering these ...

REID — Opiates.

DC QUADE — ... opiates, is that the patient should be assessed for effect shouldn't they?

REID Yes.

DC QUADE Yeah. And there seems to be no on going programme of assessment doesn't there within the notes. And when these pain killers are administered that is one form that we should be seeing isn't it?

REID Yes.

DC QUADE Yeah. And particularly going to the 12th Dr BARTON saw her in the morning.

REID Yes.

DC QUADE Yeah. And you saw her …

REID Well I presume she … well I don't know.

DC QUADE Yeah but we're assuming that aren't we yeah.

REID Yeah.

DC QUADE From her daily practice. And you saw her sometime in the p.m. presumably?

REID I think so.

DC QUADE Yeah. Well actually we can probably work that out can't we because it will tell us from the prescription chart what

time ... is it there the prescription chart Chris or did I put that ...

DC YATES — You put it there in an envelope.

DC QUADE — Yeah it will tell us on the prescription chart what time that diamorphine was changed won't it. It looks like 1640 doesn't it?

REID — Yeah.

DC QUADE — Yeah. Yeah.

REID — Is it?

DC QUADE — And it looks like 1640 because if you look ...

REID — Right.

DC QUADE — ... underneath when they've changed the medazalam as well ...

REID — Yeah.

DC QUADE — (Inaudible).

REID — It says the same time yeah.

DC QUADE — Yeah.

REID And it's the same signature isn't it?

DC QUADE Yeah. So it's presumably p.m.?

REID Yes.

DC QUADE And they would have I assume …

REID I just find that absolutely amazing.

DC QUADE Yeah. Well … so you saw her at that time?

REID Presumably.

DC QUADE Presumably. And in between time there's no … so she's been on the syringe driver first started at nine o'clock (0900) in the morning.

REID Yes.

DC QUADE And it looks like you've seen her …

REID Sometime in the afternoon.

DC QUADE … yeah sort of …

REID Middle/late afternoon.

DC QUADE ... four o'clockish (1600) you know yeah. So what's that seven hours isn't it yeah, seven hours.

REID Yes.

DC QUADE And there doesn't appear to have been any assessment of that patient on the syringe driver.

REID No there's no assessment in the particular case.

DC QUADE And particularly when you consider that she'd been on the 80 milligram.

REID Yeah.

DC QUADE Infusion.

REID Yeah.

DC QUADE And that's not acceptable is it?

REID No.

DC QUADE And the syringe driver gets changed yeah?

REID Yes.

DC QUADE On your instruction. And there again it doesn't appear to be any assessment after that. On page 108 which is the one that refers to your change ...

REID Yeah an extract is died peacefully isn't it.

DC QUADE Yes exactly. And that seems to go completely against what good medical practice tells us, various other protocols and policies etc doesn't it.

REID Yeah.

DC QUADE Do we normally ... would we normally expect to see some ... some documentation that a patient has entered a terminal phase?

REID I think it would be unlikely recorded to say in terminal phase but you know there'd be things like very poorly or maybe for TLC you'd put tender loving care on (inaudible). So that sort of documentation indicating that someone was close to the end of their ...

DC QUADE Yeah.

REID ... life.

DC QUADE And TLC is sort of Dr code isn't it?

REID — It's tender ... its actually in the nursing world it's tender loving care yeah.

DC QUADE — Yeah.

REID — But it's often used by Dr's.

DC QUADE — Yeah. Yeah but if a nurse saw TLC a nurse would be knowing that the Dr is saying this patient is dying.

REID — This patient is dying yes.

DC QUADE — Yeah. And again no memory of the patient but ... so working purely on the records what change had taken place in the patient to ... for ... presumably yourself and Dr BARTON reached the same conclusion that day that she was in terminal phase.

REID — Yeah.

DC QUADE — And what are you saying has made you think that?

