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RECORD OF INTERVIEW

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Person interviewed: LORD, ALTHEA EUERESTA GEREDITH

Place of interview: Fareham Police Station

Should say 27 September

Date of interview: 27/12/2000 Is this correct date? should be 27 Sept

Time commenced: 1414 Time concluded: 1458

Duration of interview: 44 mins Tape reference nos. (◆) 44/00

Interviewing Officer(s): DC Code A DC 92 Code A

Other persons present: Mr PRIVETT - Solicitor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(◆)	Person speaking	Text
	DC Code A	This interview's being tape recorded, I am DC Code A the other police officer is.....
	DC Code A	DC Code A
	DC Code A	I'm interviewing Doctor LORD, please can you give your full name and date of birth?
	LORD	I'm Anthea Everista Geredith LORD, my date of birth is Code A

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DC Code A	Thank you and also present is....
SOLICITOR	Richard PRIVETT, Doctor LORD's solicitor.
DC Code A	Thank you. The date is Wednesday the 27th of September, the year 2000 and the time by my watch is 14.14. This interview is being conducted in an interview room at Fareham Police Station. At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes and whilst entitled to legal advice throughout the interview and at any time you can delay the interview to take that advice, okay so if you want to stop at any time to seek further advice you only have to say and we'll leave the room and you can take that advice, okay. Okay the next part is the caution, you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court, anything you do say may be given in evidence, okay. Right just to let you know that this room can be remotely monitored and I'm just going to read this notice up here, it's capable of being remotely monitored when the tape recorder is in record mode only as it is at the moment, which basically means any other time when the machine is not recording then it can't be, okay and of course it, the explanation of that is when you want to speak to Mr PRIVETT nobody can hear that conversation, okay. What I'd like to do just briefly is just to reiterate why we've

		asked you to come in today, okay, before I do that I will tell you that you are here voluntarily, you've come here voluntarily and as such you can leave at any time, okay, you understand that?
2.16	LORD	Yeah.
	DC Code A	Right, okay, the reason that we've asked you in is obviously surrounding an allegation basically of the unlawful killing of Gladys RICHARDS at the Gosport War Memorial Hospital between the 17th of August 1998 and the 21st of August 1998, okay and what we'd like to do today is to discuss your role within the hospital at that time and some of the points that have been raised by the family and other points that we've looked at and to seek an explanation from you on those points, okay, yep. What I'd like to do first...what I'd like you to do first if you may is if you can explain the position you hold at the hospital and in particular what roles and responsibilities go with that position and then from there whether it has changed from 1998, whether there's any differences at all.
	LORD	I've been a Consultant Geriatrician since '82 so it's about sic and half, eight and half years.
	DC Code A	Eighteen and a half years.
3.20	LORD	Close, can I start again, I'm sorry.
	DC Code A	Yes certainly, certainly, yeah.
	LORD	I've been a consultant since '92, since March, since end of March '92 that's about eight and half years

now erm my duties would include being res..being responsible for an acute ward which is based at QA, and I do a certain amount of community hospital work at Gosport War Memorial Hospital where we've got two wards, Daedalus ward and Dryad ward. Back in '98 Dryad ward was a continuing care ward and still is, Daedalus was a continuing care ward with 24 beds of which 8 beds were for slow stream stroke, rehabilitation. I was responsible usually responsible for Daedalus ward, for the continuing care and these stroke patients but about..in about July '98 the colleague was Dr TANDY who was doing Dryad ward went on maternity leave and the department decided because we'd had problems with poor quality locums covering leave before that we would try and cover the duties internally, we had another part-time post come up as well so we had a few extra hands on board well we had half a consultant on board erm so I then took on just to cover the maternity leave I did Daedalus ward and Dryad ward alternate Monday afternoons and I was a consultant responsible, I also did out patient clinics supporting Gosport and as St Mary's and I also had a day hospital once a week again in Gosport which is Dolphin Day Hospital in addition to that and this is not timetabled anywhere we also do ward visits to all other departments medical, surgical,

