GMC100748-0001

FPW/155/01

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER

GOSPORT WAR MEMORIAL HOSPITAL

INTERVIEWS WITH DR. I. REID

08 08 2006
REF.

GEOFFREY PACKMAN

25

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Operation ROCHESTER.

Additional Evidence Summary.

Relating to the death of Geoffrey PACKMAN.

Series of tape recorded interviews with Dr. REID in the presence of legal representative Will CHILDS, under caution between 0907hrs – 1627hrs 08 08 2006 in respect of Geoffrey PACKMAN

Key points:-

Interview 1.

- Geoffrey PACKMAN was admitted to Queen Alexandra Hospital suffering from leg ulcers and following an incident at his home where he had become immobile.
  He had subsequently been transferred to Gosport War Memorial Hospital for nursing care
- He was described as being clinically obese, suffering from pressure sores and arthritis. His life expectancy was described as being poor, but there is nothing recorded to the effect that he was in a terminal phase of life.
- Dr. REID states that, in his position he was personally responsible for the care of Geoffrey PACKMAN whilst this patient was in Gosport War Memorial Hospital.

Interview 2.

- Dr. REID commented to the effect that when a patient was admitted to the hospital then that person would be asses by a doctor and nursing staff.
- Geoffrey PACKMAN was transferred to Gosport War Memorial Hospital from Queen Alexandra hospital because his major need was for nursing care, at that time he would appear to have been medically stable.
- On his transfer to Gosport War Memorial Hospital Geoffrey PACKMAN was prescribed DOXAZIN – 4 milligrams for high blood pressure
  FRUSEMIDE (a diuretic) – 80 milligrams per day
  CLEXANE – a blood thinning treatment
  PARACETAMOL – one gram qds this was his only pain relief
- Mr PACKMAN needed a special bed (large) due to his size

- Dr. REID commented that on a ward round, he would make an overall assessment of what he felt the main issues or patients problems were together with what could be done.
- A patient's care plan would change if there was a change in the patient's condition.
- Dr. BARTON was responsible for the treatment of Geoffrey PACKMAN on a day to day basis
- The need arose for Geoffrey Packman's condition to be investigated by means of tests etc. Haemoglobin urea electrolytes and liver function tests, the Haemoglobin tests were to detect any possible bleeding in the bowel.
- Dr. REID commented to the effect that any decision making involving a patient should be recorded.
- If a doctor was to see a patient then Dr. REID would expect to see recorded in that patients notes, any interaction, symptoms which the patient may be experiencing together with a record of the results of any examination and treatment.
- If a doctor had been called to see a patient for any reason and there had been any significant change in the patient's condition, then Dr. REID would expect to see this noted in the patient's records.
- Dr. REID commented that initiating any new treatment is significant and should, therefore be recorded
- Dr. REID had found nothing in the records of Geoffrey PACKMAN to indicate that this patient was suffering pain.
- Dr. REID was aware of the 'analgesic ladder' and stated "you have to make a judgement about what steps of the ladder you take".
- Dr. REID when asked, why with a patient (Geoffrey PACKMAN) who had been on nothing more than one gram of paracetamol 4 times daily and who had no record of documented pain, why there was no record of the reasons for prescribing morphine or other strong opiod to that patient, replied that he was only able to speculate that Dr. BARTON had felt hat this patient was in sufficient distress caused by a condition which could be relieved by diamorphine.
- Dr. REID did not have any concerns about the care/treatment of Geoffrey PACKMAN.

Interview 3

- Dr. REID made comment with regards to keeping up to date with pharmaceutical issues prescribing matters and the fact that he kept himself up to date. The BNF book was described as the 'Bible of Prescribing' and there was usually one on each ward. It was a constant source of information with regards to the possible side effects of drugs and a patient's reaction to new ones.
- Dr. REID had never seen either of the books, Palliative care Formulary or the Nurses Prescribing Formulary.
- Geoffrey PACKMAN had not been prescribed any drugs which were new or seldom used that Dr. REID was aware of; he was only ever given drugs which would be used regularly for a patient in Mr. Packman's condition.

- Dr. REID explained the layout of a prescription sheet and that one part is for the actual prescribing by a qualified person whilst the other part was for use by nurses etc. for administration of the drugs / medicines.
- Dr. REID referred to the notes of Geoffrey PACKMAN and listed the drugs prescribed to him as: - Aloperimide for Diarrhoea. On 26th August 1999 at 1800 hours. 10 milligrams of Diamorphine is muscularly prescribed on the basis of a verbal message from Dr. BARTON, with a similar dose on 27th or 28th. Alvine and mepitol dressings for skin wounds, Gaviscon for indigestion, Tempazepam 10 – 20 milligrams orally on 24th and 25th August. Doxazosin was given for high blood pressure, Frusemide 80 milligrams administered from 24th through to 31st Clexane (subcutaneous injection) twice daily on 25th and 25th August. Paracetamol 1 gram four times daily, a topical cream and Magnesium Hydroxide 10 mills twice daily.
- Dr. REID was unable to explain the discrepancies in the administration, times and dates as shown on Geoffrey Packman's drugs chart, but said that the range of 40 – 200 milligrams of diamorphine allowed nursing staff discretion to increase the dose in the event of non availability of medical staff.
- Dr. REID commented that the range of 40 – 200 milligrams was too large a range at the time when the prescription was written,
- Dr. REID spoke of the side effects of Diamorphine with one of them possibly being confusion and that a patient being drowsy may be an indication that the dose is too high.
- Proactive prescribing was discussed together with variable dosage which allowed nursing staff flexibility in administering a drug to ease a patient's pain etc.
- Dr. REID agreed that The reason for prescribing should always be recorded in the medical notes
- Telephone prescribing and verbal orders were discussed, where a nurse might telephone a doctor to explain a patient's current problem and the doctor would give an authority to administer a different drug or an increased dosage.
- Dr. REID stated that nursing staff would prefer to have a written prescription rather than to rely of verbal orders, particularly diamorphine.
- Geoffrey PACKMAN was seen by Dr. REID on 1st September and at that time Mr. PACKMAN was on a dose of 40 milligrams of diamorphine, but within hours the dose had been increased, possibly by a nurse (Jill HAMBLIN) when the patient had already been noted as being drowsy on the smaller dose.

<u>Interview 4</u>

- On 1st September it is recorded that sister HAMBLIN increased the diamorphine dose of Geoffrey PACKMAN from 40 milligrams to 60 milligrams supposedly to control the patients symptoms, DR. REID was unable to say what these symptoms were because they had not been recorded, even though the patient had been seen by a doctor only hours

previously and was noted to have been drowsy but comfortable, the diamorphine dose had been increased by half without explanation.

- Dr. REID relied upon Dr. Barton's knowledge and experience , he trusted her and the nursing staff to care for the patients
- Dr. REID acknowledged the fact that Dr. BARTON and Sister HAMBLIN were more experienced than himself in the actual care of this particular type of patient, such as Geoffrey PACKMAN, and for whatever reason Sister HAMBLIN had seen fit to increase this dose, possibly because the patients condition had changed in the few hours since being seen by the doctor, but once again he accepted that the reason for the increase had not been recorded.
- Dr. REID described Dr. BARTON and Sister HAMBLIN as a formidable pair, who knew what they were doing and that hey had an established practice of running the ward etc.
- Dr. REID was unable to say with any certainty that his clinical opinion was being ignored in this case, but admitted that on a previous occasion he had spoken to medical staff about the range of Diamorphine being too high for a patient.
- There was a discussion on the administration and prescribing of drugs and the need for syringe drivers.
- With regards to the use of a syringe driver in the case of Geoffrey PACKMAN, Dr. REID said the he could only presume that it had taken that level of administration to control the patients symptoms, and because the patient was drowsy and possibly unable to take the drug orally. Dr. REID was not able to explain why Geoffrey PACKMAN had not been given the drug orally even though this patient had accepted it orally in the recent past.
- Three was no explanation from Dr. REID as to why, when Mr. PACKMAN had been started on a syringe driver, that the matter had not been recorded or why it had been deemed necessary, even though he accepted that such a matter is a significant change in the patient's condition.
- Dr. REID commented that it was Dr. BARTON who had prescribed the syringe driver, but it would appear, from the relevant notes to have been prescribed on 26th when Geoffrey PACKMAN was seen and noted to be unwell, Dr. BARTON had finished the notes with 'keep Comfortable, I am happy for nursing staff to confirm death' but there was no mention at that stage of a syringe driver being commenced. There was a further visit by Dr. BARTON to Mr. PACKMAN but, again there is no note of the syringe driver commencing. It would then appear that on 30 08 a syringe driver was commenced with 40 milligrams of Diamorphine and 20 milligrams of Midazolam and this entry would appear to have been signed by sister HAMBLIN.
- Dr. REID agreed that Sister HAMBLIN would appear to have commenced the syringe driver, in respect of Geoffrey PACKMAN, without discussing the matter with a doctor, and when Mr. PACKMAN was apparently able to eat and drink a little i.e. he was able to swallow.
- Dr. REID commented that it was a 'big decision' to commence a syringe driver' but he was unable to say why sister HAMBLIN had apparently

taken this decision herself, or why she had written in the clinical notes, as opposed to nursing notes.

- Dr. REID said that Geoffrey PACKMAN had been seen by Dr. BARTON on 26th August, he was noted to be possibly suffering a heart attack and was sufficiently distressed that administration of Oramorph was necessary, therefore Oramorph had been prescribed in two dose strengths of 10 milligrams and up to 20 milligrams.
- Dr. REID commented that Geoffrey PACKMAN may have needed MIDAZOLAM because he had been stressed or agitated, and that this drug was mostly for mental agitation rather that physical pain.
- There was a discussion about the range of doses of Midazolam and the lack of information available for nurses regarding the dosage.

Interview 5

- This interview commenced with a discussion about painkillers and opiates.
- Dr. REID stated that Diamorphine is an analgesic and included in a group of drugs called opiates which are strong painkillers.
- Prior to taking Diamorphine, Dr. REID stated that, by referring to the 'analgesic ladder' one would start with Paracetamol and then move up to Coedine and then to extra Coedine and Paracetamol before arriving at drugs which are Opiate related, such as Tramadol. Finally there are the strong Opiates which are known as Morphine and Diamorphine.
- Within the analgesic ladder, Dr. REID stated that Diamorphine fits into stage three, which is at the top of the ladder, being the strongest level of painkiller.

- Dr. REID stated that Mr. PACKMAN had been prescribed Diamorphine in a range of 40 – 200, and this gap / range had been to allow for nursing staff to use their discretion if the starting dose had not been able to control the patient's symptoms.
- Dr. REID commented that the drug Midazolam could be used in conjunction with Diamorphine to be administered via a syringe driver and the same range of dosage would be applied in accordance with the analgesic ladder.
- Dr. REID was emphatic in stating that he would not expect a nurse to administer the highest range of a drug from the outset, he said that the lower range would be the starting point.
- There was a comment regarding the prescription for Diamorphine being prescribed to Geoffrey PACKMAN on 26th August but it had not been actually administered until 30th August, a gap of four days, and Dr. REID agreed that this was pro-active prescribing.
- Dr. REID commented that Geoffrey PACKMAN had originally been prescribed Oramorph as a regular prescription, and the Diamorphine prescription was pro-active in the sense that if the patient was no longer able to take medication orally or that the pain was not controlled then this situation would allow the Diamorphine to be introduced.

- Dr. REID was not able to comment with regards to what circumstances had arisen whereby this patient had been administered the Diamorphine i.e. whether the patient was unable to take oral medication or that the pain was not controlled.
- The interviewing officer made comment to the effect that Geoffrey PACKMAN was eating at that particular time, and Dr. REID himself said that the patient was eating small quantities.
- In these circumstances Dr. REID made comment that a pro-active prescribing policy was not required if a doctor was going to see the patient once a day or was available.
- Dr. REID stated that there was nothing in place at that time, as a guide to nursing staff regarding what increase should be made within the prescribed range of 40-200 milligrams. There were no checks or safeguards on this issue other than it was a requirement for two nurses to carry out the procedure of administration of controlled drugs such as diamorphine.
- When asked as to whether or not Geoffrey PACKMAN was in the terminal phase of his life by the time he was receiving Diamorphine, Dr. REID said that it was difficult to say, because Dr. BARTON had written on the notes, 'remains poorly but comfortable, continue with opiates over the weekend' which implied to Dr. REID that this patient was seriously ill.
- It was put to Dr. REID that there was a difference between being seriously ill and terminally ill, and he agreed that a person could be seriously ill but treatable.
- In the case of Geoffrey PACKMAN, Dr. REID said that it was difficult to say from the notes that he was terminally ill at that stage.
- Dr. REID said that he would expect to see written justification for the use of Diamorphine because it was a switch from oral medication to Diamorphine.
- Dr. REID was asked what he would consider to be an excessive dose of Diamorphine, he stated that it would vary from patient to patient. Also the fact that a patient may be opiate-naïve but the best answer to this lay with an expert in Pharmacology.
- There was a discussion regarding the conversion dosage from Oramorph to Diamorphine and the associated guidelines and Dr. REID agreed that a dose of 60 milligrams of oramorph converted to a dose of 20 Milligrams of Diamorphine.
- Dr. REID stated that he had not advised Dr. BARTON about her Prescribing regime because he had never been asked to. He had not noticed the variance of doses in this case, but said that if he had noticed the variable dosage the he should have said something.
- When Dr. REID saw Mr. PACKMAN on 1st, he noted that he was drowsy but did not feel that he had been overdosed with Diamorphine.
- Dr. REID confirmed that there was no justification in Geoffrey PACKMAN'S notes regarding the use of Midazolam.
- Dr. REID made an observation to the effect that when he saw Mr. PACKMAN on 01 09 the he was in the terminal phase of his life, because he (Geoffrey PACKMAN was taking a fair amount of opiate for pain control, he was passing 'melina stool' and bleeding from the gut, the

overall picture was one in a terminal phase of life. Therefore, despite the apparent symptoms of the patient, he was not referred to another consultant.

- Dr. REID commented on the fact that Geoffrey PACKMAN was unlikely to have suffered a heart attack and that the main cause of his deterioration was due to the internal bleeding.
- There was discussion about the requirements for a doctor to certify death and the notes of Dr. BARTON being happy for nursing staff to confirm death. Also comment was made regarding Dr. BARTON expectation of death in respect of Mr. PACKMAN because of what she had written in the notes on 26th, 'am happy for nursing staff to confirm death'.
- Dr. REID explained the policy of 'not for 555' (not for resuscitation in the case of heart attack etc.) which was the case for Geoffrey PACKMAN but he went on further to state that this did not mean that he patient was not to diagnosed, treated and possibly cured of the presenting complaints.

Interview 6

- The interviewing officer made comment to Dr. REID that Dr. BARTON had made an entry in Geoffrey PACKMAN'S notes on 26th August of two possible matters, the MI (Myocardial Infarction) and the G I bleed.
- There then followed a discussion on the matter of a death certificate and the responsibilities of the medical staff and legal requirements.
- Dr. REID agreed that Geoffrey PACKMAN is recorded as having died of Myocardial Infarction, and that there is no reference to a heart problem when seen by Dr. REID two days earlier.
- There was a discussion about the availability of supervision, guidance and study leave for staff, including Dr. BARTON if ever that person thought it useful.
- It was put to Dr. REID that, in 1999 Dr. BARTON had felt obliged to adopt the policy of pro-active prescribing due to work pressures at the hospital, but Dr. REID himself said that it didn't take long to write out patient notes and that to the best of his recollection, there had not been a time when Dr. BARTON had complained to him about the her work load being too great.
- Dr. REID made comment, saying that if there was sufficient interaction with a patient then it should be noted.
- Dr. REID stated that if there had been any adverse reports with regards to Dr. BARTON then he would have tackled her on any relevant issues, but from his understandings, she was regularly on the wards in accordance with her contract and more, sometimes two or three times a day. It was pointed out to him that there would appear to have been a gap of some six days between notes for Geoffrey PACKMAN when Dr. BARTON would have been visiting the ward where this patient was in poor prognosis.
- Dr. REID explained his personal method of ward rounds and days it was carried out etc.
- Dr. REID stated that when he saw Geoffrey PACKMAN on 1st September, that the patient was dying, he was suffering a GI bleed and he would not

be treated for it. The patient was to be made comfortable and allowed to pass away peacefully.

- Dr. REID re iterated that, in his opinion Mr. PACKMAN was suffering a GI BLEED as opposed to MI because of the huge drop in haemoglobin in a short time. Also the patient was passing black stools caused by bleeding in the upper gut.