REID — I think looking at what has happened up until then, I think I've said before you know, a frail 92 year old lady increasing pain and from little records there are seemed to be from the end of the 11th onwards irritable and drowsy, having to be started on a syringe drive would lead me to believe that this lady was close to the end of her life, and

the fact that she wasn't able to ... was drowsy and (inaudible) things indicated the end of her life.

DC QUADE

To ... to be caring for a patient and so we're accepting at this stage that this is a form of palliative care isn't it that we're on this patient yeah. I think you were saying about the ward was getting the wrong sort of patients yeah. Was this an example of the wrong sort of patient for this ward or?

REID

I think it's difficult. It was ... I mean I've said before it was a continuing care ward we started having difficulty filling the beds, there was huge pressures to move people down from the acute unit. So for the next most suitable patients. I'd seen this lady in Haslar and ... I mean I'm very struck by the fact that what I said was we'd take her over for assessment because not usually if I feel that someone's a sort of good going sort of rehabilitation I'll say we'll take her over for remobilisation. I didn't say that, I expressed concern on about pain. So I think that I mean it wasn't an unreasonable patient to move to Dryad Ward for further assessment.

DC QUADE

Okay. To ... to look after a patient in palliative care situation does that require any particular skill or qualification ...

REID

Yes.

DC QUADE ... from the Dr's point of view?

REID Yeah.

DC QUADE Yeah.

REID Well there are skills in ... I think what my view is you do have to be trained in palliative care medicine. I think ...

DC QUADE As a speciality?

REID I mean every one role well nowadays every medical student should get some training in palliative care but I didn't, I never had any training in palliative care, I'm sure that most of my colleagues would be in exactly the same position. I think often Dr's can be very arrogant, I think they know how to deal with dying patients but all the evidence points otherwise. I mean today lots of sort of evidence that Dr's do not ... are not well informed about how to manage patients who need palliative care.

DC QUADE So would a Clinical Assistant be qualified in providing this palliative care?

REID Well they could be. I mean we have ... in Queen Alexandra Hospital we have a what's called an Associate Specialist, it's almost like a sort of step up from a Clinical Assistant but she's not a consultant, but she has done a lot of ... got a lot of training and experience in palliative care.

So it's very possible for a Clinical Assistant to be trained in palliative care. I'm not aware that Dr BARTON had any such training. I mean I can't say she hasn't been to the odd training day but I'm not aware that she's had any ...

DC QUADE — So there's no actual qualification as such it's just experience?

REID — No there isn't, there's no qualification as such. You don't need ... I mean two years ago we appointed a Consultant in palliative care and he'd been a GP who'd been working in a hospice for many years but he didn't have any formal qualification in palliative care. There isn't a formal qualification in palliative care. People can do training courses or spend six months working in a palliative care unit but there's no formal training.

DC QUADE — And, so do you feel that you were able then from your experience and, yeah from your experience you were able to diagnosis and provide palliative care to Mrs SPURGIN then?

REID — Me personally?

DC QUADE — Yeah.

REID — Oh I would, I would not consider myself to be in any way an expert in palliative care, not then, not now and I know a bit about it, a little bit about it but not very much.

DC QUADE Did you think that would have had any, any impact on Mrs SPURGIN's treatment then or not?

REID I think it, yes I think it could've done.

DC QUADE I've got one last question in this topic, you looked through the records and you formed your opinion on the 12th that she was terminally ill.

REID She was terminally ill.

DC QUADE Yeah and you've explained how she was restless and whatever and we know that she died on the 13th ...

REID Yes.

DC QUADE ... so it was less than 24 hours.

REID Yeah.

DC QUADE Yeah, looking through what would you say she died from? What would you say was her cause of death?

REID I think it's very difficult to say what cause of death is in a situation where patients don't have any, you know they haven't had a heart attack or chest infection, you know no clearly diagnosable ...

DC QUADE Yeah.

REID ... there used to be whether it's still allowed or not, cause of death was allowed as sort of old age or frailty ...

DC QUADE Yeah.