		orthopaedic psychiatry throughout all the hospitals in Portsmouth and that would include St Mary's, QA, St James' and Haslar, we also visit people at home on domicile consultations.
5.33	SOLICITOR	I don't know if it would help but erm Doctor LORD's provided me with a copy of the rota that sets out her duties on a weekly basis as at August 1998 along with the rest of the consultants that she works with...
	DC Code A	Oh right.
	SOLICITOR	...so there's her working week as such at the relevant time.
	DC Code A	Okay, is this something you've produced yourself or is this come from a ....
	LORD	This is saved what happens is that if there's a change in the consultants timetable's required the Consultant Body needs as many people as possible preferably (inaudible) and we know what areas we need to cover because of the set areas and then we see how we can divide it so that we don't have much travelling in between keep up interest going because I've always done quite a lot in Gosport erm and that's where my interest and my work lies.
6.25	DC Code A	Sure, sure, okay. Where has this come from this rota?
	LORD	Er this is saved on the, the, one of the secretary's in the admittance office at QA er she does the final draft once we've scribbled in what we want and she

		saves the, she saves almost everything so we can go back to any moment in time and get out work the on call rota and we'd call this our timetables.
	DC Code A	Sure, okay.
	LORD	And we would have them for the graded staff or grades.
	DC Code A	Where are you based or where were you based at that time?
	LORD	My office is at QA and that's where I have a secretary er and my acute ward is there, I do a..twice a month I do a clinic at St Mary's but all the other...the rest of the time is in Gosport and in general terms I would be in Gosport on a Monday and Thursday.
7.17	DC Code A	Right, okay. So focusing on Daedalus and Dryad ward, what would your role be there on a Monday when you would visit? What would things you'd (inaudible)?
	LORD	It would be a consultant ward round usually with a clinical assistant we've now got a staff grade in post and a nurse er if the therapists had been involved with patients we would start off with what we call a multi disciplinary case conference if there are patients to discuss, mostly involving patients who are either having complicated rehabilitation or where we have to undertake the complex discharge planning, getting dependant people say home for example er so we would start at half two because

my morning session often overran in the day hospital on a Monday so I'd start at half two, we would discuss any patients also if the social worker wanted to come in, any discussion would be before the round then I would see each individual patient on their bed or in their, in their room nothing in public and at the end of it I would see any relatives who need to be seen and those relatives can be booked in by the nursing staff they don't have to make an appointment, they don't need to check with me they can book the appointment with the relative to turn up at the end of the round.

8.39 DC Code A — Sure, okay. So would you...what sort of things would you be looking at in terms of each patient? What would be the things you would actually attend or..?

LORD — If it's the first time they've come down and often these people have had quite protracted journeys through the health system they could have been seen on orthopaedics, then on an acute ward then ended up back say in Gosport so we would need to review the medical notes, try and find out what is the main problem, what are the other problems and we fill out that sheet that we fill in and that's called a problem sheet that often is useful for summarising the persons problems, then we try and sort out what treatment they're on medication, what is their present con...you need to examine them first, make

		sure there's no, there's nothing like an infection or something simple that can be treated, review their investigations, review the treatment and then have a rough plan preferably with a, with a name of what you want for the patient, either they could be something like we'd observe for four weeks see what happens maybe for a nursing home or maybe for gentle rehabilitation or maybe this patient has advanced cancer, this patient is for palliative care so it depends on what the patients there for, what their condition is and we certainly try to say what way for someone then you need to get the relatives on board because someone might have an advanced cancer but it may be that the family very much want them home erm so you've got to then sort of find ways of getting everything else together and in '98..in august '98 I would do each ward every fortnight, only once a fortnight because I did Daedalus ward one day and then Dryad ward one Monday and then Dryad ward the next Monday.
10.33	DC Code A	So you did alternate...
	LORD	Alternate Mondays.
	DC Code A	...alternate Mondays, okay.
	DC Code A	Is it different now is it?
	LORD	Yes because erm when Doctor TANDY came back from leave we juggled the timetables round again and Doctor REED does Dryad ward weekly and I do Daedalus ward weekly.