Interview 7

- On 23rd August, the day Mr. PACKMAN arrives at Gosport War Memorial Hospital, he is seen by Dr. RAVINDRANE and assessed. It is noted that, as on previous occasions, Geoffrey PACKMAN may be suffering a GI bleed. Dr. REID stated that a GI bleed is a life threatening medical emergency, which is treatable but with difficulty, and he explained some treatments.
- Dr. REID said that the symptoms of being pale, clammy and unwell are very consistent with GI bleeding, and he was, himself sure of this by 1st September following the results of the check. Nothing further was done because a decision had to be made as to whether or not it was in the patient's best interest to transfer to another hospital for the necessary treatment / blood transfusion etc. and whether or not a patient in this condition would even survive the transfer.
- There was no evidence, other than Dr. BARTON'S note entry to support the fact that Geoffrey PACKMAN was not fit for transfer, but Dr. REID stated that it was a judgement which had to be made at the time.
- Dr. REID said that when GEOFFREY PACKMAN arrived at Gosport War Memorial Hospital, he was not in immediate expectation of death, despite his obesity and presenting complaints. He may well have been 'on the slippery slope' but Dr. REID said that he could not tell at that time if Mr. PACKMAN would survive one week or six months.
- It was discussed that there would not appear to be anything in the medical notes where Mr. PACKMAN'S wife was made aware of his condition and the decision not to transfer him for further treatment blood transfusion.
- There was then a discussion about the very poor note keeping in respect of Geoffrey PACKMAN, in particular the administration of drugs and who had actually signed the administration /authorisation. Also it was mentioned that persons charged with looking after MR. PACKMAN had a duty of care to him and his wife, but on looking at the notes, it would seem that little was done in respect of either.
- Dr. REID said that he did speak with Dr. BARTON about variable dose prescribing but he was unable to recall as to what particular patient it was regarding.
- Further discussion on note keeping, Dr. REID said that there were no set safeguards to prevent a patient being administered an unintentional dose other than the expectation of nursing staff to start with the lowest dose.

Interview 8

- Dr. REID was referred to Geoffrey PACKMAN'S nursing notes, and he agreed that on 27th August the patient's condition would appear to have stabilised, and that there should have been sufficient time to obtain the haemoglobin results from the check on the previous day.
- Dr. REID was unable to give an explanation as to why Mr. PACKMAN had not been transferred for treatment to another hospital when his condition would appear to have improved.
- Dr. REID said that Geoffrey PACKMAN'S condition was not discussed with a gastroenterologist or the on-call medical team.
- The interviewing officer pointed out to Dr. REID that Geoffrey PACKMAN had complained of left sided abdominal pain on 29th August. Dr. REID said that it would be unusual for the cause of such pain to be M I.
- Dr. REID agreed that the Geoffrey PACKMAN was started on a syringe driver on 30th, when he is noted to have slept for long periods the previous night. He would appear to have complained of left abdominal pain and there is a 'query' indigestion' but Dr. REID was not able to give an explanation as to why Sister HAMBLIN started this patient on a syringe driver at that time.
- Dr. REID stated that he was not certain if the syringe driver was appropriate at that time, because there is no record of it being required for use at that particular time.
- Dr. REID agreed that it would appear to be the case, where a nurse had made a decision to start Geoffrey PACKMAN on a syringe driver, but there is no record of that nurse having discussed it with Dr. BARTON, so he was not able to say as to whether or not it was a satisfactory situation.
- There was some discussion regarding the haemoglobin test and the fact that the result, although available, was not received for some time, and whether or not there would have been an alternative route for the treatment of Geoffrey PACKMAN, either through his verbal wishes or the requirements of his wife and the ethics of it all.
- Dr. REID was asked if Dr. BARTON had, at any stage, made the correct diagnosis of Geoffrey PACKMAN, and he replied "I don't know"
- Dr. REID was not able to say as to whether or not Dr. BARTON had ever acted on the results of the haemoglobin check results, even though she had seen them.
- Dr. REID said that as far as he was concerned he had fulfilled his duty of care in respect of Geoffrey PACKMAN, he was aware that discussion had taken place between medical staff and Mrs. PACKMAN about her husbands condition and the management of it, he had to take some things on trust, such as what others had recorded, and these factors would influence him in his decision with regards to the treatment of this patient.
- Dr. REID said that, in hindsight, there should have been better documentation in the case of Geoffrey PACKMAN. In his opinion, Mr. PACKMAN died from a Gastro-Intestinal bleed, and if Dr. REID was to certify Geoffrey PACKMAN'S death today, then he would put the cause of death as being a Gastro-Intestinal bleed.

Code A

D.M.Williams.
Detective Superintendent.
12th September 2006

Comments on witness statements – Geoffrey Packman 24th August 2006

1. INSTRUCTIONS

To examine and comment upon witness statements in the case of Geoffrey Packman. In particular if they raise issues that would impact upon any expert witness report provided.

2. DOCUMENTATION

The report is based on the following documents.

2.1. Report regarding Geoffrey Packman, prepared by Dr DA Black (30th October 2005).

2.2. New version of report regarding Geoffrey Packman, prepared by Dr DA Black (20th June 2006)

2.3. Record of interview with Dr I Reid, 8th August2006 provided by Hampshire Constabulary (August 2006)

3. COMMENTS

3.1. Comments on witness statements.

3.1.1. I have read the interview with Dr I Reid. I do not wish to change my report of the 30th October 2005 modified on the 20th June 2006.

4. CONCLUSION

4.1. Having read all the documents provided by the Hampshire Constabulary, I do not wish to change my report of the 30th October 2005, modified 20th June 2006.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y25Q

Enter type: FULL TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 08/08/2006

Time commenced: 0907 Time concluded: 0949

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

Interviewer(s): DC Code A / DC Code A

Other persons present: MR CHILDS, SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded. I am DC Code A Chris YATES from Hampshire's Major Crime Department and my colleague is …
DC Code A	DC Code A.
DC YATES	… I'm interviewing Doctor Richard Ian REID. Doctor will you please give your full name and your date of birth?
REID	Richard Ian REID, date of birth 12/05/51.

DC YATES — Thank you. Also present is Mr CHILDS who is Doctor REID's solicitor. Can you please introduce yourself with your full name?

CHILDS — It's Will CHILDS from Radcliffes Le Brasseur in London.

DC YATES — Thank you. This interview is being conducted in an interview room at Fareham Police Station in Hampshire. The time is 0907 hours and the date is Tuesday the 8th of August 2006. Doctor at the conclusion of the interview I'll give you a notice explaining what will happen to the tapes. I must remind you doctor that you're still entitled to free legal advice. Mr CHILDS is here as your legal advisor. Have you had enough time to consult with Mr CHILDS in private or would you like further time?

REID — No I've had enough time thank you.

DC YATES — Thank you. If at any time you wish to stop the interview and take legal advice just say so and we'll stop the interview in order for you to do this yeah? We'd also like to point out that you've attended voluntarily, you're not under arrest, you've come here of your own free will. So if at any time you wish to leave, just say and you can leave, yes? We'll caution you and that is 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 and anything you do say may be given in evidence. Do you understand that caution?

REID Yes.

DC YATES Okay just for my own peace of mind I'll break it down into the three bits just so that I'm happy that you understand it. As I said it can be broken into three sections and the first is quite simple, it's your right not to say anything when asked questions by us. The second part is the slightly more confusing part. If this matter should go to court and that is an if it should go to court, it may harm your defence if you wish to rely on something as part of your defence if you had the opportunity to mention it now. In other words the court might think doctor why didn't you say that when you were asked, okay. In other words the court may draw what they call an adverse inference and as I said wonder why you didn't mention it earlier and the third and last part is again quite simple. The interview is being tape recorded and if it should go to court, should it become necessary either a transcript of the interview can be read or the tapes can be played in court. Okay on this occasion, as before, the room is equipped with a monitoring facility. Whenever that red light there is on, which it is at the moment, it means the room is being monitored. Today it's being monitored by Detective Inspector David GROCOTT. The reason we do this is to enable us to carry out any enquiries we need to, as a result of anything said here today, expeditiously and then possibly ask you about them later on in the day, yeah?

REID Yeah.

DC YATES

When the tape machine is not running, nothing can be heard in this room. So the tapes have got to be in and turned on for anything to be heard in this room. So if you want to use it to consult or anything like that it's quite safe to do so. On this occasion it will be me speaking to you the majority of the time but DC Code A will almost certainly be making some notes. As before this investigation is called, well known as Operation Rochester. It's being conducted by Hampshire Constabulary and started in September 2002. So it's been running for pretty much four years now. It's an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital between 1990 and 2000. Now as I said before no decision as to whether an offence or even any offence has been committed but it's important to be aware that the offence range, offence range being investigated runs from potential murder right the way down to assault. Now part of the ongoing enquiry is to interview witnesses who were involved in the care and treatment of the patients during that period and I believe we're right in saying you were the Consultant Geriatrician for the Gosport War Memorial Hospital during part of that time when these deaths occurred. So your knowledge of the working of the hospital and the care and the treatment of the patients is very, very central to our enquiry. Now I know you're going to want to say something in a minute but the majority, well nearly all of today will be concentrating on the patient Geoffrey PACKMAN.

REID Yes.

DC YATES He was a 67 year old man who was transferred to Dryad Ward from the QA Hospital, the Queen Alexandra Hospital, on the 23rd of August 1999 and he subsequently died on the 3rd September 1999 and the cause of death was given as a myocardial infarction.

REID Right.

DC YATES And as before all the groups of questions will come under particular topic headings. It may seem a bit repetitive but it's just a way of breaking everything down so you get a chance to explain everything. We get a chance to understand it as well and what I'll do is I'll endeavour to explain the topic headings as we change to each one. Before we go much further can I just confirm with both you and Mr CHILDS that you were provided with a full copy of Mr PACKMAN's medical file by way of advance disclosure, probably about ten weeks ago now actually I think but some time ago. Have you got this file with you today? Excellent. Right well before we go on to Mr PACKMAN you intimated that you wanted to say something about a previous interview ...

REID Yes, yeah.

DC YATES ... I'll let you open that that then.

REID Well this is in relation to the care of, the last interview, which was about Enid SPURGIN.

DC YATES SPURGIN, right.

REID Because you posed me a lot of questions around the care based on sort of review of the care by sort of medical experts who'd had sort of voiced criticisms and I just felt a little concerned that maybe the sort of the big picture had been lost in discussion around the detail. As you're aware she was a 92 year old lady who had sustained a fractured femur and who appeared to be in pain for most of her stay in hospital, both in Haslar and in Gosport War Memorial Hospital and we did have some discussion around the sort of, what the reasons for that pain might be and I think that what I wanted to emphasis was that even from the first time I saw this lady I felt that her prospects for re-mobilising and getting rid of her pain were poor. We went into summaries of why she might be having pain and we talked about the fact that the hip might be dislocated but usually that produces a sudden increase in pain whereas this lady seemed to be in pain all the time. We talked about, you know, wound infection, superficial wound infection. There wasn't any evidence of that for the first sort of couple of weeks obviously so her pain during that first couple of weeks unlikely to be due to the wound, superficial wound infection. We also mentioned and this is really what I wanted to come round and say possibly the impacts of having a deep wound infection and what I wanted just to make clear was that implications of that are sort of fairly

horrific for a 92 year old lady because it's not just a simply matter of treating with antibiotics. What one would almost certainly have to do is to take this lady back to theatre to possibly move the screw, remove the top half of the, the sort of ball and as you can imagine a further operation in a sort of frail 93 year old lady her chances of getting over that are probably less than getting over the first operation. The other possibility is that, or other two possibilities, the socket in which the hip sits ...

DC YATES Yeah.

REID ... can sometimes fracture, break, if that's the case again that's another sort of disaster in terms of trying to get someone back on their feet again in that what would probably have to happen is this lady will have to have traction applied which is, you know leg out like that with weights on the end, I'm sure you've seen pictures sort of thing. To get the pelvis to heal you're talking a minimum of six weeks, probably three months on traction so, by which time any prospect of sort of getting back on your feet has gone and the last thing is with a dynamic hip screw the head of the femur can just sort of crunch down and I've already recorded that this lady had two inches of shortening. So what I just really wanted to say was I find it difficult to see any way that this lady was going to be out of pain, in matters of what had happened and I think that when I saw her on the last occasion that the right approach was to pal..., was palliation and I mean that feeling is further borne in mind that one thing we didn't touch on was

in the nursing notes there's record to the effect that the prognosis had been discussed with the nephew who had said something to the effect that if his aunt wasn't able to mobilise and get home again, she would think that was an extremely poor outlook for her and his view was that it would be important just to let his aunt be kept comfortable. So just really to summarise in saying I felt this lady's prognosis, looking at the whole thing, was extremely poor in terms of pain relief, getting back home again.

DC YATES — From the start?

REID — From the start and there's nothing a subsequent course would change that fact, only reinforced that view. Yes I think, think that's it.

DC YATES — Well it certainly seems very clear to me.

DC Code A — It does although I have a number of questions that come up from that but I don't think it's appropriate to ask those right at this very moment because the whole purpose of today is to talk about ...

REID — Is to talk about Geoffrey PACKMAN.

DC Code A — ... Geoffrey PACKMAN. We appreciate and don't let that inhibit you today about whatever you want to speak about but it may well be that as a consequence of what you've said we may ask you some further questions later on today.

REID Yeah, okay.

DC Code A But I think it's important to do the case for which you've prepared.

REID Fine, okay.

DC Code A And, with the purpose of today's interviews.

REID Yeah.

DC YATES Okay?

REID Yeah.

DC YATES Right well moving on to Geoffrey PACKMAN then doctor. As I said we'll break everything in to topic areas for you and the first topic area I'd like to talk about is clerking. We discussed this before, it's central to ensuring that patients needs and treatments are identified and that suitable care plans is in place.

REID Yeah.

DC YATES What I'd like to do now if we can is to establish what you believe is the purpose of clerking. As I said it might sound a bit repetitive but it keeps everything in order for us and what procedures you expected to be followed and identifying what you see as the role of either the nurse or the doctor. Now if we go to the, can you give me the ...

DC Code A — It's the main file.

DC YATES — ... no the Good Medical Practice, if you can just get it out so I can, I'm going to refer you doctor to the document from the GMC, Good Medical Practice 2001. It's got an ID Reference of CSY/HF/2.

DC Code A — Before we start on that doctor you're going to, Chris is going to be mentioning a lot of exhibits, a lot of them you will be familiar with because you've seen them before. Most of them I should think and if at any time you want to see any of those exhibits ...

DC YATES — Closely.

DC Code A — ... they're here, right and that's the purpose of having them in this interview room now so you can see them.

DC YATES — Right now that's a copy, a photocopy, contained in that, in the first pages ...

REID — This?

DC YATES — ... is that right, yeah. It's just a photocopy that one is.

REID — Yeah I appreciate that I was just wondering which date this one.

DC YATES — It should be a copy of the 2001 I think.

REID Yeah but this is 1999.

DC YATES 19, yes, yeah.

REID So that's ...

DC YATES But it's, this is just a quick reference the best one we had to photocopy. We have made enquiries and the part we read from, I think you'll agree, has been in place for years, which is, they say Good Medical Practice, 'Good clinical care must include adequate assessment of a patient's condition based on history and symptoms and if necessary as appropriate examination'. It also goes on to say 'In providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, decisions made. The information given to patients and any drugs or other treatments prescribed'. It also says 'It must include taking suitable prompt action where necessary and also prescribe drugs and treatments including repeat prescriptions only when you have adequate knowledge of the patient's health and medical needs'. That's a quick summary ...

REID Yeah.

DC YATES ... of it. I think first of all would you agree that that has been the case for years? Okay, was Mr PACKMAN, and you've had a look through the notes. Well first of all can you remember Mr PACKMAN?

REID No.

DC YATES So everything we'll talk about today is, is from the notes?

REID Yes.

DC YATES Okay well from looking at the notes over the past ten weeks, was Mr PACKMAN provided with a suitable and adequate assessment?

REID Are you talking about Gosport ...

DC YATES We're talking about ...

REID ... or QA?

DC YATES ... Gosport. Gosport first. We shall talk about QA later but Gosport at the moment.

REID Well he was, the first note from Gosport is written by Dr RAVINDRANE and that sort of outlines, the sort of medical problems. There are sort of reflections of the sort of drugs he was taking, reflection of the mental status, also reflection, there's a, examination of the, it's been noted that the heart and respiratory system have been sort of examined and the legs have been looked at and there is a reference to the ulcers which would have been dressed yesterday. So Dr RAVINDRANE obviously didn't take

down the dressings but just recorded that the patient had ulcers.

DC YATES Okay.

REID So I think it's a reasonable summary of ...

DC YATES That's a reasonable summary, yeah.

REID ... of the care that had happened up to that date.

DC YATES Okay and that was Dr RAVINDRANE?

REID Yeah.

DC YATES Okay and what was Dr RAVINDRANE's position?

REID At that time he was a Senior Registrar.

DC YATES Mm, mm.

REID And the post is a training post.

DC YATES Right, okay. Now also at the Gosport War Memorial Hospital we have, or you had at that time, a Clinical Assistant.

REID Yes.

DC YATES And that was Doctor BARTON.

REID That's right.

DC YATES So what was the purpose of the Clinical Assistant in the context of looking after the patients?

REID To provide sort of day to day care and respond to needs which probably the nursing staff would have identified, like "Could you please come and assess this patient cos they're not well, or ill" or whatever. Also to clerk new patients in. To, and as part of that clerking would be you know history examination, problems, treatment plan etc and, yeah I think that's, that's basically the role.

DC YATES I mean we have a copy of Dr BARTON's job description, which we can get out if you want to have a look. I can quickly summarise or just go through the, I think it's 15 or 16 points, and I'll ask you if you agree or disagree if that's pretty much what the Clinical Assistant should be about.

REID Yeah.

DC YATES To provide 24 hour medical cover to long stay patients in the War Memorial Hospital and the patients are slow stream or slow stream rehabilitation?

