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RECORD OF INTERVIEW

Number:
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Person interviewed: BEED, PHILIP JAMES

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1214 Time concluded: 1250

Duration of interview: 36 MINS Tape reference nos. (◆)

Interviewing Officer(s): DS Code A, DC Code A
Code A

Other persons present: Mr GRAHAM - Solicitor Saulet & Co, Portsmouth

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(◆)	Person speaking	Text
	DS Code A	This is a continuation of our interview with Philip BEED. The time by my watch now is 1214pm. Philip we've had a break for what 15/20 minutes, we've not spoken about this at all during the break, you've been with Mr

GRAHAM down here. Same rules still apply, you can get up and walk out any time you want you're here voluntarily and if you want to talk to Mr GRAHAM then do so, let me know and I will leave the room for a short while and the caution still applies throughout. A couple of things that I'd like to cover from our previous interview. What's the arrangements in place at Gosport if Dr LORD isn't available?

BEED At that point in time when Dr LORD wasn't around we just had clinical assistant cover. If we needed the advice with a consultant then either nursing staff or a clinical assistant would call a consultant at QA and ask for their advice and ask for advice over the telephone or ask for them to come and see the patient or relatives if that was required.

DS Code A Would Dr BARTON ever assume that higher role?

BEED No if we need a consultant's advice we would seek it but I've not known very many occasions when we've actually needed to do that, but there have been occasions when I've contacted the consultant and arranged for him to come to ward or got their advice over the telephone.

DS Code A I've not been in a position to disclose to you this but I have had a sight of Dr LORD's report which says that Dr LORD was asked to do a

report on behalf on the hospital and she said that during that week she had no knowledge of Mrs RICHARDS because she was on a course. Now I can't formally give you anything to prove that but please accept that that does exist. Is there any particular about that week that might ...

BEED In terms of consultant cover?

DS Code A Yeah.

BEED Dr LORD actually was there on ... was on the ward on the Thursday during Mrs RICHARD's first admission and that was the day when she feel from the chair. But she was actually conducting a ward round looking at the stroke patients and therefore wasn't planning or required to see Mrs RICHARDS on that day. If we've got Dr LORD on the ward and we would like her to see a continuing care patient then we can say 'can you see this patient'. In retrospect it would have been helpful if the nurse who was looking after Mrs RICHARDS had actually asked Dr LORD to look at Mrs RICHARDS but she didn't because she'd assessed her and found nothing to be untoward, and falls aren't an uncommon thing.

DS Code A Let's move on to that in a little while, I'm still clearing up from last time.

BEED Right.

DS Code A — But we will get ... you'll get every opportunity in a few minutes to get on with that. But one of the things they were keen to clear up was what formal arrangements are undertaken at Gosport in the training of use of the syringe drive. I know you said that you send people off to the George Ward, but are there formal training requirements in place?

BEED — Every member of staff is expected to be competent in every aspect of their work and if their not then they need to identify training needs. But there isn't a formal course that every nurse must go on with regarding to syringe driver but they must have gone through out to use it and proper use of it, either with another member of staff or attended a course.

DS Code A — How do you know your staff are competent?

BEED — We have what we call supervision so all staff are supervised when they ... both when they start on the ward and then on an ongoing basis with annual appraisals. So we look at all aspects of their work and what their training needs are, so ... and it's the individual nurses responsibility to identify what sort of training support they need along with myself as Clinical Manager. So if the syringe driver wasn't something they'd used before then they would say to me 'this is not something I'm familiar

with', then I would make sure they got the appropriate training in how to use the syringe driver.

DS Code A — Do you monitor your staff throughout the year?

BEED — On an ongoing basis so we have an annual appraisal but monitoring is an ongoing thing that happens all the time, day to day and week to week.

DS Code A — I mean not understanding much about the syringe driver do practices change, I mean have they changed in two years?

BEED — Not really ... syringe drivers have only been in really common use for about the last 10 - 15 years before ... and it became more common in usage but in terms of the actual use of the syringe driver, the way it's used, that hasn't really changed over the last few years. As I say they've become more common in the last say 10 years.

DC Code A — I may have covered this point but what size of driver do you use in terms of the syringe.