DC Code A	Right is that as a direct?
LORD	The turnover was going up anyway...
DC Code A	Right.
LORD	...the Health Authorities criteria for providing people hospital continuing care changed so instead of people staying in hospital, going back about five years if there was someone very dependant, say with a very bad stroke we would say that yes this is a bad stroke, they're very dependant they cannot move out of bed at all, you offer them a bed for life. About five years ago the Health Authority said that doesn't apply anyone who's stable for four to six weeks and doesn't require what they call specialist medical and nursing intervention can be discharged to a nursing home and that had a huge implication in the numbers that were going through the ward because prior to that people were just there for life, you had time to assess them medically, you had time to get to know them, you were more susceptible to changes in their condition, you knew the families and between about sort of from about '95-'96 gradually the turnover kept increasing as we kept discharging people, it's almost as though the, the whole focus of the ward was changing as well at that time. We were aware that the turnover was increasing and in fact the figures for that year show that we had 273 through both wards which is quite high it was about I think 210 the year before

		and we were aware that the work load was high, that we couldn't get on top of problems that were cropping up and I was finding that even though I was doing the wards alternate weeks I was having to go to the other ward anyway at the end and it was sort of 7-8 o'clock before you could get back home so the wards were..the ward rounds were every fortnight but we were having to pop into the wards on a, on a weekly basis.
12.40	SOLICITOR	What would trigger those additional visits to the ward?
	LORD	It would be the nurses or Doctor BARTON was the clinical assistant then mentioning that there was a problem and that there was something that needed sorting so it would be contact from nursing or medical staff.
	DC Code A	Moving up just briefly to Doctor BARTON then, what, how do you understand her role to be?
	LORD	She was the clinical assistant er she's also a local GP and she would be there on the consultant ward round, she also popped in in the morning and in between sort of, between surgeries and was available for full contact in between, when she wasn't around her partners covered that practice still covers out of hours but we've now got a full time staff grade whose in post now Monday to Friday at the hospital for both wards and the day hospital that's only been since August this year.

13.38	DC Code A	Right so there's actually a permanent clinical assistant on the ward?
	LORD	Yeah and that again was on the back of increasing activity finding that even when I was not in say on a Tuesday having been there on a Monday that there were issues that were cropping up...
	DC Code A	Yeah.
	LORD	...plus it's likely now with all the changes in intermediate care that Daedalus ward will actually become a rehabilitation ward as from the 1st of November so the whole focus of the ward is changing as well.
	DC Code A	Right, okay so what's the diff...the rehabilitation ward sounds fairly obvious but can you just explain what that involves?
	LORD	Yes basically you're looking at people who will need to be in hospital to have in-patient multi disciplinary rehabilitation, what that means is you're probably going to need more than one therapist and they probably have medical problems as well, if someone say just fractured their arm and needed physiotherapy they could come to out-patient physiotherapy but for a lot of the elderly it might be that they've just fractured their, their arm but it might have been a heart attack that caused to fall and it might be that they've got heart failure anyway, it might be that they're living on their own with no relatives and it may be that they're are

		partially sighted whatever so they need the input of..medical input to make sure that we can get them the best general health we can and then you also need physio occupational therapists maybe speech therapist if they've got problems with swallow, social workers it's quite complex and often they're not things that you can snap your fingers and say yes you can go home tomorrow all these will be in place so Daedalus ward from the 1st of November will have patients for in..in-patient rehabilitation with a view to moving them on.
	DC Code A	Okay. So when you did these rounds as I understand it Doctor BARTON would be responsible for prescribing drugs and treatment during ....
15.43	LORD	Yes we would decide that together.
	DC Code A	That would be taken together?
	LORD	Yeah.
	DC Code A	Would it ever be taken by one or the other alone and then discussed later on?
	LORD	No because I would see the patient, the idea of that round was for, for them to have my input.
	DC Code A	Certainly I mean sorry I mean other than that round, I mean obviously you weren't there...
	LORD	Oh yes, no but if I wasn't there then Doctor BARTON would make the decisions...
	DC Code A	Yeah.
	LORD	...and I would have every confidence in her.