REID Yeah.

DC YATES And it's important to be seen not only as a medical advisor but a friend and counsellor to patients, relatives and staff.

REID Yes.

DC YATES And she was, or the Clinical Assistant was to visit the unit on a regular basis and to be available on call as necessary.

REID Yeah.

DC YATES To ensure that all new patients are seen promptly after admission. To be responsible for the day to day medical management of the patients.

REID Yeah.

DC YATES To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date and reviewed regularly.

REID Yes.

DC YATES To complete upon discharge the discharge summary and HOM60.

REID Yes.

DC YATES To ensure that prompt preparation of death certificates and for cremation certificates where appropriate.

REID Yes.

DC YATES Take part in the weekly consultant rounds.

REID Yes.

DC YATES To prescribe as required drugs to the patients under the care of Consultant Physicians in geriatric medicine.

REID Yes.

DC YATES To participate wherever possible in multi-disciplinary case conferences and discussions relating to the patients in the unit and to provide clinical advice and professional support to other members of the caring team.

REID Yes.

DC YATES To provide clinical advice and professional support to other members of the caring team. Just repeated myself there ...

REID Yeah.

DC YATES ... I'm sorry. To identify opportunities to improve services so that a high level of care can be provided within the resource available. To be available when required to advise and counsel relatives and to be responsible for liaison with the general practitioners with whom the patient

is registered and with other clinicians and agencies as necessary.

REID Yes.

DC YATES So that's 15 or 16 points and is that how you understand the role of the Clinical Assistant?

REID Broadly speaking, yes.

DC YATES Broadly speaking.

REID Yeah. I mean I haven't seen the contract ...

DC YATES Oh we can show you the contract.

REID ... well no you showed me it last time, I've seen it before ...

DC YATES Yeah.

REID ... but I hadn't seen it ...

DC YATES You hadn't seen it at the time.

REID ... at the time.

DC YATES Yes, no I accept that. So when we're talking about provide 24 hour medical cover. What would you expect or what

would you have expected then more importantly, for that to entail?

REID — Well to respond to the nursing staff, you know at any time sort of day or night to a problem with the patient.

DC YATES — Yeah.

REID — You know either you know by, maybe over the telephone or coming in and seeing or making alternative arrangements.

DC YATES — How often would you expect the Clinical Assistant to visit the patients?

REID — I don't know what, I don't know that, I mean I came in with an already established practice.

DC YATES — Yeah.

REID — Which seemed to be that Doctor BARTON usually visited two or three times a day and so I sort of accepted that as the way she sort of discharged her duties.

DC YATES — You talk about sessions don't you quite often?

REID — Yes.

DC YATES — Right how long is a session, I believe it's changed recently as well hasn't it?

REID Yeah I mean a session when you're talking about medical employment was sort of three and a half hours.

DC YATES Right so I think Doctor BARTON was contracted to five sessions per week. So it would ...

REID Yes.

DC YATES ... 18, 20, 20½ hours.

REID Yes I mean that was the payment currency if you like that was not her commitment in hours.

DC YATES Oh right. Is that, are you, are you saying, I understand what you mean by that was the payment currency.

REID Yeah.

DC YATES Are you saying that her commitment could have been less or ...

REID Yes it, oh yes definitely because she was providing 24 hour cover.

DC YATES ... cover.

REID So I would not necessarily have expected her to be in the hospital five times, three and a half hours per week.

DC YATES But you mention that Doctor BARTON was attending up to three times a day.

REID That's what was reported to me by nursing staff.

DC YATES Yes. So there's a fair chance with that level of commitment that she was actually probably ...

REID Oh yes.

DC YATES ... reaching the three and a half hours a day so to speak.

REID Yes.

DC YATES What would be the minimum then, bearing in mind that a Clinical Assistant is on 24 hour cover as you say, or 24 hour call? What would be the minimum attendance? Not when you're called in but what would be the minimum attendance that you would expect to allow really?

REID I mean it would be sort of local negotiation. I mean this was often the way of providing cover in community hospitals and it would depend on the number of beds, you know that there were in hospital. For example say it was 20 beds you might expect somebody to come in maybe for half an hour in the morning and half an hour in the afternoon and that was some, and be given a number of sessions in recognition of her coming in and the on call commitment but I, you know I wouldn't have a clue really.

DC YATES Okay, alright. I mean Doctor BARTON ...

REID It would be a matter for the local negotiation.

DC YATES ... yeah I understand what you mean. I mean Doctor BARTON had indicated anyway that she'd come in Monday to Friday from about half past seven (0730), till nine in the morning (0900). Virtually every lunch time, quite often again in the evening about seven o'clock (1900).

REID Yeah.

DC YATES Especially if she was the duty doctor.

REID Yeah.

DC YATES I was going to ask how would you ensure that a Clinical Assistant attended the hospital but you've pretty much answered that saying that it was all down to local negotiation was it, you're saying?

REID Yes and I mean in some sense it was left to the, it would be left to the Clinical Assistant to decide themselves how they discharged their duties. I mean within the, so I mean all I think it says there is you know attend regularly. It doesn't specify how regularly but it says come on the ward round once a week. So that would be expected that someone would be there for that but for example I mean someone might just choose not to come in regularly and just respond

to the calls as they came in. I mean I wouldn't say that was a good way of doing it but ...

DC YATES — Yeah so, and with Mr PACKMAN the actual clerking which is the topic area that we're trying to, that we're working through, that was actually on this occasion done by ...

REID — ... Doctor RAVINDRANE.

DC YATES — ... yeah and I think he's written up as Doctor RAV or something hasn't be?

REID — RAVI.

DC YATES — RAVI.

REID — Yeah.

DC YATES — Alright. From the notes then why was Mr PACKMAN admitted to the War Memorial Hospital?

REID — Right. I mean it, I mean it doesn't specifically say but I mean it refers to the, to the leg ulcers.

DC YATES — Right. If you actually go through the notes, which I know you have already, I might just be able to, if I can find the right bit, would I be right in saying that he suffered a fall at home?

REID I wasn't aware that he'd suffered a fall at home. I thought he was immobile.

DC YATES Um, I thought he suffered a fall and was then immobile but he was, two ambulances anyway took him to ...

REID QA.

DC YATES .... Yeah the A&E at QA. He's morbidly obese?

REID Yes.

DC YATES Leg ulcers and cellulitis.

REID Yes.

DC YATES So once he was transferred from the QA to the War Memorial Hospital. What sort of care was he there for?

REID Well I mean it doesn't specifically say in the notes why he was transferred from QA and there's also no reference in the QA notes as to why he was transferred.

DC YATES Transferred.

REID But reading between the lines my view is he was transferred for nursing care.

DC YATES Would it be what's called continuing care or ...

REID Well I mean probably and I think it's, well almost certain given this, the fact that this man was morbidly obese with pressure sores on his buttocks and the leg ulcers and cellulitis. I mean I think it, I mean I don't know whether it's helpful to say at this stage, someone just, I mean I just happened to mention to one of our ward sisters that I was being questioned about this patient and she said "Well I think I remember him" she said "We actually had to put two beds together on Ann Ward because he was so obese" and I sort of have a vague memory of that but nothing more. I think it's important to say that just to sort of emphasis just how large this man was.

DC YATES I think somewhere in the notes or I've read somewhere it actually took two ambulances, two ambulance crews ...

REID Yes.

DC YATES ... to take him to the hospital where he was so heavy and ...

REID And I think that if you're as obese as that and it said that he hadn't been walking for a week before he came into hospital. He'd got pressure sores, he'd got severe arthritis in his knees. He, this man is terminally ill. In the sense that he's not going to get back on his feet again, he's got huge risk factor for developing infection etc. So his life expectancy is poor.

DC YATES ... and he was ...

REID Only 67 or 68.

DC YATES ... 67, 68.

REID Tragic.

DC YATES Mm. So are you saying with a man of that age, of that obese there's no chance of him losing weight or, that's what you're saying is it?

REID Yeah.

DC YATES So normally the first function is when a patient arrives on a ward is clerking?

REID Yeah.

DC YATES Right and on this case, on this occasion it was done by Dr RAVINDRANE.

REID Yeah.

DC YATES Quite often it's done by the Clinical Assistant ...

REID Yes.

DC YATES ... at the War Memorial Hospital.

REID Yes.

DC YATES What notes would have been available to, actually Dr RAVINDRANE on this occasion, when the patient arrived, on admission?

REID Well one, one would have hoped that the notes from Queen Alexandra were transferred with the patient.

DC YATES And is that a normal practice?

REID Yes. It doesn't always happen but that's what should happen.

DC YATES Okay and the actual process of clerking involves the examination and the recording of ...

REID Yeah looking at the notes, see what's happened already.

DC YATES Yeah.

REID ... taking the history and get one from the patients, examining the patients and making a plan.

DC YATES Excellent and on this occasion you feel that that's quite a satisfactory clerking do you?

REID Yes I mean I think it would have been helpful just to have said, you know plan and for you know admitted for leg ulcer management and nursing care. Or pressure sore management and nursing care.

DC YATES But he has been examined as we can see.

REID Yeah.

DC YATES I think we've touched on this already but why is this initial assessment, this clerking, so important?

REID Well it's to set the direction of travel for the patients care. So that those who come along behind us know what the initial thoughts, plans are.

DC YATES And I think people have mentioned before something like a, it also sets a baseline?

REID Yeah.

DC YATES And you can tell whether a patient is improving ...

REID Yes.

DC YATES ... or deteriorating?

REID Yes.

DC YATES Had, you touched on this slightly, earlier. Had the opinion been formed then, on Mr PACKMAN's admission at the War Memorial Hospital that he was in fact in a terminal phase of his life?

REID Well there's no record to that effect.

DC YATES Right.

REID Not that I can, not that I've seen.

DC YATES From reading the notes, which I accept is all you can do now.

REID Yeah.

DC YATES Over this period of time you certainly said earlier on that the prognosis for this man, a 67 year old man who was that morbidly obese, not been mobile for a week, arthritis in his knees, the ulcers etc, was very poor.

REID Yes.

DC YATES If you turn to, I think, hopefully I'm right, pages 44 and 45 I'll see if I can find any originals and these, the it's an SHO, it's the clerking notes at the QA and they run for ...

REID Two pages.

DC YATES ... two pages. Now would you say this is a good example of clerking?

REID That's what I would expect the clerking to look like in Queen Alexandra Hospital.

DC YATES — Mm, that's it. Now the patient's already been to one hospital, he's now been transferred to the War Memorial Hospital and what you say is it wouldn't be normal practice then, having had such a full, if you've come from one hospital now it would not be normal to have such a full entry ...

REID — That's right.

DC YATES — ... right. But again on page 54 isn't it, which is Dr RAVINDRANE's entry, it's not as detailed but it seems to, it does show the problems ...

REID — Yeah.

DC YATES — ... and the treatment plans etc. Is there anything you want to add on clerking?

DC Code A — No not at the moment Chris, no.

DC YATES — Right we'll carry on along the theme of clerking then with the initial assessment. Now the idea of just asking you a few more questions about the initial assessment is to identify what you consider to be the fundamental purpose of the initial assessment. What routine you'd expect to be followed and the reasons behind the assessment. So what routine would you expect, you know adopted to to follow on an initial assessment?

REID — Well as I say ...

DC YATES Now you've explained it can, it can differ between the two hospitals ...

REID ... yeah.

DC YATES ... because one is admission from outside and the other one is a transfer but what, well we'll start with the QA then, what routine would you expect your doctors to follow on initial assessment?

REID Well taking a full history from a patient ...

DC YATES Yeah.

REID ... if the history's not available from the patient, speaking to relatives. If the relatives aren't available you know are they being (inaudible) neighbours, friends, GP whatever. Cos the history, the history is really sort of key.

DC YATES Right.

REID And 80 per cent of diagnosis is made on the basis of the history, that would be followed by examination of the sort of four main sort of body systems. Heart, chest, abdomen and the nervous system usually and anything else that seemed appropriate. Then a statement as to what the sort of diagnosis or problems were and an investigation and treatment plan.

DC YATES Right, which, yes I mean that's how I would picture it. Now move that on to what would you expect then having, a patient having been transferred to the Gosport War Memorial Hospital? What would you expect of an initial assessment there?

REID Well I think an outline of the sort of problems, the main problems. Asking the patient if they had any particular sort of symptoms which were troubling them. Um examining them and you know making a treatment plan.

DC YATES Right so you'd still expect the examination?

REID Oh certainly expect an examination, yes.

DC YATES And ...

REID I mean that might be only a very basic examination ...

DC YATES ... yeah.

REID You know just listening to sort of heart, chest, checking blood pressure.

DC YATES Mm, okay but also the hope should be, the doctor should be equipped with the notes from the previous hospital?

REID Should be yes.

DC YATES Which is going to help with the previous medical history I suppose?

REID Yes.

DC YATES Okay. Again I mean that Good Medical Practice Guide covers this that good medical care must include an adequate assessment of the patients condition, placed as you say, on history and symptoms and if, it says actually '... and if necessary appropriate examination'. But you're saying that you would expect at least a basic examination?

REID I would expect you know the persons pulse rate and blood pressure and ...

DC YATES Yes.

REID ... and possibly temperature. You know just make sure the patients were stable.

DC YATES Okay and once the examination has taken place, once the, that initial assessment has taken place where would you expect that to be recorded?

REID In the medical notes, well the bit that had been done by a doctor, it's meant to be in the medical notes.

DC YATES Yeah and how would you expect that to be written?

REID Well sort of problems, examination, plan.

DC YATES So and it would be abbreviated, short and precise?

REID It would be fairly short in size yeah.

DC YATES But covering those ...

REID It should cover the salients.

DC YATES ... yeah problems, what the care plan is going to be, what you expect, yeah. Who would you expect to then read that entry?

REID Well any sort of doctor who is following on behind but also the nursing staff.

DC YATES That's what I was going to ask, would nursing staff read it?

REID They might do.

DC YATES Okay. How normally then, having made that examination and come up with treatment plans, care plans etc, how would that normally be passed on to the nursing staff?

REID Well I mean if, I mean I can only say what I'd, I would do.

DC YATES Yes.

REID — Which would be, I'd probably have, seek out the senior nurse I'm talking about the War Memorial here and say "I've seen the patient there's nothing to be, or there are things to be done and these are the things". So I'd normally want to speak to the nursing staff to you know give them some guidance because I wouldn't just want to rely on them looking at the notes. I mean I couldn't say that, that sometimes that didn't happen or if you're called away to see someone then the nurses might have to go to the notes you've written.

DC YATES — But with a new patient once the patient's been seen by the doctor initially, if the nurses hadn't had verbal direction they'd know where to go?

REID — Yeah they would know, yeah go to the medical notes.

DC YATES — When would a patient be seen by a doctor for the first time then and we're talking about transferring to the War Memorial Hospital? Would you be seen straight away or ...

REID — Well we used to expect them to be seen that day, although if they come in very late at night, I mean I don't know what the GP, Clinical Assistant or the GP's on call might do is say to the nurses "Well are they stable, you know is the pulse and BP okay and do you feel that it could wait until the morning?" and then the patient would be clerked in sort of the following day.

DC YATES Yeah so there wasn't a particular time for ...

REID No.

DC YATES A patient could appear at any time?

REID No.

DC YATES So looking at, and it is page 54 then, having looked at that assessment what does that tell you that Mr PACKMAN was being treated for?

REID Well what it says is repeat, sort of like down the bottom of the page is rpt is repeat, hb is haemoglobin which is a blood test, u's and e's which are another set of blood tests and lft's but it doesn't refer to any other medical treatment.

DC YATES So you've got, yeah so the bottom sort of like three lines says 'Repeat haemoglobin' what did you say the other one was?

REID There's the haemoglobin, urea and electrolytes and the last one is lft's, which is liver function tests.

DC YATES And why would these be asked for, is this a regular ...

REID Well my guess is that because Dr RAVINDRANE's recorded up near the top of the page, about fifth or sixth line down, ? Meleana. Meleana means that, well it's a motion that's basically composed of motionless blood and

there's also been reference in the medical notes at QA to this patient passing black stools and that can be passing blood and in these circumstances you would want to check what someone's blood count is and urea and electrolytes, liver function test they are just sort of fairly basic.

DC YATES Fairly basic.

REID Yes.

DC YATES So on the initial assessment then Dr RAVINDRANE has actually written 'Query meleana, 13th of August' which is ten days prior, so he's looked at them, it would appear he has had a chance to look at the notes, from writing that.

REID It would appear so.

DC YATES And he's thought I want this checked out so he's asked for blood.

REID Yeah.

DC YATES So reading through the, that initial assessment, he's obese, he's got arthritis in both knees, he's immobile and he's got pressure sores ...

REID Pressure sores.

DC YATES ... he's on a high protein diet and Dr RAVINDRANE's also worried about the fact that he's possibly bleeding and he's having that checked.

REID Yeah but he's also, after that episode, the haemoglobin had been checked again ...

DC YATES Yeah.

REID ... and it was stable, which is what he said ...

DC YATES Yeah.

REID ... in his next statement.

DC YATES Excellent. So what was then the medical care plan are you saying for Mr PACKMAN?

REID I think it was just to check that he was his haemoglobin was still stable, reading between the lines.