BEED — It's a ... well it's a 24 hour driver, it's a grade B MS26, and for most ... for the common doses we use, we use a 10 ml syringe but the important thing is the amount of medication which is in it which is actually 60 millimetres in length. So you can use any size syringe but the total travel of the syringe is 60 millimetres

which you measure up against the gauge on the syringe driver itself. And the doses we were using on Mrs RICHARDS we would use a 10 ml syringe.

DC Code A — What would you use generally across the board?

BEED — Usually a 10 ml syringe made up to 60 millimetres of travel which actually makes 10 ml.

DC Code A — What other sizes do you use?

BEED — If we needed either greater dilution or if we needed to ... the dose came to a volume greater than 10 ml we would either use a 20 ml or a 30 ml syringe but again it's the length of travel that's significant and it's 60 millimetres for 24 hours.

DC Code A — What would cause something to use greater dilution, what sort of ...

BEED — There are some drugs which actually can be an irritant if they're not diluted enough and I can't think what those are off the top of my head. One is the Parkinson's drug which we use needs to be diluted to a bit more than 10 ml, but also if we're using very very high doses of diamorph...of the drug, so we're usually using a high dose, a combination of diamorphine and medazalam and hyoscine and if you were using above a certain ... I think over about 80

milligrams of medazalam you need to ... you need a volume greater than 10 ml so you can use a larger syringe.

DS Code A — Moving on you were on about Dr BARTON comes in every morning.

BEED — Yeah.

DS Code A — How long for?

BEED — Usually for about 20 to 30 minutes.

DS Code A — What does she do during that 20 to 30 minutes?

BEED — The nurse in charge will go through all the patients on the ward with her and usually in the ward office and talking about how they've been in the previous 24 hours or over the weekend if it's been a Monday. Discuss any changes in care and medication, get tests written up, get drug charts changed and discuss any particular aspects of their care, and if there are particular patients which need to be seen personally by the doctor then the nurse in charge and Dr BARTON would go together and actually see him, examine the patient or talk to the patient or whatever's required. Then back to the office and writing any notes and any change in care plans that are needed.

DS Code A — So there are occasions when ... if nothing changes the doctor wouldn't see the patient?

BEED — She wouldn't specifically see every patient every day only patients which as nurses we've

identified need to be seen or Dr BARTON feels that she needs to see.

DS Code A — So the doctor relies on your judgement?

BEED — Yeah.

DS Code A — In an ideal world is that common practice?

BEED — It varies but in our particular ward it's quite relevant because most of our patients are fairly stable and their condition isn't changing much on a day to day basis and there isn't any real change, any major change on a ... just from one day to another. So we don't need to actually see a doctor unless there's anything particular the doctor is going to check and do, and we know of those patients where there is a particular problem, a particular issue. So I'm quite happy from a nursing point of view that that's an acceptable practice and appropriate to the needs of our patients. If all patients have been got up and toiletted at that time of the morning, so to actually see if it wouldn't affect their care or there wouldn't be anything to be found but it would disrupt time for them which is quite personal when they are having assistance with washing and dressing and using the toilet and so on.

DS Code A — How would the doctor know if a patient was improving or deteriorating?

BEED — From the information we supply to her.

DS Code A — Is it not realistic to expect that the doctor is looking after you actually sees you to make that judgement?

BEED — The nursing staff actually work very closely with the patient so we actually get a very good picture of how a patient is doing and any particular problems they have and how they are. So they are actually getting a better picture talking to us about how the patient has been over the past 24 hours than actually seeing the patient at one point in time. So it's about working as a team working together and we work very very closely with our medical staff and the care of patients.

DS Code A — Is there a great deal of trust between yourself and Dr BARTON?

BEED — Yes.

DS Code A — How long have you worked with Dr BARTON?

BEED — As long as I've worked in the War Memorial, so three years.

DS Code A — Three years?

BEED — Yeah.

DS Code A — Is that a good sort of professional relationship?

BEED — Yes.

DS Code A — Is there a social element to it?

BEED — No.

DS Code A — But it's someone that you deal with day in day out?

BEED Yes.

DS Code A Have you ever disagreed?

BEED Yeah on some issues yes, yeah. And if we do disagree then we discuss that and hopefully come to a resolution. I mean that's not just with Dr BARTON but also with Dr LORD and other nursing colleagues there are some things where a decision is not absolutely straight cut so you want to discuss and agree on what the appropriate course of action is.

DS Code A Is it a healthy regime when you feel able to?