		have been initiated or they'd say that someone's in heart failure we've tried this and then we would review the drugs together so we would decide with the nurse, the nurse that was present, Doctor BARTON and myself we would decide on what treatment to write up. I mean often if Doctor BARTON was there she would write it up on the chart but it would be on, on my instructions.
17.52	DC Code A	But it would be a joint call?
	LORD	Yeah, and I..yeah.
	DC Code A	I mean in terms of hierarchy then in terms of who has the final...
	LORD	I would.
	DC Code A	...say, you would say so? Okay, has there ever been an occasion where you've had to erm question Doctor BARTON's actions over a particular patient in terms of either the level of treatment given or the type of treatment?
	LORD	Not that I can recall.
	DC Code A	Okay is there ever been any disagreements between the two of you as to you know what to do about a particular patient?
	LORD	Not at all. If Doctor BARTON rang for advice she'd follow what was, what was recommended.
	DC Code A	Okay.
18.38	SOLICITOR	What sort of experience are you aware of that Doctor BARTON has in geriatric medicine?
	LORD	She's been a clinical assistant certainly longer than

		have been initiated or they'd say that someone's in heart failure we've tried this and then we would review the drugs together so we would decide with the nurse, the nurse that was present, Doctor BARTON and myself we would decide on what treatment to write up. I mean often if Doctor BARTON was there she would write it up on the chart but it would be on, on my instructions.
17.52	DC Code A	But it would be a joint call?
	LORD	Yeah, and I..yeah.
	DC Code A	I mean in terms of hierarchy then in terms of who has the final...
	LORD	I would.
	DC Code A	...say, you would say so? Okay, has there ever been an occasion where you've had to erm question Doctor BARTON's actions over a particular patient in terms of either the level of treatment given or the type of treatment?
	LORD	Not that I can recall.
	DC Code A	Okay is there ever been any disagreements between the two of you as to you know what to do about a particular patient?
	LORD	Not at all. If Doctor BARTON rang for advice she'd follow what was, what was recommended.
	DC Code A	Okay.
18.38	SOLICITOR	What sort of experience are you aware of that Doctor BARTON has in geriatric medicine?
	LORD	She's been a clinical assistant certainly longer than

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	I've been a consultant it must be at least ten, twelve years she only left us in June, June or July this year erm she's an experienced GP the...in Gosport there's also a GP ward to which the, to which the GP has right of admission and I certainly know quite a few patients in Gosport I admitted under her care say for palliative care and things like that directly onto the GP ward so she's sort of a very dependable, sensible GP.
DC Code A	Okay in terms of the pharmacy which I understand is at QA?
LORD	Yeah.
DC Code A	What or do you have any control over any part of that pharmacy? What are your responsibilities in relation to the running of the pharmacy?
LORD	The stock items are agreed and again that's been reviewed with the wards that are changing tempo if you like and what is, what we require we can usually get down within by the next working day so if we fax something through this afternoon it will come down by lunchtime the next day, if we need anything urgently they will taxi things down straightaway from QA, if we need to get supplies say for argument like antibiotics we don't stock and it seems a long way to get a taxi and it's something that the local chemist would stock we also have prescription pads that...DFP10's that we can write a prescription on and get it from the pharmacy across

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		the road.
20.21	DC Code A	Okay what is your understanding of the pharmacists role at Gosport hospital at that time in'98?
	LORD	The pharmacy cover hasn't improved and this is something we've been asking for. The pharmacist with it's I think it's a couple of time a week looks at the charts and picks up what's required sometimes mentions this is a possible interaction but it's, we don't have a daily visit and he just checks the stocks and makes sure things are all right.
	DC Code A	Okay, when you mention charts is that individual patient charts?
	LORD	Yeah but I don't think they check everyone's I don't know what system they've got for that.
	DC Code A	Okay, I appreciate that. When you mention interaction between drugs can you explain what that means?
	LORD	Er just say sometimes say someone's on Wolverine which is something you use to thin the blood and a lot of people are on now for prevention of strokes, certainly antibiotics could interfere with that and then by, they usually write in green and they'd write something in the...on the side to say what interaction you might that the Wolverine controlled was here by so it's just alerting doctors to the possibility the systems different at QA where we've