DC YATES Yeah reading between the, is there anything, was there any plan about his obesity or his immobility?

REID No.

DC YATES Okay. What was your responsibility then as the consultant with regard to Mr PACKMAN?

REID Well I was responsible for this care while he was in the War Memorial Hospital.

DC YATES Mm, mm okay. Just fine the pages, I think pages 82 and 83 is the nurses care plan.

REID Yeah.

DC YATES Or part of the nursing care plan. So he's constipated ...

REID Yeah.

DC YATES ... or is prone to constipation.

REID Yeah and Dr RAVINDRANE's noted that there's constipation too.

DC YATES So the nurses have either been told or taken it from Dr RAVINDRANE's notes and the desired outcome is to try to achieve a regular bowel movement.

REID Yeah.

DC YATES That's to be evaluated daily. (Coughs) excuse me. So that's one of the plans that they wish to put into, he's got a urinary catheter in place as well.

REID Mm, mm.

DC YATES According to this, to the, if you look at page 84.

REID Yep.

DC YATES So obviously this care plan is for that. He's unable, if you look at page 86, unable to maintain his own personal hygiene, requires full assistance.

REID Mm, mm.

DC YATES So, and that's just part of his immobility, I would assume.

REID Mm, mm.

DC YATES So looking through those the plan is to keep him comfortable but I haven't and I can't see anything, which is what you said earlier, about trying to reduce weight or anything like that.

REID Yeah.

DC YATES And you've told us that the direction has come from ...

BUZZER SOUNDS INDICATING THE END OF THE TAPE

DC YATES ... oh that went quickly, the direction has come from either Dr, verbally, Dr RAVINDRANE verbally telling them or if he hasn't, he's looked at the notes. Okay well that buzzer

is just signifying that's the end of that tape. Is everyone happy just to crack on?

DC QUADE Mm, mm.

DC YATES Okay well the time is 0949 hours and we'll turn these tapes off and put some others in.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y25R

Enter type: FULL TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 08/08/2006

Time commenced: 0952 Time concluded: 1036

Duration of interview: 44 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC Code A YATES

Other persons present: MR CHILDS, SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This is a continuation of the interview of Doctor Richard Ian REID. The time is 0952 hours. Doctor just to couple of things. Can we just confirm that the interview was stopped as the tape ran out, we've changed the tapes but we haven't spoken to you about this matter while the tapes been off?
REID	Yeah.

DC YATES Okay. Right we've been talking about initial assessments and clerking, you've explained how that's worked and the fact that the nurses actually get their direction from the doctor either verbally or look at the notes.

REID Look at the notes.

DC YATES Okay and that, is that how a nurse, or nursing staff decide what care plans to put into place? Are they told specifically each and every care plan to put in place or are they told ...

REID No they're independent professionals so they make their own assessment. So I mean as you've seen there's nursing care plans which address, you know hydration, feeding, bowel care, mobility, all the rest so they would make their own assessments, nursing assessments.

DC YATES Okay.

REID So what they, they'd be looking at the medical notes is what's this, is there a sort of medical plan.

DC YATES Right Geoff is there anything you want to ask about that?

DC Code A No.

DC YATES Right if we can move on then doctor to the existing treatment and condition of Mr PACKMAN and in the case of Mr PACKMAN what specific ailments he was suffering.

We're going to ask questions to get an understanding of why various medicines were prescribed and also try and get an explanation as to what medical records would have been available to you and also other doctors and what you would have reviewed. Now you've already said in order to offer the correct and appropriate care medical practitioners should be aware of pre-existing medical history, prescriptions and care plans, is that correct?

REID Yes.

DC YATES And you said that that notes from the QA should have been available ...

REID Yes.

DC YATES ... to the Clinical Assistant, you said sometimes that doesn't always happen. It appears they may well have been looking at Dr RAVINDRANE's initial entry. So what process would normally be followed upon a patient's arrival at the War Memorial Hospital?

REID Well they would be assessed by the doctor, but almost certainly, first of all they would be assessed by the nursing staff.

DC YATES Okay. On page 54 which is Dr RAVINDRANE's assessment isn't it, we've already covered what Mr PACKMAN was suffering from that needed him to be admitted to the War Memorial Hospital. What, why is a

patient moved from one hospital to another? Like for instance in this instance from the QA to the War Memorial Hospital?

REID — Well, yeah well usually because they no longer required the, usually medical facilities that are available or are only available in Queen Alexandra Hospital. So in this case it would appear that he was medically stable, his major needs were nursing needs and he was transferred to the War Memorial Hospital.

DC YATES — Okay and the War Memorial has often been described as a cottage type hospital is that right?

REID — That's right, yes.

DC YATES — I think, well I can actually point you to the page anyway page 168, so, hopefully it's the same page in yours, if not it'll be there or thereabouts.

REID — Yeah.

DC YATES — Right what medication was Mr PACKMAN taking at the time of his transfer?

REID — Right, um, it looks as though the prescription sheets been written when he went into the War Memorial Hospital. So what I mean by that is sometimes they used the existing ...

DC YATES — Yeah.

REID ... prescription sheet from Queen Alexandra Hospital but I mean I see Dr RAVINDRANE's signature down this page ...

CHILDS Which page are you on, sorry just so that ...

REID ... sorry this is page, oh sorry this is page 170 I'm talking about

CHILDS ... right.

REID Because that's the, so that's the 23rd the day of admission.

DC YATES Yeah.

REID And I would imagine that most of that treatment has been continued from a previous prescription chart in Queen Alexandra. Yes it's, the previous chart was on page 174A which moves on to 177. I think they're all part of the same ...

DC YATES Yeah it certainly appears that way doesn't it?

REID ... the same charts.

DC YATES So what medication was he, was Mr PACKMAN on at the time of leaving the QA shall we say?

REID Okay. He was on Doxazosin, 4 milligrams.

DC YATES Yeah and what is that?

REID It's used in the treatment of high blood pressure.

DC YATES Right.

REID He was also on Frusemide which is a diuretic, 80 milligrams a day and he was also on Clexane which is a blood thinning treatment, 40 milligrams twice a day. He was on regular paracetamol, one gram qds and that looks about his regular, that's what he was on at the time of, when he left QA.

DC YATES So we've got tablets for high blood pressure.

REID Yes.

DC YATES And tablets for thinning his blood, is that right?

REID Well it's, that's an injection for thinning the blood ...

DC YATES Yeah.

REID ... that's Clexane.

DC YATES Clexane.

REID Water tablet to get rid of fluid.

DC YATES Water tablets, diuretics and as far as pain relief ...

REID Paracetamol.

DC YATES ... Paracetamol. Now if you turn back some of the pages to the prescription sheet which was written out, I think by Dr RAVINDRANE actually, on his admission.

REID Yes.

DC YATES Which is page ...

REID 170 is it?

DC YATES ... I think so. He cont..., how does his medication continue is there any alterations or ...

REID Doxazosin, Frusemide, Clexane, Paracetamol, looks as though he's also written up Magnesium Hydroxide, that's the MGOH2, which is at the bottom of the page which is for bowels. He was on a cream but, I don't know what cream it is, 50/50 cream or something, he was on that before, that's it so DR RAVINDRANE has added Magnesium Hydroxide.

DC YATES ... and what, sorry what was the, what was the Magnesium Hydroxide ...

REID For constipation.

DC YATES ... for constipation.

REID Yes.

DC YATES So the only pain relief that he was on was Paracetamol ...

REID Yes.

DC YATES ... at that stage. Geoff do you want to carry on here I want to find something, is there anything you want to ask on that? While I look.

DC Code A While Chris is doing that doctor ...

REID Yeah.

DC Code A ... why, we, I know the answer to this but I want to get it from you, why, why, why was that patient transferred from, what's the process to go through for that patient to be transferred from the QA to Gosport War Memorial Hospital?

REID Well the, normally what would happen is the, on one of the ward rounds at QA the decision would be made that this patient didn't need to be in QA any longer where, where the needs are, it would be the patient maybe discharged home or do they need continuing hospital care for one reason or another and then make a decision about where it would be appropriate to transfer that patient to, given their needs, you know medical, nursing, phsyio, whatever.

DC Code A — And who would make, who is it who would ultimately to make the decision to transfer?

REID — Well it would usually be the consultant or senior registrar.

DC Code A — Mm, mm but someone from elderly medicine obviously?

REID — Mm.

DC Code A — Yeah and do you know who it was in this case?

REID — Well I think it was Dr TANDY.

DC Code A — Can you have a look at page 50 for me please?

REID — Oh yes it was Dr CHATTERTON

DC Code A — Yeah.

REID — He's the Specialist Registrar.

DC Code A — And that's dated what, the 13th of the eighth isn't it?

REID — Yes.

DC Code A — Yeah and just above his signature it says ' Transfer to Dryad Ward on the 16th' doesn't it?

REID Yes that's right.

DC Code A And you mentioned just now, you remember, you were saying, was it you who said you remembered it or somebody else remembered something about the bed size or ...

REID It was the Ward Sister.

DC Code A ... .the bottom, it says 'Transfer on the 16th of the eighth'. As we know he didn't transfer until the 23rd did he?

REID Yes.

DC Code A Do you know why that was?

REID No.

DC Code A There was ...

REID I mean there may, I don't know, they might not have been a bed available.

DC Code A ... no I think what it was ...

REID Or it might have been because of this query about ...

DC Code A ... in the nursing notes, later on in the nursing, well in the nursing notes there is a mention of, page 120 doctor. I'm

just wondering whether some of these things might jog your memory you see.

REID There's nothing there that I can see.

DC Code A No perhaps it wasn't 120 then. It might be later, bear with me I'll find it. Right, oh there are two, there's a 120 and there's a 120A ...

REID Oh right, okay.

DC Code A ... it's that page you've got in front of you now, 120, if you look at the entry for the 13th, yeah it's about half way down.

REID Oh right, yeah.

DC Code A It says he's seen by Dr CHATTERTON doesn't it?

REID Yeah.

DC Code A 'Transfer to Dryad Ward as and when bed available' and then the same date, time 0950, they booked a bed on Dryad Ward ...

REID Yeah.

DC Code A ... but it looks as if ...

REID They gave information about the patient's weight and his Waterlow Score ...

DC Code A ... yeah.

REID ... and so they obviously wanted to make sure that they had ...

DC Code A But if you carry on reading it ...

REID Yeah.

DC Code A ... I advised them of present bed from Huntley Health Care, Jan PEACH aware, I think Jan PEACH is a Senior Administration ...

REID Senior Nurse.

DC Code A ... oh is she a senior nurse is she?

REID Yeah.

DC Code A Yeah and then 'Try to organise transfer of bed'.

REID Yeah. A special bed had been brought in for him.

DC Code A So that backs up what you're saying doesn't it, that backs up what you're saying ...

REID Yeah. Yeah.

DC Code A ... that he needed an extra bed size, special made and in the bottom, the same date, two o'clock (1400), 'Dryad Ward phoned they are unable to get hold of a large ...' and then it doesn't carry on for some reason does it?

REID No. It's on page 119.

DC Code A Oh is it, thank you.

REID Yeah.

DC Code A Profiling bed at present, that's it and then dated the 15th they can't take him. Hopefully get the bed tomorrow and that was dated the 16th and it just, that actually, it doesn't really seem to say what happened about the bed does it but presumably by the 23rd they'd sorted it out.

REID Looks like they did, yeah.

DC Code A Yeah. I was just hoping they might've, you said about the large bed and I was hoping that might've jogged your memory that's all, of the special needs of this patient.

DC YATES Yeah I'm fine (inaudible). If we just move on for the moment to the purpose of stay and aims and care plans, okay but they're put in place to allow a nurse or medical practitioner to follow a particular course of action. We touched on this already haven't we and then the progress of the patient can be monitored and results reviewed and care

altered accordingly if necessary. So that's the purpose of the care plan which you said. What input did you have in a care plan?

REID What you mean in this case or generally?

DC YATES Well generally first of all.

REID Well on a ward round you know I would sort of make an overall assessment of you know what I felt the main issues or problems were and what needed doing about it.

DC YATES And did you have any input in this particular case?

REID Well only on the, on the sort of 1st of September.

DC YATES Mm, mm okay well what and we have touched upon it already but what was the care plan that was put into place in respect of Mr PACKMAN then?

REID Well as I see it, it was he had largely nursing needs and there are nursing care plans which reflect his needs. Although the medical bit was Dr RAVINDRANE wanting to make sure that the blood count was stable.

DC YATES Right and did the care plan ever change for Mr PACKMAN or while he was at the Gosport War Memorial Hospital?

REID Well I mean there's ...

DC YATES — Well I'll rephrase it, I'll rephrase the question for you. Why would the care plan change?

REID — ... because of a change in the patients condition.

DC YATES — Right. Now in the case of Mr PACKMAN did the care plan ever change?

REID — Well the nursing care plans as far as I can see didn't change. The medical care plans, I mean as you're aware from looking at the notes, I mean Doctor BARTON was asked to see him on the 26th because he'd become unwell and there's a note written, notes as to what she thinks should happen.

DC YATES — Yes 26th, 'was called to see male, clammy, unwell, suggests ...

REID — 'Suggests ...' ...

DC YATES — ... Query MI, treat stat, Diamorph and Oramorph ...

REID — ... Oramorph.

DC YATES — ... overnight.

REID — Yeah.

DC YATES — Alternative possibility GI Bleed but no ...' ...

REID Haemotomosis.

DC YATES ... yeah. 'Not well enough to transfer to Acute Unit' ...

REID Yes.

DC YATES ... 'Keep comfortable. I am happy for nursing staff to confirm death'.

REID Yes.

DC YATES Okay. So was that a change in the care plan?

REID Well I would say so.

DC YATES Right.

REID It's a change in the patient's medical condition.

DC YATES It is, yes but is there a change in the care plan it's, because I note it's a change in the condition and there's two possibilities.

REID Yeah and I mean the care plan was just to treat the patient, you know being clammy, unwell which was by giving a stat dose of diamorphine and giving Oramorph overnight. There's an indication that the patient's not well enough to transfer to the Acute Unit and that that patient should be kept comfortable.

DC YATES — Mm, I'll come back to the transfer to the Acute Unit a bit later on but just quickly how can a patient be not well enough to transfer to an Acute Unit?

REID — Well if they're, if they're, you know you have to make a judgement by their sort of other condition, which involves you know sort of looking at the patient. How dis...., if they were distressed, in pain, looking at observations etc.

DC YATES — If the same patient became, or had become that unwell at home what would happen?

REID — Well the ambulance service would be called and they would, one would presume, try to get the patient into hospital.

DC YATES — And what facilities were in place at the War Memorial Hospital should the need arise to transfer a patient?

REID — Well the ambulance service is available.

DC YATES — It would be ambulance service would it? Okay but I shall come back on this (inaudible) anyway.

REID — Yes I mean, I think what one would do is you have to make a judgement about whether the right thing to do is to transfer, take the patient into hospital. Given the situation of a patient at home or a patient at the War Memorial

Hospital is the first thing, well can hospital help and is it appropriate, what were the wishes of the patient, family etc.

DC YATES — Right the named nurse for Mr PACKMAN I have here is Freda SHAW from what I can make out from the notes. What was the role of the named nurse?

REID — The named nurse was the, if you like the sort of, I suppose the key sort of worker for the patient. The nurse who's sort of overall sort of responsibility well certainly co-ordinating the nursing care, liaising with the family etc that's what I would understand it to be.

DC YATES — Okay and would you discuss anything with the named nurse in particular?

REID — It would depend, I mean (inaudible) were with the nurse who was on the ward round, who might or might not have been the named nurse.

DC YATES — Okay. So named nurse may or may not get verbal direction from the doctor ...

REID — That's right.

DC YATES — ... but it would be up to her to at least look at the notes?

REID — Yes, well or, up for the nurse who's on the ward round to communicate it to the named nurse.

DC YATES Okay. There were, talking of the other thing, the nursing care plans, what was recorded as the care plans? I think you'll find them on pages, running from about page 62, 60, yeah it's Staff Nurse Freda SHAW was the named nurse. Medical notes, nursing notes, other care plans (inaudible) actually 80 something, 82 care plans, right have we been through any of these, the immobility.

REID Mm, mm.

DC YATES Urinary catheter, personal hygiene one that's not filled in we have the handling profile and that says 'He's fully orientated, time and place, his compliance is good. Pain needs to be controlled'. Yeah?

REID Mm, mm.

DC YATES The nutritional assessment ...tool

REID Yeah.

DC YATES ... it's been completed on one day only by the looks of it.

REID Mm, mm.

DC YATES And the actual nutritional assessment tool giving a total score is 17 which is in the high risk bracket.

REID Yeah.

DC YATES It then goes on to the sores to his buttocks, in between his thighs and blisters to both feet and heels. And I think that about covers the care plans doesn't it?

REID Mm, mm.

DC YATES Right, again we've discussed this before who decides on what care treatment plan would be for Mr PACKMAN? Who decides on that?

REID Well the nurses just, the nurses.

DC YATES Right and we can see, is this a normal example of how a care plan would be drawn up?

REID Yes.

DC YATES Who was responsible for the treatment of Mr PACKMAN on a day to day basis?

REID Doctor BARTON, you mean medically?

DC YATES Medically would be Doctor BARTON and then nursing would be ...