REID ... and that is the categorisation that I would say here, an old lady who'd unfortunately had a fracture neck of femur which you hadn't been successfully, her operation not successful certainly not in terms of relieving her pain and she just sort of went sort of down hill thereafter.

DC QUADE Sure, yeah, okay.

REID I think it's quite difficult to fill that certificate in.

DC QUADE Yeah we'll cover that in a moment. Chris.

DC YATES I've just got a couple of questions, the tape will run out in a couple of minutes anyway but going back to the range in prescriptions, in particular Diamorphine ...

REID Yeah.

DC YATES ... 20 to 200 and correct me if I'm wrong but you said the nurses would choose where to start but they were expected to start at the bottom of the range. Would the nurses actually refer to the BNF themselves?

REID — I've no idea.

DC YATES — And certainly in the case of the Clinical Assistant, which is Dr BARTON in this case, did she refer to the BNF?

REID — Well I don't know.

DC YATES — Because if, one would assume that if a doctor has referred to the BNF, British National Formulary, they wouldn't have set those sort of parameters.

REID — No I mean I think I've referred to already but I mean there were palliative care guidelines sort of out there, you know the Wessex ones which I certainly hadn't heard of and certainly you know in medical magazines for example, you'd often see guidelines published on palliative care. So I mean it could be that Dr BARTON was working to guidelines other than the BNF but I just don't know. I don't know where she, you know ...

DC YATES — Because bearing in mind what Enid SPURGIN was receiving in a way of MST I think she was on 20 milligrams of MST every 12 hours wasn't she?

REID — ... yes.

DC YATES — 40 milligrams a day.

REID Yes.

DC YATES And looking back on the records you're not convinced, you're not happy that that was necessarily controlling her pain.

REID That's right.

DC YATES So if for instance she was going to stay on MST, you would possibly have halved that …

REID Increased, yes …

DC YATES … plus the 30 milligrams.

REID … that's right, yes. Unless I mean there might've been circumstances where the patient was in so much pain you'd have said, you know I don't think this is going to be enough and I'm prepared to make the judgement if you like, take the risk of doubling the dose for example but in general terms the 50 per cent rule was the sort of …

DC YATES Yeah, also but if you actually halved it …

REID … go up to 30 you mean?

DC YATES … go up to 30 milligrams.

REID Yes, yeah.

DC YATES That would translate to 20 milligrams of Diamorphine?

REID I'd have to look at the chart to confirm that.

DC YATES Just put it away again but, yeah, there you go.

REID I'm very, yes.

DC YATES Yeah I'll leave it there just in case. So that is right at the bottom of the range that Dr BARTON's prescribed isn't it? So you've actually, you're actually increasing the lady's pain relief but that hits right at the bottom of the range.

REID She prescribed 20 didn't she?

DC YATES No she prescribed 20, 20 to 200.

REID Yes, yes sorry I'm with you now, yes that's right at the bottom of the range, yes.

DC YATES But she was started on 80.

REID Well I can't explain that you'd have to ask Dr BARTON.

DC YATES Now who would've actually started, Dr BARTON's prescribed it, who would've actually started the patient on it?

REID — I would imagine it would be the nursing staff and it's usually the nursing staff who, job that, if the drug can be drawn it's not usually the doctor.

DC YATES — Okay it just appears that you've referred to the BNF as almost a bible and certainly you refer to it and you've referred to it several times during the ...

REID — Yes.

DC YATES — ... course of the interview. I just wonder if anyone else refers to it at that hospital?

REID — Well I mean there's a BNF in every ward and you know I would imagine the nursing staff would refer to the BNF.

DC YATES — Right so it is available for the nursing staff it's not just used by the doctors?

REID — Oh no, no, no I mean I can't put my hand on my heart and say but it's my recollection that every drug trolley you know will have a BNF on it or there'll be a BNF besides the medicines cupboard in the drugs room.

DC YATES — Yeah, okay.

DC QUADE — Right the time by my watch is now 1041 and what we'll do is we'll end this tape and take a comfort break I think.