	got a technician visit every day and erm it's a case of staffing and funding.
DC Code A	Moving on to Mrs RICHARDS and she was in the hospital on two separate occasions, what contact did you have with Mrs RICHARDS during those periods?
LORD	I had no contact with her or her family at all and I haven't any contact since.
DC Code A	Mmm, okay. Why was that? Are there reasons for that?
LORD	The first admission if I remember right was a... I would have done a round on Daedalus on the 10th and I've checked the ward diaries to see when I did the ward rounds. She was admitted on a Tuesday the 11th of August would have been a Tuesday and she went back to Haslar on the Friday, with hindsight I would have been on the ward shortly after she fell on the Thurs..13th afternoon but I wasn't alerted to the fact that there was someone with a fall that the nursing staff were worried about but with hindsight I was on the ward that afternoon the 13th and theoretically could have seen her but wasn't alerted to the fact that there was a problem.
SOLICITOR	So you're on the ward on the Thursday in relation to the slow stream stroke patients?
LORD	Stroke, stroke patients I wouldn't have seen her, she wouldn't have been a patient...she wouldn't have been a patient for that afternoon, a regular

		review that afternoon.
	DC Code A	And you're saying unless you...
	LORD	Yeah.
	DC Code A	...it was highlighted you wouldn't have seen her?
	LORD	No.
	DC Code A	And in fact that was....
	LORD	Yes.
	DC Code A	...the case, okay. On the second period...
	LORD	Yeah.
	DC Code A	...which was between the 17th and the 21st?
23.37	LORD	Again on the 17th and 18th I was on study leave in London, I attended a course on Parkinson's disease and I should have been on Dryad ward on the 17th but I would have been in hospital on the 17th, I would have been in the hospital so if there was a problem they would have probably asked me to see Mrs RICHARDS...
	DC Code A	Right.
	LORD	...but I wasn't around erm I was back at work on the 19th, the Wednesday erm and would have been there on the Thursday afternoon again but again she was not a patient for review and again neither the nursing or the medical staff sort of alerted me to the fact that they wanted me to see either Mrs RICHARDS or the daughters.
	DC Code A	Okay so the fact you weren't there on the 17th and 18th would somebody have taken over responsibility for your rounds on those days?

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	LORD	It is not possible the department's so busy if they mess around particularly when it's short, short term leave the acute work gets covered by registrars because we've got two other tiers er on the acute side, in the community hospitals it's..if we're not there for a round basically it's very difficult with the time, where the timetables are to make that round up at another time, the...all the geriatricans are very accessible and during the day if the ward phoned through to the admissions office at QA could have spoken to anyone who was available, out of hours there's a duty rota which all the wards in our department get including the community hospitals and they would know which consultant was on so after five and that consultants always contactable through QA switchboard er for advice so no-one would have done my ward round when I wasn't there and I could not make that up any other time in the week but there was someone available for advice but again no-one was contacted.
	SOLICITOR	That was Doctor GRUNDSTEIN...
	LORD	Doctor GRUNDSTEIN, STEEN.
	SOLICITOR	...on call?
25.46	DC Code A	So he's a generally if someone needs to...needs advice from a consultant it would be to call him?
	LORD	Yeah.
	DC Code A	But his role wouldn't be to perform the role that you would normally be doing on those days?

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	LORD	No, no.
	DC Code A	Okay, so the Thursday then that's a day allocated...
	LORD	Yeah.
	DC Code A	...I've got your rota here for...
	LORD	Yeah.
	DC Code A	...purely for slow stream...
	LORD	Yeah.
	DC Code A	...stroke patients, okay. In terms of when you make your visits on a Monday would you and you mention you look through every, every patient so on a Thursday, it's purely you focus on the slow stream...
	LORD	Yeah.
	DC Code A	...patients.
	LORD	The reason we split it is that it was too mu..it was two different nursing teams that with the strokes and the continuing care patients and I think they used to have quite a busy Monday morning and (inaudible) have to return at about 6 o'clock after I'd finished Daedalus to finish paperwork off in the morning so really putting the strokes in there would have meant I'd have been there until about 10 o'clock.
26.55	DC Code A	Okay.
	LORD	It would just...I split it to the Thursday because also because I'm in Gosport on Thursday morning alternate, first thing Thursday mornings I've got a clinic so it also meant there was a consultant