REID One of the nurses who was on duty.

DC YATES ... yeah.

REID The named nurse.

DC YATES Oh right and we have, if you go back to 54 as well, page 54, what planned, I think it's page 54. What planned investigations were to be carried out?

REID Well it says haemoglobin, urea and electrolytes and liver function tests.

DC YATES And the reasons for the haemoglobin were again, I know you've mentioned it before, it's just so that we get it straight. The reasons for the blood test?

REID Well Dr RAVINDRANE has written 'Query Meleana' so query, questioning whether there's bleeding from the bowel.

DC YATES Okay and you said the others are just normal ...

REID Yeah routine tests.

DC YATES ... is there anything you want to ask Code A?

DC Code A No.

DC YATES No. Right if we move on then to the medical records. Again the little booklet that we've placed, I know it's a photocopy there, CSY/HF/2. It's the GMC Good Medical Practise Guide, talking about the medical records is it right to say that recording of interactions with patients is a

fundamental requirement with any health care professional? The actual recording of interactions.

REID Of interaction with ...

DC YATES The patients.

REID ... the patients, yeah.

DC YATES Okay. Quoting from that book, well summarising that book it says that a doctor must keep clear, accurate, legible and contemporaneous records.

REID Yes.

DC YATES Which report the relevant clinical findings, the decisions made. The information given to patients and any drugs or other treatments prescribed, that's on page three. There's another booklet, GJQ/HF/15, Geoff. That's here, that's another GMC booklet, 'Withholding or Withdrawing Life Prolonging Treatments'. Have you seen that booklet or similar?

REID Yes, published in 02, approved in May 2002.

DC YATES Yeah is that a book that is constantly updated or ...

REID That was the first edition.

DC YATES ... that was the first edition, okay, right. It's a book that we found and looked at anyway but it's page 30 specifically states that the decision making process should be recorded. Has that changed over the years?

REID Well it wasn't, this wasn't.

DC YATES No but has that, is that any different to how it would've been 20 years ago?

REID The principles, oh right, nothing has to the principles no.

DC YATES And we're talking about particularly medical records, I think it's suffice to say, it's fair to say that decision making processes should be recorded by a doctor.

REID Yes.

DC YATES Okay. Albeit this, this second booklet is, first edition was after Mr PACKMAN.

REID Yeah.

DC YATES But bearing the documents in mind and bearing the ...

REID The principles.

DC YATES ... the principles of these documents I seek an explanation as to how the medical records were completed in this case.

What would you expect to be recorded in the medical records of a patient? What would you expect ...

REID — Well ...

DC YATES — ... if a doctor sees a patient, what would you expect to be recorded by the doctor in the medical records?

REID — ... well providing, I presume we're talking separately from the admission process?

DC YATES — Separately from the admission process.

REID — I'd expect you to record details of that sort of interaction or if the patient was experiencing, you know if a patient had symptoms, recording what the symptoms were. Record the results of any examination carried out as a result of that and any treatment.

DC YATES — If a patient's condition hadn't changed ...

REID — Yes.

DC YATES — ... what would you expect?

REID — I think it depends what situation you're talking about. I mean I do regular ward rounds so I would generally put in condition unchanged if that was the case, you know just a brief note. I think if, well from looking at those as a Clinical Assistant then I would not be expecting a note in

every patients records every day but I would expect a note if the patient, if a doctor had been called to see the patient and there had been a sort of significant change in a patients condition.

DC YATES — You're moving onto exactly what I was going to ask. So certainly if there was a significant change in a patients condition you would expect that to be recorded?

REID — Yes.

DC YATES — And if there was a significant change, in fact what do you call, how would you explain a significant change?

REID — Well I think that's up to the interpretat...., you know up to individual interpretation but in general terms if you're initiating any new treatments that's a significant ...

DC YATES — Right.

REID — ... significant change.

DC YATES — So what importance did you or probably do actually, place on the completion of medical records? Personally

REID — Well it's important in terms of trying to sort of hand on care but it, you know I think it's, also I'd like to emphasis that when you use this, that in somewhere like the War Memorial Hospital where GP's only, really available as they're kind of called out and then would also place

reliance on nursing records and information from the nurses. So that somewhere like the War Memorial Hospital one is never going to entirely rely on the medical record, simply because the medical staff aren't there all the time.

DC YATES — All the time, okay. So would that be, was that normal for the Gosport War Memorial Hospital then? Or a hospital like the Gosport War Memorial Hospital?

REID — Well in any hospital, I mean in QA I'd rely on what the nurses have to tell me about the patients, as well as the medical record and looking at the nursing record if I thought that was appropriate.

DC YATES — Okay. Where then, looking at the medical records that you have in front of you, where has it been recorded in the records that Mr PACKMAN was in pain?

REID — I cannot see any reference to him being in pain.

DC YATES — And we have covered that his only pain relief, prior to admission to the War Memorial Hospital was Paracetamol?

REID — Yes.

DC YATES — I know we've covered this on a previous occasion but can you explain to me what the analgesic ladder is?

REID — Yes it's, it's sort of a protocol for the management of pain which suggests that you start with you know low strength

pain killers and if these don't control patients pain then we move onto the second step of the ladder which is moderately strong analgesics and if those don't then move onto the third stage. I think as I've said before you have to make a judgement about what steps of the ladder you start.

DC YATES — You start on, yeah I fully understand that. Now with a patient that is, not been on anything other than, I think it's one gram Paracetamol four times a day ...

REID — Yeah.

DC YATES — ... to, there's no documentation of pain ...

REID — Yeah.

DC YATES — ... why isn't there any documentation relating to why Morphine or other strong opiods were, analgesics were prescribed?

REID — Well ...

DC YATES — In the medical notes.

REID — ... yeah, Doctor BARTON has recorded that the patient was pale, clammy, unwell, ? Myocardial Infarction. I mean I can only speculate but in that situation patients can often be breathless and feel extremely distressed having a heart attack and heart attacks needn't necessarily be accompanied by pain. I think one has to make, so my

guess would be that Doctor BARTON felt that this patient was sufficiently distressed, possibly had a condition that would be relieved by the administration of Diamorphine and that's what she did.

DC YATES — Is this a normal remedy for Myocardial ...

REID — For Myocardial Infarction Diamorphine would be standard treatment.

DC YATES — ... okay. Well, so would that explain why the Oramorph was prescribed with no alternative?

REID — Yes I mean I think, my, my supposition is that Doctor BARTON felt that this patient was sufficiently distressed and could be likely to be continually to be sufficiently distressed that she wanted to prescribe diamorphine.

DC YATES — Okay. Geoff is there anything you want to ask?

DC Code A — No.

DC YATES — How we doing on that tape time?

DC Code A — 33.

DC YATES — Can I ask you then doctor about your ward rounds, you've mentioned those a couple of times already this morning? I believe there are opportunities for doctors and nurses to review a patient.

REID Mm, mm.

DC YATES Yeah?

REID Mm.

DC YATES And you discuss and decide on any change of treatment as necessary and I believe are an integral part of a doctors duties.

REID Mm, mm.

DC YATES So what I want to do is try and get an explanation as to how you expected these rounds to be conducted and the role that you saw ward rounds playing in the care and treatment of the patient at that hospital. So I mean how often did the Clinical Assistant conduct rounds?

REID I'm not aware that she did a regular round of every single patient and what I've said before is I understand that she came in every morning and usually in the afternoons too and asked the nursing staff if any patients had problems and she'd then go and see these patients.

DC YATES Right, so yeah and that could possibly make sense as well, so Doctor BARTON's attending every day, I mean ...

REID It would be a physical imposs..., ...

DC YATES ... you've said that a ward round would take you ...

REID ... three and a half hours.

DC YATES ... three and a half hours just to do, see each patient once. So she's relying on, possibly her previous knowledge of the patients anyway. So if some were in more, more need of care, of attention than others and what the nursing staff say. So it's select, selective patients she could see.

REID Yeah. I mean I think the situation on a continuing care ward like Dryad is not dissimilar to a nursing home where the patients needs are primarily nursing and the GP gets called in as appropriate.

DC YATES Okay. Would a Clinical Assistant conduct their rounds with anyone else, apart from yourself on your rounds, but ...

REID Well I'm not aware whether Doctor BARTON did her own rounds and whether when she went to see patients whether nursing staff accompanied her.

DC YATES Okay.

REID I mean I would imagine that some occasions nursing staff would. You know if they were particularly concerned about a patient on other occasions, you know they probably didn't.

DC YATES Okay. How often, did you as a consultant, conduct your rounds?

REID Usually once a week.

DC YATES Once a week and what day was that normally?

REID It was usually a Monday.

DC YATES And would Doctor BARTON be present then?

REID Alternate weeks.

DC YATES Alternate, she had responsibility for another ward, is that correct?

REID Yes.

DC YATES So you've touched on this already but how did your rounds differ from, from the visits that the Clinical Assistant was making?

REID Well I saw every patient.

DC YATES You would see each and every patient?

REID Yes.

DC YATES And how long would, I'm sure they would vary, but on average how long would a consultation with a patient take?

REID About ten minutes.

DC YATES About ten minutes and what did that entail that ten minutes, what would you be looking at?

REID Well the first thing I'd want to know from the nursing staff and Doctor BARTON if she's present, if there were any particular medical problems they were concerned about and in general sort of where we were going with the plan of care if you like. Then I'd speak to the patient, find out how they were and then if I thought it was appropriate examine the patient and then record my findings of examination and what the future plan should be, if you like.

DC YATES Okay. Well your assessments and your responsibilities as a consultant are very integral in the care and treatment of patients is that right?

REID Mm, mm. Well I mean yeah I think in somewhere like Gosport where someone is coming round once a week, you know the Clinical Assistant is pretty key to decision making.

DC YATES But did you have any concerns about the care and treatment of Mr PACKMAN or were any concerns raised to you?

REID Not that I am aware.

DC YATES Did you hear of any concerns raised about how the consultants supported their, and I use the term juniors but you've already said a Clinical Assistant is quite senior but, but did you ever hear any concerns raised about how the consultants supported their staff?

REID No I haven't heard anything.

DC YATES Am I right in saying you were the consultant ...

REID Yes.

DC YATES ... responsible for the care and treatment of Mr PACKMAN?

REID Yes.

DC YATES So can you explain to me what you understand your responsibilities as a consultant to be?

REID Well in overall charge of care.

DC YATES Mm, mm but did you have any supervisory position with Doctor BARTON or ...

REID Well yes is the short answer to that. In that you know I was responsible for all care and when Doctor BARTON was working in the employment of the Health Care Trust provides sort of day to day treatment.

DC YATES ... although you made, you have made it clear for it's, the role of Clinical Assistants you say is not a training post?

REID It's not a training post.

DC YATES Right so the Clinical Assistant would differ from your Senior House Officers?

REID Yes one would expect them to take sort of more responsibility, take higher level decisions than a doctor in training would.

DC YATES Right.

REID And I wouldn't you know expect the Clinical Assistant to refer to me for every decision on a patient.

DC YATES So how many times did you see Mr PACKMAN?

REID I saw him once in QA and once at the Gosport War Memorial Hospital.

DC YATES Okay. Now did you have any concerns as to how other doctors were performing in their role in respect of Mr PACKMAN?

REID No.

DC YATES — And did you give sufficient support to the Clinical Assistants, and other doctors in order that they carry out their work?

REID — Well I thought I did, I mean I didn't, wasn't aware of any concerns.

DC YATES — And did you ever raise any concerns at all yourself about the care of Mr PACKMAN?

REID — No.

DC YATES — You didn't have any concerns. Geoff.

DC Code A — When you saw Mr PACKMAN in the QA …

REID — Yes.

DC Code A — … which was on Ann Ward wasn't it?

REID — Yes.

DC Code A — What was your responsibility to that patient at that time?

REID — Well …

DC Code A — What was your role, why did you see him?

REID — … right I think it says on the, well the discharge summary sheet, that I was the consultant in charge. I think that's

actually a mistake and the reason I say that is because I see, I only saw the patient once and Dr TANDY with whom I shared Ann Ward saw the patient three times.

DC Code A — You saw him on the 9th of August didn't you?

REID — Yes.

DC Code A — Yeah.

REID — Now what I think, what used to happen I, Doctor BARTON, it's a Nightingale Ward so Doctor BARTON, Dr TANDY had responsibility for patients on one side of the ward and I had responsibility for the other side. But if a new patient had come in on Dr TANDY's side of the ward before her ward round I would see that patient. So that every patient was seen by a consultant as soon as possible after admission. All future contacts would be with the consultant who was looking, so I think that probably it was Dr TANDY's patient although it's actually recorded as being mine.

DC Code A — Just two seconds before we go away from that.

REID — It's page 14.

DC Code A — That's right, yeah, still looking as there are still more questions I want to ask about.

BUZZER SOUNDS INDICATING THE END OF THE TAPE

DC Code A — If you look at page 121 doctor …

REID — Yes.

DC Code A — … and there's a note there, this is done, these are nursing notes aren't they?

REID — Mm, mm.

DC Code A — There's a note there dated the 9th of the eighth, it says, 'Spoke with wife on visiting, informed what Dr REID has said and what we would be looking to do' and that would be looking to …

REID — Go to Gosport War Memorial Hospital.

DC Code A — … go to Gosport War Memorial and that was dated the 9th of the eighth wasn't it?

REID — Right. Yeah.

DC Code A — So that was a decision presumably you had made on the 98th of the eighth was it?

REID — Well presumably.

DC Code A — yeah three days after he came into hospital.

REID Yeah.

DC Code A So you look as if you have made the decision that on the 9th of the eighth that he should be going to Gosport.

REID Yeah from that yeah.

DC Code A Yeah, okay. Okay Chris.

DC YATES Okay well that tape is just about to stop now so the time is 1036 and we'll turn the recorder off.

GMC100748-0097

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y25S

Enter type: FULL TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 08/08/2006

Time commenced: 1055 Time concluded: 1139

Duration of interview: 44 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC2479 YATES

Other persons present: MR CHILDS, SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This is a continuation of the interview with Doctor Richard Ian REID. The time is 1055 hours. The date is the 8th of August 2006 and doctor can you just confirm that we took a short break while we stretched our legs?
REID	Yes.
DC YATES	Same people are present?
REID	Yes.

DC YATES And have you been asked any questions about this matter while the tapes have been off?

REID No, no.

DC YATES Thank you. Right the last tape ran out we were just about to start on another topic area which is the topics of pharmacies and really I think the prescription and administration of controlled drugs. It's a specialist subject and what we want now is explanations as to how you were involved in pharmaceutical prescriptions. Your level of training and understanding of the drugs that were prescribed by others, as well as yourself and the uses of those drugs and how did you ensure that you were up to date in the knowledge that you had in respect of pharmaceutical issues. So we'll start that one off quite easily, what pharmaceutical training had you received at the time of Mr PACKMAN's admission to the hospital?

REID Well medical student.

DC YATES As a medical student. How would you keep up to date with pharmaceutical issues and new drugs and ...

REID Well by reading certain medical journals and research papers and you get to know what drugs are coming on the market. There's often review articles about the appropriate use of new drugs (inaudible) often lectures to be sort of

updated and so, and colleagues keep you up to date with things to.

DC YATES ... yeah, is it compulsory or is this self discipline to read these articles and attend lectures then?

REID I mean there's not, there's nothing compulsive about doing the pharmacy but we now have to do so many hours per year of what we call continuing professional development which will, there will be pharmaceutical issues within that.

DC YATES Was that the case at the time of Mr PACKMAN's admission?

REID I think we had to do, yes fifty hours a year. It started around that time I wouldn't like to be ...

DC YATES So it's almost ...

REID ... absolutely sure.

DC YATES ... an hour a week sort of thing?

REID Yes.

DC YATES As and when. So you'd know what drugs to prescribe the patients from your medical training and from lectures and further development?

REID And experience.

DC YATES And experience. There's a book called the BNF, the British National Formulary ...

REID Yes.

DC YATES ... which has got a reference of CSY/HF/12.

REID Yes.

DC YATES What role did that book play?

REID Well I mean that's a sort of, I think we've referred to it before as the bible of prescribing.

DC YATES Is that a book that you carry around in your briefcase or is there one on every ward?

REID There's usually one on every ward.

DC YATES Yeah. Okay and how often are they updated those books?

REID Six monthly.

DC YATES Six monthly and the hospitals always have the most up to date?

REID Almost invariably, yes.

DC YATES — Okay. How many pharmacists worked at the War Memorial Hospital in 1999?

REID — No idea.

DC YATES — Right.

REID — I mean I believe there was a part time pharmacist but I don't know any more than that.

DC Code A — Incidentally on the BNF doctor how do they change in the six months? What causes the changes every six months?

REID — Well ...

DC Code A — Is there anything typical or ...

REID — ... research and new drugs would become, new drugs becoming ...

DC Code A — ... mostly new drugs?

REID — ... yes.

DC Code A — Yeah.

REID — And occasionally there'll be deletions of drugs you know which have hit the media with nasty side effects etc, which weren't picked up at their trials.

DC Code A — Yeah, okay.

DC YATES — And how often would you refer to that book?

REID — Well pretty frequently.

DC YATES — That's purely for the prescribing of drugs is it or ...