BEED I think so yeah. I think if you are always agreeing on everything you could be agreeing on something that's incorrect so yeah. And there isn't ... neither of us have a problem with pointing out to one another that we're not happy with a decision or an agreement or whatever and we think it needs to be discussed further or looked at.

DS Code A Are there any examples you could give where you and Dr BARTON have disagreed?

BEED Certainly there's times when looking at whether patients should go home or not. A lot of our discharges home are very very risky and the patient is wanting to go home but the safety of the patient and their likelihood of success at home is very questionable. One of us may think yeah they should go, go ahead and give it a try

and the other just saying we shouldn't even be contemplating at home. So quite often that's an area where we would say ... where one of us would be saying one thing and the other saying something different and would have to decide what we were going to do. Although usually the agreement is in line with what the patient wants to do.

13.17 DS Code A That's one of the other points I wanted to clear up with you is are there many instances where the medical opinion as to the course of treatment differs from that of the family and how do you reconcile that?

BEED There are a lot because of the nature of the work we do and we've got people who are very dependent, often with very poor prognosis and relatives often are quite unrealistic as to what might be practical and achievable. So that's ... the way of dealing with that is one to pick it up very early to know what the family ... say one of my first things would be talk to patients and their families and find out what they're expecting and what they think will happen, hope will happen. And carry out our own assessment with the medical staff and Physiotherapist and Occupational Therapist as what we might actually be able to achieve. Then you have to go into discussion and also

the care we do is often geared around actually exploring what people ... you know what can be achieved and what might happen. So it's a matter of working together, it's what we call multi-disciplinary team on trying to get the best outcome for the patient within the scope of what's possible.

14.36 DS Code A Can families influence that decision?

BEED It depends what the decision is, but if it's a very ... we would always want to make decisions which are right for the patient and if a family is really wanting something which is not right for the patient and not in the patient's best interest then we would have to be quite up front about what we need to do and what's appropriate. But we would still always take into consideration the relatives and try and work towards meeting what they and the patient want and where we can't making sure they understand what we can't ... what we need to do or what we can't do or what we have to do.

DS Code A Who makes that decision ultimately. If it comes to telling the family 'no'?

BEED If it really came to a difficult decision then it would be passed on to the consultant. So where we get into a real difficult decision that we can't ... I mean if it can be resolved at a nursing level or a medical assistant level then that's what we

do, but if it really can't be resolved then we pass it up the level to the consultant who will make the final decision and convey that to the family.

15.52 DS Code A On occasion if it's ... this is a bit hypothetical, but if families have a request that it really doesn't fit in with your nursing plan would you alter the nursing plan to accommodate that if it was a little bit detrimental?

BEED We would also try and work with the patients and the family and there's been lots of occasions where we try to do things which we actually know professionally from our own experience we're not likely to succeed at, but we give it a try anyway. And times when we've instigated courses of treatment for patients which we know actually won't benefit them and actually probably aren't necessarily the best treatment for them but it's what the family are saying they would like, so we try and meet the relatives where we can.

Family not medical staff decisions

DS Code A It's difficult ...

BEED Yeah. It is difficult because in those situations you've got to decide do you do what the family want which is not necessarily best for the patient but the family don't want the same. There's a compromise there somewhere that you have to achieve.

17.02	DS Code A	It's a skill that you develop over ...
	BEED	Over 20 years and will continue to develop over another 20 years I suspect.
	DS Code A	I think as far as the background goes I'm fairly happy. I've a nod from Lee whose not got any supplementary questions for me.
	DC Code A	Not at the moment no.
	DS	The notes are on the tape in front of us and we're here because of Gladys RICHARDS. Can you just in your own time and take your time, you know you said that there were perhaps some things in her notes that weren't fully recorded. Make reference to the notes please do, again it's not an exam, but can you just tell me all about this particular case, nice and slowly.
	BEED	Has this got the duty rotas in it as well?
	DS	I'm sure we can get hold of ...
	DC Code A	I've got a copy of the duty rotas here.
	BEED	Cause that would just give me an idea of the dates we're talking about.
	DS Code A	Now this particular tape has got about 30 minutes on it, is that gonna be enough time for you to do that?
18.07	BEED	I think so yeah.
	DS Code A	What I want you to do is really as much as you can and get as much detail and information out of you as I possibly can.

DC Code A For the purpose of the tape there's the duty rotas, copy of with the relevant dates there.