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		presence in Gosport twice a week.
	DC Code A	Okay and at that time you were not made aware of..
	LORD	No.
	DC Code A	...any concerns or anything regarding Mrs RICHARDS or...
	LORD	Not at all.
	DC Code A	Okay. What I'd like to do now is I've got the notes here for Mrs RICHARDS during the time she was in the hospital and I'd like to show you the drugs that were prescribed and administered to Mrs RICHARDS during her time and which my colleague is just getting out there.
27.57	SOLICITOR	I think we've probably got..
	LORD	Yeah.
	DC Code A	You may well have a copy of this anyway.
	LORD	Yes.
	DC Code A	I'm just wondering if you could talk us through the drugs that are there, what your perception is of what they are there to do and then we'll discuss some more issues about them after that.
	LORD	Right we'll start...
	DC Code A	I think we're just concentrating on the 17th aren't we?
	DC Code A	We are, yeah so the four drugs in particular I'm interested in is the diamorphine...
	LORD	Yeah.
	DC Code A	...the hyoscine, the midazolam and the haloperidol which I understand were all loaded onto a syringe

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driver?

LORD Yeah. The oramorph within that she's had if we got back to the 17th you can give er liquid morphine which is the oramorph preparations that have had four hourly intervals and if because it is short acting and if you're looking for pain control then you look at giving at least five to six doses a day unless they're very sleepy in between and cannot, and cannot take a dose so she'd had a total of it is 10 milligrams per 5 mils and if you work it out it works out to 45 mils over a 45 milligrams over a 24 hour, 24 hour period. The, if you stick with the morphine, that was followed by diamorphine which is administered in a syringe driver now the syringe driver is better for continuous control, it is also better if people cannot swallow and it, you've got room to adjust the dose on a daily basis if you so wish, with any morphine preparation it is inevitable that you'll get some amount of drowsiness but it is good being controlled and it is something we use quite a lot of in our day to day work. The dose of diamorphine in the syringe driver was almost static at 40 milligrams over the next 4 days, she was on haloperidol, on haloperidol when she came in I think she'd been on haloperidol probably since about Christmas the previous year, the psychiatry correspondence that we've seen erm so because of that it's usual to keep some amount of anxioulitic

My Mother did not regain conciousness at all from 17th August

going and the haloperidol recommendation would be sort of about 5, 5 to 10 which is over a 24 hour period.

DC Code A — And what is that specifically supposed to target that drug?

30.47 LORD — It is more the sort of behaviour, agitation, more the dementia side that people can get, when someone is...who's demented is restless it's like a baby crying you've got to work through the, the things that could be distressing them starting from the most simplest things to other things and often if someone with dementia very restless, then pains, pains a problem, it depends on what you think of the patient when you see them, so that's the haloperidol. The midazolam is an anxioulitic, it's sort of a valium equivalent that's used intravenously really mostly for anaesthesia, it can be used in syringe drivers over a 24 hour period and again it's more for sedation reducing anxiety, it can also be used as an anti-convulsant say for arguments sake someone was an epileptic for whatever reason is not able to swallow and take their medication you can use midazolam subcutaneously in syringe drivers as an added convulsant as well, I would suspect that in Mrs RICHARDS case it was used as an anxioulitic rather than as an anti-convulsant. The hyoscine really is for secretions in throat what's commonly

Haloperidol -> behaviour, agitation. Not necessary

Midazolam - not necessary - Patient unconcious from Diamorphine

Not present. ->

No "death rattle" at all

known as the death rattle and this would be an extremely low dose and the recommended is usually 8 to start with 800 over 24 hours because what happens is once people are really very ill and secretions that can get in their throat you can suck them out using a suction catheter but that is often distressing and very difficult for the person and also for the people who are watching and you can just dry up secretions a little bit with it, it just makes people a bit more comfortable.

32.45 DC Code A — Okay, you comment on the fact that the hyoscine is a...the dosage there, in terms of the other levels of dosage for the others, comment on the strength of those?

LORD — Erm the haloperidol again er there is no direct conversion of haloperidol orally to subcutaneous, I second the recommendations in the palliative care guidelines would be 5 over 24 hours.

Not palliative care.