REID — Oh no often looking for the side effects, you know and some, somebody could come in with some symptom and say, wonder if it could be drug, cos a lot of symptoms are due to side effects from drugs. So we use it very frequently for, for that to look up the side effects of drugs cos you can't keep it ...

DC YATES — So it would be a question of going through the notes, finding out what drug a patient may be on ...

REID — ... what the patient's on and then looking ...

DC YATES — ... and looking at the side effects ...

REID — ... at that and ...

DC YATES — ... would coincide with ...

REID — ... yeah.

DC YATES — ... okay. Right what about the PCF, which I think is the Palliative Care Formulary, a similar sized book with a

reference of GJQ/HF/18. Is this a book that you're familiar with?

REID — Never seen it.

DC YATES — You've never seen it?

REID — No.

DC YATES — Okay and the, I think it's the Nurses Prescribing Formulary is the other book we've got.

DC Code A — Yeah.

DC YATES — Which is GJQ/HF/17.

REID — No I haven't seen that either.

DC YATES — In relation to Mr PACKMAN then were any of the drugs used in his treatment, were any of them new or seldom used?

REID — Oh God I.....

DC YATES — Have a look, yeah.

REID — No I don't see anything there. There's nothing that stands out, no.

DC YATES Were any of the drugs that were used to treat Mr PACKMAN used outside of their licence, I think they call it?

REID I think, without looking, without looking at that it would be difficult to say

DC YATES But I'm right in saying the meaning of being used outside their licence, if Drug A, was intended for flu ...

REID Yeah.

DC YATES ... but experience tells doctors that it's actually, works very well for B ...

REID ... works well for something else, yeah.

DC YATES ... yeah then that can be used?

REID Yes, yeah.

DC YATES But it's not necessarily what the drug was initially licensed for?

REID That's right.

DC YATES Is there anything that, is there anything that jumps out on you there? It's not a trick question cos I'm not going to say ha, ha, yes there is but is there anything that jumps out?

REID I can't, ...

DC YATES So I think it would be probably fair to say that with all the drugs that have been prescribed there, that are on those prescription sheets, there are all, are they all regularly used?

REID ... yes.

DC YATES Yeah and regularly used for the sort of disorder that Mr PACKMAN had?

REID Yes.

DC YATES Yeah.

REID No I can't see.

DC YATES What was the purpose of the Wessex Protocols? Have you ever heard, had you heard of the Wessex Protocols?

REID No.

DC YATES Have you heard of them now?

REID There's a Wessex Palliative Care ...

DC YATES Handbook.

REID ... Handbook which I hadn't heard of at the time.

DC YATES Right, okay. Now we have a got a copy and this is CSY/HF/3. Sorry Geoff.

DC Code A That's alright, it's here. This is a copy of that.

REID I've seen that now, yes.

DC YATES But you were not aware of that in 1999?

REID I wasn't aware of that (inaudible) no.

DC YATES Okay what pharmacy guidelines were available for the prescribing of medicines within the Gosport War Memorial Hospital?

REID I couldn't tell you.

DC YATES No. Is that through time that's elapsed or you wouldn't have known?

REID Um, well certainly time that's elapsed, I mean I'm not, not aware ...

DC YATES Okay, no that's just a ...

REID ... we did have Drug Therapy Guidelines in Queen Alexandra Hospital but I'm not clear whether they were designed, if you like, with say Gosport War Memorial

Hospital in mind cos clearly it's two very different situations. But I'm not aware of any sort of specific guidelines for drugs in Gosport.

DC YATES — Okay. Geoff is there anything you want to ask here?

DC Code A — So did you apply the guidelines from the QA down at Gosport?

REID — No, no. I think it's unlikely I'd have done that. A, I don't think there'd be copies on the ward down in Gosport and because it's often, in relation to patients who are sort of acutely unwell and can only be used where patients are say to be regularly monitored. Which is not the case down in Gosport so a lot of them wouldn't be applicable down at Gosport. I mean some might be, I mean I couldn't, I couldn't say.

DC YATES — Okay? In prescribing medicines there's a requirement obviously to complete different parts of a prescription chart?

REID — Yes.

DC YATES — Perhaps we can go, have you got that blank copy somewhere Geoff?

DC Code A — Mm, mm.

DC YATES — Perhaps we could hand you a blank copy and ask you if you could actually explain what the various pages for, are, on a prescription chart and how they should be completed.

DC Code A — Have we seen this one .

DC YATES — Think so, it might be separate. Here give us the folder while you're looking through there, it might be separate.Here I've got it Geoff.

DC Code A — Oh you got it.

DC YATES — Yeah. This is CSY/HF/10, it's a blank Fareham and Gosport NHS Prescription Sheet. Is that the sort of sheet that was being used at the time in 1999?

REID — Yes I think so, it looks similar the heading would be different. Yes.

DC YATES — Yeah.

REID — Yeah it's essentially that except with a different heading.

DC YATES — Can I ask you to explain what each, because each page I think has got a different …

REID — Yes, yeah, okay …

DC YATES — … part to it.

REID ... well there's sort of, the first page you've got, well the second, the first page is a sort of cover ...

DC YATES Yeah.

REID ... sort of information. Second is for once only drugs and also for as required prescriptions.

DC YATES So can you explain once only drugs please?

REID Well I mean one of the examples given here is pre-medication so if someone's going for an operation.

DC YATES Operation. So it's a drug that is likely to only be used the once?

REID The once, yes.

DC YATES Yeah and won't be part of a treatment or a continual treatment?

REID Um, well it could, I mean you, for example I mean the case in point you might want to give a stat dose of Diamorphine and then follow it up for as required or regular cos a patient needed immediate relief of the symptoms so you might write it in this section and then prescribe it regularly after that.

DC YATES I see yeah, yeah and the as required drugs mentioned, as it says, as it says on the label?

REID Yes, yeah.

DC YATES Drugs that will be used as the patient ...

REID Yes.

DC YATES ... requires it.

REID And pages three and four are for regular prescriptions, drugs required regularly and then daily review prescriptions, that's probably the sort of least used section but it's, I mean drugs, like blood thinning types like Warfarin where the dose has to be monitored and adjusted in the light of blood results, that sort of thing you might put in there.

DC YATES Right, okay and who completes these sheets?

REID Well it can be any sort of qualified doctor but I mean usually it would be the person who, in the case of somebody who has been admitted to hospital, the admitting doctor, so the Senior House Officer, the Clinical Assistant etc.

DC YATES So, and am I right in thinking that the doctor fills out one half of a page and the rest is for the administration of the drug?

REID That's right, yes, the recording of administration.

DC YATES Which the nurses do.

REID Nurses do.

DC YATES Yes. What was the, what was the prescribing policy at the Gosport War Memorial Hospital? Was there a prescribing policy?

REID Not that I'm aware of at that time.

DC YATES Right. What medicines and drugs were prescribed to Mr PACKMAN?

REID At Gosport?

DC YATES At Gosport.

REID Would you, how do you want, do you want to start in chronological order or from the prescription sheet?

DC YATES Take it from the prescription sheet it will probably easier to follow later wouldn't it.

REID Right, okay. Well if you turn to the sort of, to page 168 which is the once only medications.

DC YATES Yeah.

REID And the first drug that's prescribed is Aloperimide and I think that's 2 milligrams, I think these are a 2 milligram tablet, the route I think is PO for oral and the dose is 2. Aloperimide is usually used to treat Diarrhoea. Do you want me to keep going through them?

DC YATES Yes please, yeah so on the 25th of August ...

REID Yeah at, whatever I can't, I'm not quite sure what the time is but ...

DC YATES ... yeah that's alright.

REID ... then the 26th of August 1999 at 1800 hours, Diamorphine 10 milligrams is muscularly prescribed on the basis of a verbal message from Doctor BARTON and then I'm not sure whether it's the 27th or 28th a similar dose was prescribed ...

DC YATES 28th it looks ...

REID ... right but there's no time against that.

DC YATES ... yeah, that's Diamorphine?

REID Yeah. Then going down the as required prescriptions ...

DC YATES Yeah.

REID ... there's a Alivine Dressing which is applied to skin, presumably to wounds, Mepitol dressing to wounds. Gaviscon which is used for indigestion, which was given once on the 25th of August at midday (1200) and then Temazepam 10-20 milligrams orally, one or two tablets, which is 10 or 20 milligrams, prescribed on the 24th of August, given on the 24th of August at 2210 and the 25th of August at 2205. 10 milligrams the first time and 20 milligrams on the second occasion.

DC YATES And what is Temazepam for?

REID Sorry it's a sleeping tablet and the next page I've got is just exceptions to ...

DC YATES Yes, no.

REID ... okay. Then the next page, page 170 is Doxazosin 4 milligrams. That's a drug which is used to treat high blood pressure and that was administered well from the 24th through to the 31st and was omitted on the 1st of September. Similarly with Frusemide 80 milligrams administered from the 24th through to the 31st. Clexane which is an injection, subcutaneous injection, administered twice daily from the 24th and the morning of the 25th. Paracetamol 1 gram, four times daily, started on the, or continued from the 23rd. Then a sort of topical cream, I'm not quire sure what 50/50 cream is for. Then it's Magnesium Hydroxide to be given by mouth, 10 mils, twice daily and that was given intermittently.

DC YATES Right so just quickly then that's Dox ...

REID Doxazosin, yeah.

DC YATES ... and what's that for the treatment of?

REID Blood pressure.

DC YATES Frusemide?

REID Usually for the treatment of heart failure or ankle swelling.

DC YATES Like a diuretic of some sort, yeah.

REID Clexane is to prevent clotting. Paracetamol is pain killer. Magnesium Hydroxide is for constipation, laxative.

DC YATES So he's suffering, possibly then, you would assume with his bowels anything from constipation to diarrhoea?

REID Yes and there's just the one dose of Aloperimide given ...

DC YATES On the 25th.

REID ... on the 25th.

DC YATES Yeah.

REID And you know the Magnesium Hydroxide was withheld for several days after that and then given again.

DC YATES Yeah. Okay. Now daily review prescriptions ...

REID Mm, mm.

DC YATES ... that's actually still under regular prescriptions isn't it?

REID Yeah and so regular prescriptions, Metaclopromide 10 milligrams intramuscularly every 8 hours, a verbal message.

DC YATES What's that for?

REID It's for nausea and vomiting.

DC YATES Right.

REID And that was administered twice on the 25th and the 26th. Aloperimide again is, was again written up presumably for, about three doses of it, presumably following an episode of diarrhoea and then it was stopped and then Oramorph was written up, oral solution 10 milligrams, four hourly on the 26th of August but the patient doesn't seem to have received any.

DC YATES Why would that be the case doctor?

REID — Well I can't think why if it's written in the daily review section, um, I mean the only, the only reason I can think of is that ...

DC YATES — Well on the 26th, all the drugs have been ...

REID — ... where it's on the, on the prescription sheet that's in the reverse, could, if you, could you give me a ...

DC YATES — ... look at ...

DC Code A — Which book is it?

REID — ... it's, no it's just a blank prescription sheet.

DC YATES — ... sorry have you got a blank prescription sheet?

DC Code A — Yeah.

REID — So that's written on there. The way the drug charts were laid out was it's a plastic three section folder like this, so you opened the thing up ...

DC YATES — Yeah.

REID — ... you could see this and it was enclosed by some transparent covers here. So with something written on there someone might not have turned over the page to look at it.

DC YATES Yeah.

REID I mean that's a, I mean I'm only speculating but it seems a bit strange that it was given in a, I can't explain that and then followed on by Diamorphine 40-200 milligrams subcutaneously in 24 hours. Written up on the 26th but doesn't look as though it was given until the 30th and then on the 31st and then the 1st when the dose was discarded at 1915 and replaced by 60 milligrams and then it was further increased to 90 milligrams on the 2nd of September. The next, and Diamorphine as you're aware is an analgesic. Midazolam is a sedative written up on the 26th in a dose of 20-80 milligrams subcutaneous in 24 hours. I mean I'm speculating here that the first dose of 20 milligrams was given on the 30th at the same time as the Diamorphine above. Do you follow?

DC YATES Yeah.

REID And ditto the 20 milligrams on the 31st and then 40 and 60 milligrams on, or 40 milligrams initially on the 1st and then increased to 60 milligrams later on that day, 80 milligrams on the 2nd. Then moving over the page and I supposed this might be the reason why the, that sort of, Oramorph wasn't given earlier because it's written up under regular prescription chart, 10 milligrams in 5mls, to be given orally, 10-20 milligrams four hourly and prescribed at 6.10, 2 o'clock and 6 o'clock which the patient receives for three days from the 27th and in addition a 20 milligram dose at night time at 2200 hours which is administered from the

26th. So I don't know why that daily review of the Oramorph on page 171 was written up and then Hyoscine has also been prescribed with a dose of 800 micrograms to 2 milligrams subcutaneously in 24 hours, written up on the 2nd of September but never administered.

DC YATES — Why are those ranges of drugs prescribed? For instance Diamorphine 40-200 milligrams I should think that is?

REID — Well I think as we've discussed before in the, in the immediate sort of non availability of sort of medical staff it would allow the nursing staff discretion to increase the dose.

DC YATES — Well taking that as a particular example, the Diamorphine 40-200 milligrams is that …

REID — It's too large a range.

DC YATES — … too large a range?

REID — Yes.

DC YATES — When you're doing your rounds do you check and read through all the prescription sheets?

REID — Usually I do.

DC YATES — If you'd noticed this would you have left it 40-200 milligrams?

REID — Well I mean I noticed that I did see the patient on the 1st of September when this prescription was (inaudible) and I don't remember noticing it so I can't say what my thoughts were at the time but I think at that time the patient was either on 60 or 90 milligrams so it may have been that I felt that you know in the near future the patient might need that sort of dose but I don't think it was appropriate at the time the prescription was written.

DC Code A — But when you saw the patient on the first …

REID — Yeah they were taking …

DC Code A — … it was 40.

REID — … 40 milligrams.

DC Code A — Yes.

REID — Yeah.

DC YATES — So …

REID — No …

DC Code A — Was it not?

REID — … was it, I thought it was 60, 60 mill …

DC Code A — It was 40 and then it was discarded.

DC YATES — ... and it went up to 60.

REID — And then it went up to 60.

DC Code A — And then later that evening it went up to 60.

REID — Yeah okay I mean with hindsight I should have ...

DC Code A — What time was your ward round doctor?

REID — ... well I would think it was almost certainly in the afternoon. Usually it was, if it was a Monday it was usually afternoon.

DC Code A — And the dose was increased at 1915 wasn't it?

REID — Yes, that ...

DC Code A — Yeah so that was way after your ward round then wasn't it?

REID — ... yes, yes.

DC Code A — Yeah and your ward round states that the patient was rather drowsy doesn't it?

REID — Yes it does.

DC Code A — Yeah, okay.

DC YATES — I mean what are the, for instance what are some of the side effects of Diamorphine?

REID — Well drowsiness, nausea, vomiting, constipation, respiratory depression.

DC Code A — Does confusion come into that as well?

REID — It could do.

DC YATES — Well accepting that these are what you call common side effects, is it that the intention when giving a patient diamorphine that you make them drowsy?

REID — No.

DC YATES — Is the intention to relieve the pain?

REID — Relieve the pain or distress the patient's suffering.

DC YATES — So am I right in thinking a patient is drowsy may be an indicator that the dose is slightly high?

REID — Yeah it might be.

DC YATES — What is a proactive prescribing policy doctor?

REID It's prescribing in the event that a patient may develop something or if, it can also be I think applied to, writing up a variable dose. So that if someone gets more pain or more uncomfortable, whatever the dose could be increased so they don't need that particular dose at the time but might require it at a later stage, that's my understanding.

DC YATES But, so the proactive prescribing policy is, your understanding is that is prescribing in a case that a patient may need a particular drug?

REID Yeah.

DC YATES An example I give, which is probably totally the wrong example but if I'd just come out of an operation amputated leg shall we say ...

REID Yeah, you ...

DC YATES ... you're going to know it's going to hurt when I wake up ...

REID ... yes so you prescribe proactively.

DC YATES ... proactively but at the time I possibly might not need it because I'm still under the influence of anaesthetic of whatever.

REID Yes, yeah and that would be good practice ...

DC YATES Yes, yeah.

REID ... because you'd tried to avoid something.

DC YATES The variable, the other one is a variable policy ...

REID Dose.

DC YATES ... and that's the ranges is it?

REID Yes.

DC YATES And so what is the purpose behind a variable dose?

REID Well it's to allow nursing staff the flexibility in terms of if a current dose isn't relieving patients symptoms to increase the dose.

DC YATES I'm sure we'll move on later, shortly on how doses can be increased and what the recommendations are but allowing a variable dose of 40 to 200 milligrams, Diamorphine in this case, is that, is that necessary?

REID I think we sort of covered this ground last time, I think no it isn't necessary.

DC YATES Okay. What would you expect a variable dose to be in a case like this?

REID — I think it's very difficult to say what I would've expected at the time but prob..., cos things have moved on a long way since then but I mean I would've thought something like, if a patient was, if 40 milligrams was an appropriate starting dose, at that time I would've thought something like 40-80 would've been an appropriate sort of variable dose prescription. That wouldn't be acceptable now.