BEED Mrs RICHARDS was transferred to us on the 11th August which was a Tuesday, that was Val who was on a late shift with an enrolled nurse by the name of Code A She came to the ward sometime around lunchtime and was admitted by enrolled nurse Code A when she came on duty at 3.30. She was a very confused lady, very agitated. She'd had a fractured neck of femur fixed surgically at Haslar and had come to us for assessment and gentle rehabilitation. The note from Dr REID who is a consultant who saw her in Haslar gave us the background information about her confusion, her falls over the last six months and the fact that she was already in a nursing home and that the family were unhappy with the nursing home and didn't want her to return there. So our overall picture at that time was someone whose prospect of regaining mobility was going to be limited because of her confusion and her poor hearing and the fact that she already had a history of falls. So even when we got her mobile that history of falls wasn't likely to change and that if we were able to provide her with some rehabilitation we would have to, with the family, look for a nursing

home which was suitable to her needs and acceptance of the family. She was in a single room. We screened her for MRSA which is a anti-biotic resistant bacteria, I mean that's routine for patients coming from an orthopaedic ward. It was very apparent that she was quite confused. She was also, in my judgement, in considerable pain from that hip and myself and Code A actually gave her some analgesia and that was oromorph and we gave her a fairly small dose. We gave her a 10 milligram dose of oromorph that afternoon to try and make her comfortable. Her daughter came in later that afternoon and talked about not wanting her mum to go to Glenheathers and also talked about the fact that she felt her mother communicated and when she was getting agitated it was because she wanted to go to the toilet. My professional view was that if she could communicate with her daughter, it wasn't certain, but she certainly wasn't ... Mrs RICHARDS certainly wasn't able to communicate very effectively with us either understanding what we were saying or pass anything meaningful to us. She had a further dose of oromorph at a quarter to midnight given by the night-staff, that's Staff Nurse Code A at night and a further dose at 6.15

Not prior to Admission as on Admission ??

Why?

in the morning. I was on a half day on the Tuesday and really saw no great change in her that day. On the Thursday I was actually a day off and I came back to work on the Friday morning to work a long day which was a 7.30 start and was advised on arrival at the ward that this lady had a fall from her chair the previous day, which initially had looked to be, not to have caused any injury or any problem and was actually helped back into a chair, but later on in that evening had noticed that the hip appeared to be dislocated. So the nurse in charge that evening had contacted the duty doctor whose advice had been to keep the lady comfortable over night and to arrange an x-ray and treatment the following morning. Dr BARTON was on the ward not long after that so we immediately saw her examine the lady, made sure she was pain free and started plans to arrange an x-ray. Her daughter had been contacted the night before and arrived in ... whilst Dr BARTON was there so advised her what we were planning to do. I arranged an escort to go with Mrs RICHARDS to x-ray and her daughter accompanied her as well. That x-ray was completed later on in the morning and confirmed that the hip was dislocated. So Dr BARTON came back to the ward and we

arranged for the lady ... Mrs RICHARDS to be transferred to Haslar with a view towards having dislocation reduced under sedation. Talked to the daughter Mrs LACK and explained what we planned to do. Gave Mrs RICHARDS oromorph analgesia again to make her comfortable with her hip and that would already initiate the sedation process so hopefully they wouldn't have to wait too long for her to be sedated when she got to Haslar. I then arranged transport and then arranged one of my nursing staff to actually escort the patient to Haslar and she went accompanied by .... went to Haslar accompanied by one of my nursing staff and daughter's followed. Later on that Friday Mrs RICHARDS' daughter Mrs LACK came back to the ward to collect some wash gear for her mother who was going to stay in Haslar, certainly overnight. I think at that time it was thought that she would come back to us on the Saturday and advised us they'd reduced the dislocation and would place her mum back. I knew that Mrs LACK was very angry about the fact that her mum had dislocated her hip and that there had been a delay in notice, when that dislocation had been noted and x-ray and treatment. And one of the things I specifically asked Mrs LACK is whether she was happy for

her mum to come back to us which she said she was and I was quite clear in that in that she had the option of looking to alternative arrangements if she didn't want her mum to come back to our particular ward. I was at that point not only looking after Mrs RICHARDS but actually looking after Mrs LACK and her sister Mrs McKENZIE who were getting quite upset and fraught and I could see potentially they could be quite angry and difficult relatives. I knew that we needed to make sure we've provided them with the care they need as well as their mother. Mrs LACK actually came back ... didn't come back to us straightaway cause I knew that she didn't recover from the sedation very quickly at Haslar so she actually came back to us on Monday lunchtime. I was on duty at 12.15, I'd probably ... I usually arrive for my shift a little bit early just to make sure I'm all sorted out and ready to start and Mrs RICHARDS arrived round about the time I arrived on the ward and was uncomfortable and in pain really from the time she arrived on the ward. Her daughters arrived a little while afterwards. The nurse actually looking after ... the nurses were already on duty actually settled her into her bed and I quickly became aware that there was something going on there with