DC Code A — Okay, what about the diamorphine and the midazolam?

LORD — Erm the midazolam I can again I think it depends on the clinical judgement at the time because to a certain extent haloperidol would have a calming effect as well and really without seeing Mrs RICHARDS and knowing how agitated and distressed she was it is difficult to know why er the midazolam and the haloperidol were used.

DC Code A — Combined, okay. In terms of the diamorphine?

	LORD	Erm the top dose for diamorphine that's recommended is up to 250 erm and again it depends on people's clinical judgement as to how much pain, distress people are in as to how much you, you do prescribe.
	DC Code A	Okay.
	LORD	And again I, I think if you've seen someone you can see yes I, I did see them, they were really, really agitated and when having seen someone I just...you can't guess really.
	DC Code A	Certainly, okay. In terms of..I appreciate what you're saying that you didn't see Mrs RICHARDS but I take it now you've got an understanding of some of the problems she had and her age and etc...
	LORD	Yeah.
	DC Code A	...In terms of those four drugs would that be symbolic of someone who's on palliative care, on a course of palliative care treatment?
	LORD	In what way?
34.53	DC Code A	In your judgement would you look at that knowing what you know about ....
	LORD	Yeah.
	DC Code A	...Mrs RICHARDS now and think this looks like she's on a palliative care regime, this lady is...you know what the condition of her or whatever, could you comment on that?
	LORD	I think it's highly very unusual for someone to require that amount of someone who's up and

	walking wouldn't, wouldn't require this degree of sedation erm and the fact that some...that this dose was administered and that they've kept the administration went on for a few days means that we've now got into the, into the palliative care situation.
DC Code A	Okay. And again this is to get an explanation from you generally, in terms of palliative care could you just explain what exactly that means? What the term it actually covers?
LORD	What it means is that you're trying to keep the person as comfortable as you can while accepting that this is probably the beginning of the end if you like, or they're nearing, now nearing the end and together with that you really call them symptom control as your main target so try to keep the person as comfortable as you can and address all the issues that would affect that comfort so in addition to just washing and bathing them, is there anything that's distressing them, try and alleviate that and sometimes I don't really know it's a case of what is...what's going on, someone's really very distressed is it pain, is it distress because they're in an unfamiliar environment, is it discomfort from bowels, see you address the symptoms as much as you can, try and target the problems if you think someone's constipated then that needs to be relieved, if someone's not emptying their bladder

then maybe they need a catheter erm and address the issues as, as quickly and as simply as you can because you know you haven't got much time to wait and see and if together with that you've got to get all the psychological things on board, do they know they are dying, do they want to fact the fact that they are dying, do their families accept that they are dying so there are the other sort of psycho social aspects to it as well. Are all the family members aware, you know have they made their peace you know they're quite a lot to the dying process then and then you've also got to and again this is time consuming is to work out which family knows, how best are we going to keep mum comfortable, any sort of pain killer you use has side effects, any form of heavy sedation will make them drowsy and will inevitably cause a deterioration, do we go for that, what happen if they spike her temperature do you want them moved back to acute at this stage for intravenous antibiotics so there are few what if situations to address as well and there will inevitably be the sort of what if they have a cardiac arrest, what is the resuscitation so you try and deal with the symptoms you've got, you try and prevent things like say pressure sores which could be really distressing and which you know will be a problem with someone dependant so there are really quite a lot of issues around that and it's

Mother totally unconcious - no effort to see any change in level of pain - no address to level of hydration - therefor death inevitable through continuous drug regime and nothing else.

		difficult to know what you prioritise first, you try and get everything on board but someone sometimes that someone deteriorated very rapidly you don't really have time and then you've got to make quick decisions.
	DC Code A	Okay, so I mean in terms of palliative care, in terms of setting up that level of treatment...
	LORD	Yeah.
	DC Code A	...and the decision taking that this person is dying. Who's responsible for making those decisions within that amount of hospital at that time?
39.11	LORD	At that time it would be on, on a day to day basis it would be between the nursing staff, whichever senior member of the nursing staff that was on and Doctor BARTON. If they were concerned at all they could always make phone contact and get advice erm usually they had a fair grasp of the situation and I can't think of an instance where it's required me to come down in between when I wouldn't have been there er ....
	SOLICITOR	Erm I'm sure its not the impression that you left that the palliative care regime would presumably grow gradually it wouldn't be a decision to implement palliative care as from today for instance.
	LORD	No, no I mean you've got to take someone's previous history when their...what they're suffering from before, what they were like before into