DC YATES — Right. So I think some, some people seem to get the two types of prescribing policies confused and, the proactive and the variable policies and call one the other. How do they come about? We'll start with the proactive policy then which is prescribing in case a patient may need a particular medication. How did that policy come about?

REID — I mean that's always been ...

DC YATES — That's always been the case?

REID — ... it's always been the case.

DC YATES — Right, okay and the variable dose then, policy?

REID — Well it's, I mean I'm, I'm not an expert in palliative care and I haven't and I've certainly never worked in a community hospital before and I, I can't recollect using sort of variable dose prescriptions very much before this. I just can't remember.

DC YATES Had you worked in this field, you'd worked in this field before had ...

REID Not in palliative, I hadn't worked in palliative care and where I'd worked before in a community hospital we had Monday to Friday, 9 to 5 medical cover.

DC YATES ... so is the, could it possibly be the fault of the lack of medical cover that this practice ...

REID Yes.

DC YATES ... was in place?

REID Because there wasn't someone there all the time.

DC YATES 9 to 5, 24 hours or whatever?

REID Yes.

DC YATES Have you got CSY/HF/27 Geoff? Policy. It's a very poor copy I must admit, it's a faxed copy. CSY/HF/27, I know you have seen this before because we've shown you. Protocol for the prescription and administration of diamorphine by subcutaneous infusion.

REID Yeah.

DC YATES Prescription, under the heading Prescription, 'Diamorphine may be written up as a variable dose to allow doubling on

up to two successive days, eg, 20- 60', that's been written over it's very difficult to see but it's been cut down by some '... but the reason for prescribing should be recorded in the medical notes'. If I just hand you that.

REID Yeah.

DC YATES And it is difficult to see in parts but do you recognise that?

REID Well I, I think I said last time I recognise these two pages and then you showed me something else later on which is, in a slightly different format and I recognise, obviously the covering letter from me so, I mean I didn't immediately recollect it but um, ...

DC Code A It was the same text wasn't it but it was in a different layout?

REID ... yes a different font and, yeah.

DC YATES Well this is a policy about variable doses, is that right?

REID Yeah well it was a sort of draught ...

DC YATES A draught.

REID ... protocol.

DC YATES And what date was all that?

REID Well the letter, the other exhibit you showed me I think it was a letter from December 1999 asking somebody else to take a look at it.

DC YATES So what spurred you on, or made it necessary to bring this protocol about?

REID Well I think, I think as I've said before a number of things. I mean I was aware of the Gladys RICHARDS complaint and although I hadn't seen the notes I was aware that there were issues around prescribing. In our wards at Queen Alexandra Hospital I think we'd had a complaint about the use of opiates where the problem was related to poor documentation, why the opiates were being administered. SHIPMAN had happened sort of in the Autumn of 1999. The, I think the Chief Medical Officer produced a sort of, or the Department of Health had produced a report which was, and I can't remember what it was entitled, was it called Clinical Governance, which really made it much clearer what sort of health professionals responsibilities were. I became aware that we didn't have a policy in Gosport and I think all of these things together sort of prompted ...

DC YATES I think it's actually only fair to say that because, I mean yes we have spoken on other days about other matters but perhaps we should make it clear during this interview. You had an additional role in 1999 didn't you?

REID ...yes that was as Medical Director of the Portsmouth Health Care Trust.

DC YATES Which is why possibly you would've had these responsibilities of ...

REID Yes, yeah.

DC YATES ... yeah, okay. Can I just have that back.

DC Code A But you did have some concerns about the prescribing in Gosport?

REID Um, I, I don't, I mean I remember speaking to Doctor BARTON about a variable dose prescription and as I remember it was 20-80 and I accepted her explanation for that.

DC Code A Yes.

REID But I don't recollect having concerns in relation to what a patient had received. You know with what dose they'd actually been given by the nursing staff.

DC Code A But you felt it necessary to instigate a policy?

REID Well yes, for all these other reasons.

DC YATES I mean included in this policy though under Prescription is, is one sentence which is quite important. 'The reason for prescribing should be recorded in the medical notes'.

REID Yes.

DC YATES Was that always the case, should be recorded ...

REID Yes.

DC YATES ... in medical notes? And an interesting paragraph under administration. 'If pain has been adequately controlled within the previous 24 hours the nurse should administer a similar dose of Diamorphine over the next 24 hours. If the previous 24 hour dose has made the patient unduly drowsy etc, the nurse should use his or her discretion as to whether the dose to be administered for the next 24 hours can or should be reduced within the prescribed doses regime and if the minimum dose appears to have made the patient too drowsy the on call doctor should be contacted'.

REID Yes.

DC YATES Lots of references to drowsiness. 'If the patients pain has not been controlled a nurse should use his/her discretion as to the dose to be given over the next 24 hours, ie, he or she may administer up to double the previous 24 hours dose'. Which I mean that has been scribbled out by somebody else ...

REID I think Dr VARDON .

DC YATES ... yeah Val VARDON and I think and lowered, is that correct?

REID Yes I think so yes, yes.

DC YATES It's not double the figure it's increased by half isn't it ...

REID Yes.

DC YATES ... is the recommended ...

REID Yeah.

DC YATES ... so if it was 40 it could go up to 60?

REID Yes.

DC YATES Yeah. Now was this document used as policy at the Gosport War Memorial Hospital? I know this came out in 1999 and this came out after Mr PACKMAN.

REID It may, it may have been, it may have been used or the documentation surrounding the charting of the pain may have been used from December 1999 or early sort of 2000 as a sort of pilot. We certainly did try to, I remember we that we tried to pilot on a couple of wards I think, one at QA, about having better documentation around the

administration and I'm particularly thinking about nursing documentation and the reasons why it had been given.

DC YATES That's the infusion of pain control chart ...

REID Yeah.

DC YATES .. and the Diamorphine infusion of pain control chart.

REID Yes that's right.

DC YATES Is there any way that the actual protocol though before agreed and sanctioned it should have made it's way on to the wards.

REID Well it shouldn't have done.

DC YATES So again talking of ranges though, if you, if you're prescribing a range of drugs between, you know even between 40 and 80 what is the purpose of having a doctor on call? If a range of drugs has been given so that the nurses can actually have the ability to make the decision themselves as to where ...

REID Well the nurse might want to phone up the doctor to sort of check that um, that you know that, you know say the patients in control, can I increase the dose to 60 milligrams if she felt uncomfortable about doing that.

DC YATES ... so ...

REID And there's always going to be a need for doctors to respond to other things.

DC YATES ... well turn the question around on itself then, if there is a doctor on call what is the need for prescription dose within a range?

REID Well it's, I mean nurses and nursing policy really prefers there to be a written prescription rather than receiving a verbal order. So that's the thinking behind that.

DC YATES Okay. Can you explain what is meant by telephone prescribing and how it works?

REID Well I'd assume what is meant by telephone prescribing is what we call a verbal order. In other words a nurse phones up the doctor with a problem and the doctor says, could you give the patient such and such.

DC YATES Mm, mm is there a protocol that nursing staff have to follow during that or would you not be ...

REID There certainly is now, there may have been at that time but I couldn't, I'm not sure, I just don't know to be honest.

DC YATES ... okay well what is that protocol now then, what have they got to do now?

REID Oh well there is a protocol but I couldn't tell you what's ...

DC YATES Oh right.

REID ... what's in it.

DC YATES Yeah. Geoff?

DC Code A Well only to say that on the 26th one of the nurses, as a result of Mr PACKMAN not feeling very well, it's page 62 by the way, contacted Doctor BARTON by phone and Doctor BARTON prescribed, I think it was 10 milligrams wasn't it, of Diamorphine?

REID Yes.

DC Code A Which was given at six o'clock ...

REID Yeah.

DC Code A ... and then a further dose I think was, no I'm not sure but I think a further dose was given later on and that was without the proactive prescribing wasn't it?

REID Yes.

DC Code A So that was an example of how pain can be controlled by nurses contacting the doctor ...

REID Yeah.

DC Code A ... and that was part of Doctor BARTON's role.

REID I think there's a lot of reluctance to administer opiates from verbal orders.

DC Code A Well then, and then again later on that day Doctor BARTON came back into the hospital ...

REID No I really meaning in terms of writing up a variable dose prescription. The nursing staff would prefer to have a written prescription rather than to rely on verbal prescribing, particularly diamorphine but obviously in ...

DC Code A ... but then that would go into that conversation shall we call it, of who controls what, what is then administered, when you've got this proactive prescribing policy in place, who controls what is administered?

REID ... well it's the nursing staff.

DC Code A Mm.

REID And that has to be, and that, it's a balance judgement of what of which is better giving verbal orders or you writing up a variable dose prescription. There are advantages and disadvantages to both.

DC Code A Because you, you saw the patient didn't you on ...

REID The 1st.

DC Code A ... the 1st.

REID Yes.

DC Code A And the patient was drowsy, yeah?

REID Yeah.

DC Code A And you must acknowledge ...

BUZZER SOUNDS INDICATING THE END OF THE TAPE

DC Code A ... you must acknowledge that at that time the patient was on a dose of 40, yeah, that afternoon?

REID Yes.

DC Code A And then, but within a short space of time of you leaving the patient ...

REID Yeah the dose has been increased.

DC Code A ... within hours the dose has been increased by, who, was the dose increased by doctor? Turn to page 64 if you will. The top entry is dated the 1st of the ninth and it's signed at the bottom.

REID I don't know who the signature, but it looks, Sister HAMBLIN is it, Jill HAMBLIN?

DC Code A It looks like it to me doesn't it?

REID Yes.

DC Code A So is Sister HAMBLIN using her vast experience and greater experience of, of community care hospital over your experience there?

REID Well I mean she's written 'Diamorphine increased as previous dose not controlling symptoms'.

DC Code A But there's no mention of that in that afternoon's visit is there?

REID No there isn't, no, no.

DC Code A And in actual fact you said that the patient was drowsy.

REID Yes.

DC Code A Okay, Chris.

DC YATES It's not controlling a lot of symptoms really though isn't it?

DC Code A Chris the tape is just coming to an end so we'll have to turn it off.

DOCUMENT RECORD PRINT

DC YATES The time is 1139.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y25T

Enter type: FULL TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 08/08/2006

Time commenced: 1142 Time concluded: 1216

Duration of interview: 34 MINUTES Tape reference nos. (→)

Interviewer(s): DC Code A / DC Code A YATES

Other persons present: MR CHILDS, SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	Right this is a continuation of the interview with Doctor Richard REID. The time by my watch is 1142 hours. Doctor just a brief break while we changed the tapes. Can you confirm that it's the same person present?
REID	Yes.
DC YATES	And that you haven't been asked any questions while the tapes have been off?

REID No.

DC YATES Thank you very much. We were just, well DC Code A had just pointed to page 64, an entry by Sister HAMBLIN on the 1st of September, which is the day that you visited the patient, is that correct?

REID Yes.

DC YATES And she has actually increased the dose from 40 to 60 milligrams.

REID Yes.

DC YATES Because the pain hasn't been controlling the symptoms.

REID No the symptoms haven't been controlled.

DC YATES Yeah, what symptoms is she talking about?

REID I don't know.

DC YATES Because she hasn't recorded it. Yet when you saw the patient, which was the afternoon I believe wasn't it?

REID Mm, mm well on the, well probably the afternoon, I'm assuming it was a Monday.

DC YATES Yeah. You've actually used drowsy.

REID Yes.

DC YATES Which is quite often a side effect of too much Diamorphine?

REID Well it could be but I think I would have to say that sometime to get people pain free they actually are drowsy.

DC YATES So it's a bit of a ...

REID Balancing act.

DC YATES ... grey area, balancing act?

REID Yes.

DC YATES Which brings me back to the fact then because of the variable prescription and it is a complicated judgement call, made by doctors, a sister has been allowed to just up the dose by half again and again no explanation in the notes as to why, other than 'Not controlling symptoms'.

REID Symptoms, yeah.

DC YATES But the patient was drowsy earlier on.

DC Code A And you've actually, in your entry of the 1st of the ninth, you've actually put 'Rather drowsy but comfortable'.

REID 'But comfortable'.

DC Code A — So that isn't an indication that there's ...

REID — Well certainly not at the time that I saw the patient.

DC Code A — ... but Sister HAMBLIN saw the need to increase the dosage within a few hours of you seeing the patient.

REID — Yeah.

DC Code A — Yeah. So you've already said that you're not, you weren't, I think you're saying you're not an expert now but you weren't an expert then in palliative care?

REID — I certainly wasn't, no.

DC Code A — No?

REID — No.

DC Code A — And you weren't experienced in that type of hospital work?

REID — No, no.

DC Code A — No. Were you comfortable about being in the Gosport War Memorial Hospital at that time?

REID — Yes.

DC Code A — You were?

REID Yes.

DC Code A Yeah. Why was, why were you comfortable being there?

REID Um, well I felt that I, I mean I trusted, I felt that Doctor BARTON provided good care to the patients and that I trusted the nursing staff, I thought they were well motivated. I'd had patients best interests at heart.

DC Code A Any other reasons for this trust in the other medical staff there?

REID No.

DC Code A Did you not tell us earlier on that Doctor BARTON, I don't mean earlier on today but I mean in a previous interview, Doctor BARTON was, I'm not sure of the correct, the right words to use but it was more or less along the lines of she was at least as experienced as you were ...

REID Yes.

DC Code A ... possibly more?

REID Yes.

DC Code A Yeah and, and was that the case with some of the nursing staff as well about their experience of caring for those sort of patients?

REID Oh certainly in terms of certain cases, long term nursing conditions, pressure sores, they knew far more about it than I did.

DC Code A And would that have been obvious to the other staff in the hospital when you went there that that they had more knowledge of these things?

REID Oh certainly know more about nursing matters than I did.

DC Code A And what about Doctor BARTON would she have been aware that she had probably more experience of this type of care than you did?

REID Oh yes, yes.

DC Code A Yes. So did they ever acknowledge that to you? Do you know what I'm saying, if I move ...

REID (Inaudible).

DC Code A ... if I move from one post to another within my job ...

REID Yeah.

DC Code A ... I'm a Det..., let's say for arguments sake I'm a Detective Sergeant and, or a Detective, yeah Detective Sergeant and I move into another department that I'm not familiar with, maybe fraud investigation or something like

that and it quite often for a Detective Constable to give me advice on experience ...

REID — Yeah.

DC Code A — ... and say "Look I'll show you want to do" even though ...

REID — Yes, yeah.

DC Code A — ... I'm his senior officer.

REID — Yes, yeah, yeah.

DC Code A — Above him in rank that he would show me, was that happening at the Gosport War Memorial Hospital?

REID — Well I mean I was happy to, I mean I was very happy to rely on Doctor BARTON's sort of knowledge and experience.

DC Code A — Yeah and you did did you?

REID — Yes.

DC Code A — Yeah and did that reliance go on to the nursing staff as well, you trusted ...

REID — Oh yes, definitely ...

DC Code A ... what they were doing?

REID ... yeah.

DC Code A Yeah.

REID Definitely.

DC Code A So could this have then been a reason why Dr HAMBLIN took it upon herself to increase that dosage to, by half again even though you had already seen the patient shortly before and hadn't seen any need to increase the dosage, you were saying the patient was comfortable?

REID So are you saying that Sister, because I if you like, might've acknowledged that she and Doctor BARTON were more experienced at this than I was that this gave her sort of freedom to ...

DC Code A Well she was comfortable within that probably ...

REID ... to do what she wanted.

DC Code A ... was she?

REID Was she, sorry was she comfortable ...

DC Code A She, did she feel comfortable in her role in that case?

REID ... I think so yes, yeah as Ward Sister, yes I mean I think she was, I think she's a very caring Ward Sister and I think she enjoyed nursing patients with no pressure sores and you know patients who need a lot of nursing care.

DC Code A But you are a doctor, yeah?

REID Mm, mm.

DC Code A And you're a consultant, yeah?

REID Mm, mm.

DC Code A You prescribe drugs and see over the administration of them, yeah and do you think that she felt she knew more about that drug and that patient than you did?

REID Oh I wouldn't like to say that.

DC Code A But it's there in black and white isn't it that she actually ...

REID Yeah.

DC Code A ... increased the dosage after you'd ...

REID Yes.

DC Code A ... seen the patient and felt no need to increase the dosage?

REID — Yeah well I mean patients, I mean a patient's condition can change in the space of a few hours, so it's, I mean it's not out of the bands of possibility that the patient's condition changed and that you know did need more sort of Diamorphine and Midazolam and I just can't, I can't say.

DC Code A — No, no now I'm not saying that you haven't been honest with us because you have and you've been very helpful but tell the truth and is it the situation that Doctor BARTON and Dr HAMBLIN were actually running that ward and was it hard for you to break into that?

REID — Um, ...

DC Code A — You described them once as formidable didn't you know what I mean you?

REID — ... yes I'd certainly picked up the sort of vibes that, if you like, they knew what they were doing, this is how they managed patients on that ward and as I've said already I trusted both Doctor BARTON and Sister HAMBLIN and the nursing staff and I think there's no doubt that that sort of influenced me that they'd been doing this for longer than I had been and it seemed to be established practice and yes that was the situation..

CHILDS — I suppose the question is taken one stage further, did you see any evidence that they were actually ignoring your clinical opinion?

REID — Well I can't ...

DC Code A — Well I ...

CHILDS — I've stretched too far but I think that's what you're getting at really isn't it?