Mrs Richards

daughter saying that ... 'why is mum uncomfortable and what's going'. And really from that point in time I made sure as nurse in charge that I was heavily involved with Mrs RICHARDS care cause I could see potential difficulties with the both the patients care and the family. One of my nursing staff looked at the position of the leg and couldn't anything appear to be dislocated which was one of the concerns the family were bringing up that the hip had dislocated again as soon as she got back to the ward. But nevertheless what we did was got in touch with the doctors ... I'll just refer to the notes because I think ... I think she settled down after coming to us. One of my difficulties is that it's so long ago and the sequence of events is ... I believe what happened is she actually settled down whilst Dr BARTON came and clerked her in and then as soon as Dr BARTON had left the ward again she was again screaming in obvious pain and distress. So we contacted Dr BARTON and agreed to have another x-ray of the hip taken to check whether there was anything we needed to do or if all was in order there. There was a difficulty in getting that x-ray done because we needed a doctor's signature on the x-ray form and we don't have a doctor actually on site, and it took a while to get

see drug chart.
10mg in 5ml.
2.5ml = 5milligrams
4 x Oramorph. Between 1pm and 8.30pm.
Prescription reads 4hrly.

a doctor to actually come into the hospital and sign the x-ray form. But the x-ray took place at quarter to four and we gave Mrs RICHARDS some pain-killer 2.5 milligrams of Oramorph prior to that just after 1 o'clock to try and make her comfortable. The x-ray was done, the daughters were upset they weren't allowed into the x-ray room but that's not a decision that I'm responsible for that's up to the duty radiologist. That was seen by Dr PETERS who is one of the partners in Dr BARTON's practice and he looked at it and said there was no dislocation and that we need to make sure Mrs RICHARDS has proper pain control, and for Dr BARTON to review her the next morning. Mrs RICHARDS at this point was in a lot of pain, a lot of distress, generally looking unwell. She was refusing to eat and drink anything other than a very small amount, any attempt to try and provide her with the nursing care she needs so she was incontinent or needed washing or needed repositioning was making her ... causing even more pain and distress, it made it very difficult to nurse her. We used the oral medication overnight so we gave her oromorph at 1 o'clock, again at quarter past three, yeah I gave a dose at quarter past three and that wasn't effective so I actually had to give another

Aug.

11th.	10mg.	
11th.	10 mg	
12th	10 mg.	
13th.	10 mg.	Oramorph.
14th.	10 mg.	
17	5 mg	
17	5 mg	
17	5 mg	
17	10 mg	
18th	10 mg	
18th.	10 mg	

Drug Sheets

18th PLUS. 40 mg Diamorph
Same day.

19	40 mg	Diamorphine
20	40 mg	"
21	40 mg	"

In addition to above.
ALSO. on 14th. Dr Barton says 7.5 ml of Oramorph of 10mg in 5ml given. That equals. 15mgs - in letter to Haslar.

Aug.

11th.	10mg.	Oramorph.
11th.	10 mg	
12th	10 mg.	
13th.	10 mg.	
14th.	10 mg.	Phillips Bead.
17	5 mg	
17	5 mg	
17	5 mg	
17	10 mg	
18 th	10 mg	
18 th.	10 mg	

18th PLUS. 40 mg Diamorph
Same day.