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		consideration.
	DC Code A	On this particular page here obviously are you saying that at that...looking at those drugs and the quantity and the type of drugs that a decision was made on or around the 17th, 18th of August that Mrs RICHARDS was dying and therefore the role of the hospital staff at that time, from that point was to make her comfortable and pain free as possible?
40.30	LORD	That would be my interpretation from this.
	DC Code A	Yeah. Are you able having to..having looked at the notes, I appreciate you have looked at these notes before haven't you, this isn't the first time sorry the first time that you've seen these patient notes. Are you able to indicate from the patient notes and I do appreciate that you never saw Mrs RICHARDS, are you able to indicate a cause or a reason or what Mrs RICHARDS was dying of?
	LORD	It's difficult because she's been a lady who was severely demented er who from psychiatrist notes did spend a lot of time asleep but then could walk unaided as well...
	DC Code A	Yeah.
	LORD	...and people with fractured hips particularly people who are demented do quite badly following surgery, now I know she came through surgery the first time and came through a replacement, a dislocated hip the second time, the third time it's difficult to know what the deterioration was from

17th. Discharge shows fit for discharge – able to transfer – eating etc. NOT dying *

		and in quite a lot of patients you can't say yes this is a, b and c that's causing the deterioration and a lot of it is on clinical judgement how you see the person.
41.43	DC Code A	Yeah but so having read her notes you can't indicate to us of any particular thing that Mrs RICHARDS was dying of?
	LORD	No.
	DC Code A	No, no. It's a blunt question but the four drugs that were administered from the 17th, 18th ...
	LORD	Mmm, mmm.
	DC Code A	...would they have possibly been a direct cause of her death, would they cause her to die?
	LORD	I don't think they would have been a direct cause of her death but they're not drugs that would..any drug that is sedating will, and once people are sedated the problem with it then is they end up with things like chest infections, stasis in the lungs and it's not a sort of healthy environment to be in.
	DC Code A	But am I right in saying that the...the..you mentioned her lungs and (inaudible)...
	LORD	Yeah.
	DC Code A	Is that as a direct result of the administration of those drugs? They cause the fluid on the lungs?
42.46	LORD	Not the drug, the drugs do cause some element of it...
	DC Code A	Yeah.
	LORD	...but if someone's deteriorating anyway the bodies

	sort of shutting down at the same time it's a clinical thing...
DC Code A	Yeah.
LORD	...it's not like there's someone what's the easiest thing to say that has high blood pressure you can take a reading...
DC Code A	Yeah.
LORD	...and if someone's got high blood pressure or they haven't got high blood pressure...
DC Code A	Yeah.
LORD	...when someone's dying it's, it's your clinical impression of someone...
DC Code A	Yeah.
LORD	...and it's probably something we don't write down in detail but it...
DC Code A	I take it what you're trying to say is experience would tell a doctor who's dealt with...
LORD	Yeah.
DC Code A	...elderly people for many, many years that they'd form an impression at that stage of I've been here before this lady is dying, let's make her pain free and comfortable?
LORD	Yeah.
DC Code A	Yeah, hypothetically,(buzzer sounds for end of tape) we'll make this the last question for the time being, hypothetically I think we all appreciate that Mrs RICHARDS was in pain, if Mrs RICHARDS was given diamorphine and diamorphine only

	would she have lived longer than what she did?
LORD	I don't know the answer to that.
DC Code A	You don't know, okay, okay.
DC Code A	Okay that buzzing noise means we've got about two minutes left so what we'll do is conclude the interview and give you a chance to have a break and then we'll probably have some further questions on another tape, okay?
LORD	Yes.
DC Code A	Is there anything at this stage you want to add or clarify anything you've said so far?
LORD	No.
DC Code A	Okay the time by watch is 1458, I'm turning the recorder off.