19	40 mg	Diamorphine
20	40 mg	"
21	40 mg	"

In addition to above.
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Following Xray

supplementary dose at quarter to five to increase the effect of that and another dose at eight thirty and then more overnight. Throughout that time I was talking with the family about mum being poorly and what we were going to do and the fact that priority ... the agreement with the family was the priority here was to keep the mum pain free and comfortable. There was a certain amount of difficulty in that ... there was obviously something going on between Mrs LACK and Mrs McKENZIE in that they were saying ... different daughters were saying different things to me at different times and it was an obvious dispute and disagreement going on between them but I tried to keep them both involved and both informed of what was happening and what I needed to do. There was really no improvement overnight and the pain control was obviously keeping her comfortable but still not eating and drinking and still looking unwell. She was reviewed by Dr BARTON on the following morning which would have been me Tuesday 18th at which point the view was that the transfer to Haslar wasn't appropriate because there was no dislocation that was going to be fixed and that the likely cause of the pain was a haematoma and that the pain control wasn't effective as it

Mrs Richards had infact had 45 mgs iv in a Period of 16hrs.

As Nurses we know the difference to sleeping and the unconscious state.

My Mother became unconscious and did not require further medication after the 0.430 dose given my night staff.

We saw my Mother at 0.830 on the 18th and she was unconscious UP TIll 0.430. She was, as stated, able to take medicines by mouth.

was and this lady's overall condition was very poor and likely to deteriorate further and the appropriate course of action was to use a syringe driver so we would could give continuous analgesia, kept Mrs RICHARDS comfortable as opposed to giving doses which we were having to give every four hours and top up if they weren't quite right. The family arrived ... I held off initiating that because we knew that it would ... that sedation would cause a drop in level of consciousness. I wanted to discuss that with the family before we actually started it so when the family came in that morning I presented the overall picture to the family, discussed with them just how poorly mum was and that we were looking at palliative care to keep her comfortable and that we wanted to use a syringe driver to keep her pain free. The family agreed to that and we started that at 11.30 in the morning and that quickly established a level of pain control which allowed us to look after Mrs RICHARDS properly, keep her clean, keep her dignified. And really from there through to the rest of the week we kept Mrs RICHARDS comfortable and looked after her needs and made sure we looked after the family. So the daughter stayed with her throughout but we made sure they

Already unconscious

somewhere they could rest, they could eat and drink, but they were looking after themselves, kept them informed as to what was happening, tried to provide appropriate level of support as they were going through a difficult time. They did require an awful lot of our time and we have to balance our time between all our patients and relatives and if people ... some people need more time than others then that's what we give but they did tie up an awful lot of my time, our time. Myself and one of the night staff were spending a much larger amount of time with them than we perhaps would with other relatives. I knew they were ... I was fully aware that one of the daughters was intending to make a complaint about the incident when mum, Mrs RICHARDS, had fallen from the chair. I spoke to her myself about it and what we'd done and what we'd not done and when you're dealing with a complaint if you can resolve it on ward level you do but if you can't resolve it then it needs to go on to a higher level and Mrs LACK clearly decided that she wanted to take this complaint to a higher level. So my role at that point, although like complaints, is to actually support her in doing that and I'm quite happy to do that so I actually put her in touch with the appropriate people to take her complaint to and

gave her the resources to photocopy the complaint and I actually looked through the complaint that she'd made but I didn't ... other than the things I'd already discussed with her I didn't respond to it at that time cause I knew that it would need a proper investigation. Really it was then a matter of looking after Mrs RICHARDS as her condition gradually went down hill over the next five days. I think I was mainly on late shifts thereafter so ... spending time with her and she eventually passed away late on Friday night, and the nursing staff on duty at that time would have just dealt with that in the normal way we deal with. The family wants to be very involved with ... after mum had died with ... laying her out and taking her to the mortuary and so on. The time we spent with the family did make it difficult to keep nursing records up to date and we knew that was a problem at the time, particularly that the ward was very busy at that time, I don't think any patient didn't get the care they needed but when the ward is very busy you have to sort of prioritise your work and decide what you're going to do and what you're not going to do and make decisions in that respect. It certainly was a very busy time for us, I had people on annual leave and loads of people go off sick as well

		which made hard work. Anything else you need to ....
37.36	DS Code A	I think on that you've led us through. Obviously we're gonna come back to you on some points and just say can you explain this in a bit more detail, can you explain that in a bit more detail. It's ten to one, you've spoken for twenty minutes, do you want to take a break?
	BEED	I don't mind.
	GRAHAM	It's all in your hands.
	DS Code A	I tell you what let's take a break for lunch and then we can sit back and see what we want to come back and you can have a stretch anyway. Okay. If everyone's happy with that by my watch the time is ten to one and we're turning the tape recorder off.