DC Code A — ... well you haven't stretched it too far but that is the question that we might ask of you then in this case, especially in this case.

REID — ... yes.

DC Code A — Do you think that was the situation in this case, in this particular (inaudible).

CHILDS — I suppose really ...

REID — (Inaudible).

CHILDS — ... I'm saying did you have any evidence, I mean we can obviously sit and look at the notes all day and see what may have happened but I mean whilst you were there did you think to yourself they're ignoring my clinical opinion?

REID — I can't say I thought that.

DC Code A — Well going on a similar line then, you've already spoken to DC YATES in the last interview, last tape I believe where

you've agreed that that range of Diamorphine was too great wasn't it?

REID — Well I questioned you know the variable dose prescription and Doctor BARTON's response and if I remember Sister HAMBLIN was there at ...

DC Code A — Was that in particular, in relation to this case?

REID — ... I can't remember who it was in relation to.

DC Code A — Because if you remember we had this conversation in another interview.

REID — Yeah.

DC Code A — Yes, so this is the second ...

REID — I remember being in one conversation with Doctor BARTON about variable dose prescribing and I can't remember who it was. I've honestly no idea which patient it was.

DC Code A — ... so you've had the conversation once but what I'm saying is if it's happened at least twice ...

REID — Twice.

DC Code A — ... and we've shown you it twice, yes?

REID Yes.

DC Code A You've only mentioned it once.

REID Yes.

DC Code A So ...

REID But I don't know when that conversation took place.

DC Code A ... but what I'm saying is if, if at the time on this patient ...

REID Mm, mm.

DC Code A ... it would appear then at least on one of these patients you've not mentioned the 200 milligrams at all have you?

REID To Doctor BARTON?

DC Code A Yeah.

REID That's right, yes.

DC Code A That is right isn't it?

REID Yes it is right.

DC Code A So it's either this patient or the patient we dealt with last time, which was Enid SPURGIN who we mentioned earlier?

REID Yeah.

DC Code A Yeah?

REID Mm, mm.

DC Code A But in the case of Enid SPURGIN you did actually decrease the dose?

REID The dose, yes.

DC Code A So is that one the likely one that you probably spoke to Doctor BARTON about?

REID I don't, I don't know, I just don't know. I can't recollect. I honestly can't.

DC Code A Okay. Okay.

DC YATES Administration of drugs, who administers the prescribed drugs?

REID The nursing staff.

DC YATES And what training do the nurses have in the administration of drugs?

REID I don't know but they get training.

DC YATES Can any level of nurse administer drugs?

REID Only registered nurses.

DC YATES Okay. There's a drug register on the wards is that right?

REID Yes.

DC YATES What is the purpose of that?

REID It's to, well it's to keep the records of the sort of stock and issue of controlled drugs.

DC YATES Okay. Syringe drivers, right the use of syringe driver is that normally dictated by a doctor?

REID Well I mean I think it would normally be a sort of consensus decision but the nursing staff would, well it has to be written up by a doctor.

DC YATES Yes.

REID So, well that would probably be on the basis of the nursing staff saying, well Mrs so and so is finding the injection distressing or the patient's very drowsy to take oral medica..., that sort of conversation.

DC YATES Yeah cos there are different reasons aren't there for deploying a syringe driver like the one's who can't take an oral dose and ...

REID Yes, yeah.

DC YATES ... okay. What training had you had in the use and deployment of syringe drivers?

REID Well as, none.

DC YATES And did you ever set them up?

REID No.

DC YATES Okay. What is a syringe driver?

REID It's a device which delivers a constant rate of drug to a patient either sort of under the skin or into a vein.

DC YATES So why, why are they used? What are the benefits of it?

REID Well patients who may not be able to take medication by mouth and if a patient symptoms have only been controlled by Diamorphine say such that it's making them drowsy and that does happen and maybe you know patient preference, they prefer this than having repeated injections or tablets and this also enables the blood levels of the drug to be kept sort of fairly constant so in comparison to taking it by mouth where you get, the level rises high and then drops down again and when it rises high that may make a patient drowsy or it may make them sick or whatever and by delivering it at a constant rate you may avoid these problems.

DC YATES Right, that's explained quite a few questions that one. Are there different types and styles of syringe driver?

REID Yeah there are two, well there were, to the best of my knowledge there were two types of syringe drivers which were deployed in Portsmouth Health Care Trust.

DC YATES What was the difference between them?

REID Well it was, one delivered in milligrams per minute and the other in mils per hour, which is just a recipe for ...

DC YATES Oh right.

REID ... I don't know whether both types were available in Gosport, I couldn't say that but I know that as Medical Director across the Trust we'd had a problem with this so we standardised in one type.

DC YATES Right. Who prepares the drugs for the administration of a syringe driver?

REID The nursing staff.

DC YATES It's down to the nursing staff again is it, right. So why in this case was Mr PACKMAN given drugs by way of a syringe driver?

REID — Presumably because, I mean presume because he was, he was drowsy and it had taken that sort of level of Diamorphine to control his symptoms.

DC YATES — So are you saying it's another way of ensuring a patient, if a patient is going to receive a, higher doses then a syringe driver is possibly the better way of ...

REID — Yes.

DC YATES — ... of um, ...

REID — If you need large doses then it's obvious repeated injections are painful.

DC YATES — ... because, the thing is Geoffrey PACKMAN was still able to take oral medicine at the time wasn't he, he was given pills of Oramorph ...

REID — Yeah.

DC YATES — ... and, in fact why wasn't he given Oramorph continually or given Oramorph?

REID — I mean I, I can't answer that, I mean it says that he slept for long periods of time on the 29th, condition remains sort of poor and syringe driver commenced. So it may have been because he was you know sort of intermittently ...

DC YATES — Drowsy.

REID ... up and down.

DC YATES Why isn't there an entry on the medical records that a syringe driver was now deemed necessary?

REID Well I can't, I can't answer that.

DC YATES I mean is this a significant change in the patient's treatment and ...

REID Yes I, in general terms I think, in general terms it's a change in the patient's condition.

DC YATES ... so who has actually deemed a syringe driver necessary?

REID Well I think it would be I'd have thought a sort of combination of sort of decision between as I say the nursing staff who are looking after the patient and you know the doctor.

DC YATES Right again there's nothing recorded on the medical notes to say ...

REID No there isn't.

DC YATES ... did Sister HAMBLIN prescribe drugs?

REID Well she's, nurses aren't allowed to prescribe drugs.

DC YATES — Right. Because a there is an entry in the nursing notes as we've seen that a syringe driver is being used.

REID — Mm, mm.

DC YATES — Mm, Geoff.

DC Code A — Yeah because, who actually prescribed the syringe driver in this case Dr REID?

REID — Well the prescriptions, Doctor BARTON prescribed the syringe driver.

DC Code A — And what was the date of it Doctor?

REID — It was written on the 26th but as far as I can see it was, looks as if it was started on the 30th because of …

DC Code A — So if you look at page 55 …

REID — … mm, mm.

DC Code A — … please.

REID — Yes.

DC Code A — And can you read that entry from Doctor BARTON there on the 26th?

REID Yes. 'Called to see, pale, clammy, unwell, suggest query MI stat dose or Diamorph and Oramorph overnight. Alternative possibility GI bleed but no Haematemesis. Not well enough to transfer to QA. Keep comfortable. I am happy for nursing staff to confirm death'.

DC Code A So there's no mention of the syringe driver there is there?

REID No there isn't.

DC Code A And her next entry is the 28th.

REID Yes.

DC Code A And what does that say?

REID 'Remains poorly but comfortable, please continue opiates over weekend'.

DC Code A Okay and if I ask you to turn to page 63 please, so there's no mention of a syringe driver there either is there?

REID No there isn't.

DC Code A If you turn to page 63.

REID Yes.

DC Code A And if I direct you to the 30th of the eighth ...

REID Yes.

DC Code A ... which is about two thirds of the way down.

REID Yes.

DC Code A Can you read that entry please?

REID 'Condition remains poor, syringe driver commenced at 1445 with Diamorphine 40 milligrams, Midazolam 20 milligrams. No further complaints of abdominal pain. Very small amount of diet taken, mainly puddings. Re-catheterised this afternoon ...' ...

DC Code A Draining is it?

DC YATES Draining?

REID ... I don't know what, yeah, draining the catheter, '... when possible encourage fluids. Dressings also renewed'.

DC Code A And who do you think signed that one doctor?

REID That looks like Sister HAMBLIN's writing.

DC Code A It does doesn't it?

REID Yes.

DC Code A So shall we go through that entry a little bit here?

REID	Okay.
DC Code A	Okay. Condition remains poor.
REID	Yeah.
DC Code A	Syringe driver commenced at 1445.
REID	Yes.
DC Code A	At 40 milligrams. What was the prescription on?
REID	40 milligrams.
DC Code A	Yeah but what was the prescription written?
REID	40-200.
DC Code A	Was it 40?
DC YATES	40 – 200, yeah.
DC Code A	Yeah, okay. So she started at the lowest didn't she?
REID	Started at the lowest dose, yeah.
DC Code A	But she doesn't seem to have discussed this with any doctors does she?

REID No. Well there's no record of that.

DC Code A No and this was from a prescription that had been written up two days previous.

REID Four days previously.

DC Code A Four days previous, yes?

REID Yeah.

DC Code A Yeah and 'No further complaints of abdominal pain'.

REID Yeah.

DC Code A So the patient was obviously, before she gave him the syringe driver it appears that he may been complaining about abdominal pain.

REID Yes.

DC Code A Yeah. 'Very small amount of diet taken'.

REID Yes.

DC Code A So he's eating?

REID Yeah.

DC Code A Yeah. Mainly puddings?

REID	Mm, mm.
DC Code A	Yeah?
REID	Uh, huh, mm, mm.
DC Code A	So he's able to swallow then isn't he?
REID	Yes.
DC Code A	'When possible encourage fluids'.
REID	Mm, mm.
DC Code A	So he's obviously drinking as well.
REID	Yes.
DC Code A	Yeah and again this is Sister HAMBLIN again and she is the one who has made the decision to start a syringe driver isn't she?
REID	Well ...
DC Code A	It's been prescribed ...
REID	... it's been ...

DC Code A ... but she's the one who's made, it, from this it looks as if she's made the decision doesn't it?

REID ...yes.

DC Code A There's an absence in the records of any doctor's input there isn't there?

REID Yes there is.

DC Code A Yeah. In fact I think on the same date it looks like she's written an entry in the, in the clinical notes, doesn't it?

REID Yeah '... re-catheterised, barred, pre-filled, size 14...', that's the size of the catheter, '... reference ...', something or other, '... lot ...' something or other.

DC Code A Why would she have written that into the clinical notes?

REID I haven't the faintest idea.

DC Code A Cos that page is for ...

REID Medical notes.

DC Code A ... medical notes isn't it, it's not for nursing staff is it?

REID No, no.

DC Code A It's not where she should be recording things is it?

REID No. No it's not, no.

DC Code A It's not, so here we have the sister who's making big decisions isn't she? It is a big decision isn't it?

REID To commence the syringe driver?

DC Code A Syringe driver, yeah.

REID Mm, mm.

DC Code A Yeah and for some reason she's actually writing in the clinical notes now as well.

REID Yes.

DC Code A Why do you think that was then?

REID I haven't the faintest idea.

DC Code A No.

REID It seems a very strange thing to do.

DC Code A It does doesn't it. But she did rule the ward though didn't she?

REID Um, she was a strong personality.

DC Code A — And she spent more time on the ward than you did ...

REID — Oh yes.

DC Code A — ... and she spent more time on the ward than Doctor BARTON did?

REID — Yes.

DC Code A — She was Ward Manager wasn't she?

REID — Yes.

DC Code A — Strong personality. Okay Chris.

DC YATES — How we doing for tape times?

DC Code A — Twenty three.

DC YATES — Have you got anything more else to ask about that?

DC Code A — No.

DC YATES — Oramorph then, why was Oramorph prescribed? Why would it be prescribed?

REID — For pain or distress.

DC YATES — Okay now looking at the, the prescription sheets etc, why and when was this drug administered?

REID — Why and when? Oramorph was, pardon me, prescribed on the 26th of August in two dose strengths of 10 milligrams and up to 20 milligrams four times daily and then 20 milligrams at night. That was first administered on the 26th, which was the day Doctor BARTON made a note to the effect that the patient was cold, he was pale, clammy, unwell etc, ? MI, Myocardial Infarction, heart attack and my presumption is that Doctor BARTON felt this patient was sufficiently distressed by having a possible heart attack that the administration of Oramorph was necessary.

DC YATES — Right, but it's just, I think we'll always come back to ask these questions but why was no other form of pain killer prescribed as an alternative to Oramorph

REID — Well you have to make a judgement at the time you see a patient about where to start and (inaudible).

DC YATES — Right and you've just been referring to page 172 haven't you doctor?

REID — Mm, mm.

DC YATES — Why has a range of 10 milligrams to 20 milligrams been prescribed?

REID — Um, ...

DC YATES — Of Oramorph?

REID ... well I'm only surmising but this was a very, he was a very big gentleman so Doctor BARTON may have felt concerned that 10 milligrams wouldn't be enough.

DC YATES Does that, does that go hand in hand then the the larger a person is the more, immune is the wrong word, but more resilience he'd have to a pain killer?

REID Well I mean I'm not an expert but I would say probably yes. You know a frail old lady, a little lady you'd certainly give less to than some others.

DC YATES Would anything else have a bearing on, you know resistance to something like Oramorph?

REID Well you know renal function etc, can have a bearing on it, kidney function.

DC YATES Yeah and opioid naive as well I suppose, not being used to it?

REID Yes, yes.

DC YATES One of the side effects of, oh no we'll go onto that later otherwise I'm just going to confuse it all by jumping on. So in a nutshell then you're saying that a decision has to be made by the doctor, a judgement so to speak, as to ...

REID What an anal ..., ...

DC YATES ... what an appropriate analgesic would be?

REID ... yes.

DC YATES Geoff have you got anything on that one?

DC Code A Sorry?

DC YATES Obviously not Midazolam, what is Midazolam?

REID It's a sedative.

DC YATES It's a sedative and why was it used in relation to Mr PACKMAN?

REID Well there's no, I'm just trying to see when it was first administered, I think probably the 30th. Presumably because he was agitated and stressed and that's the sort of indications for it. It's for mostly mental agitation rather than physical pain.

DC YATES Well this is a good example of why keeping good clinical notes could be really handy though isn't it?

REID Yes, absolutely.

DC YATES And what I'll, I mean I'm sure I'll be right in thinking that attending a hospital once a week as a consultant, you're almost left in the same sort of position. If there's no one

there to ask you haven't a clue what's been going on, have you?

REID — Well there's the nursing staff there.

DC YATES — Nursing staff are there to ask, yeah. What, are there any other forms of sedative that could've been used?

REID — Oral sedatives?

DC YATES — Any oral sedatives?

REID — Yes.

DC YATES — I mean, well this particular drug appears and I'm talking as a layman here but it appears to be commonly used in patients at the terminal end of an illness.

REID — Yes.

DC YATES — Is this why this drug was prescribed on this occasion?

REID — Is this why, well I mean it may well be that at, you know by the stage that that was, well written up, either prescribed or administered that it was felt that Mr PACKMAN was in the last few days or hours of life.

DC YATES — Okay. How would you determine how much Midazolam to prescribe?

REID I'd look at the BNF.

DC YATES Which we've covered before. Again there's the range of parameters for the administration of this drug, I think it's 20 to 80 in this case isn't it?

REID Yes.

DC YATES What is the purpose of that?

REID Well again it's to allow nursing staff discretion if patient's symptoms aren't relieved by the sort of, at the starting dose.

DC YATES But it always, each time we come onto this subject of this range, we almost always, well I will almost always say, how do the nurses know where to start giving this range?

REID Well as I've said before I would expect nursing staff to start ...

DC YATES Start at the bottom.

REID ... at the lowest.

DC YATES Well they don't always do that do they?

REID Well they should do unless there's, you know documented reason why.

DC YATES So where is it recorded in the medical notes, the prescribing instructions to the nurses saying, here's the range start at the bottom?

REID There isn't I mean as I ...

DC YATES Would you expect there to be?

REID ... no I would expect nurses always to start with the smallest ...

DC YATES Okay.

REID ... dosage range and if they didn't administer that then to record why they'd done that as amendment.

DC YATES So how, so on a range of drugs, the nurses start at the bottom and it's not working, so they decide to increase it, where's the guidance for them on how to increase it?

REID There isn't.

DC YATES So how are they expect to know? Would they refer to the BNF or ...

REID Well the BNF doesn't give much guidance so what one would be looking to nurses who are used to doing this, using their own experience.

DC YATES ... so, right. So they would follow the normal policy would they of, of increasing it by half ...

REID Well what had, ...

DC YATES ... or ...

REID ... been practised within the environment in which you were working.

DC YATES ... mm. Right are, were there any safeguards in place to ensure that Geoffrey PACKMAN didn't receive an excessive dose of Midazolam? Be it in any instructions or ...

REID Well there aren't any instructions in the notes.

DC YATES ... correct me if I'm wrong but I think the prescribing guidelines suggest a range starting at about 5 milligrams a day?

REID Of?

DC YATES Of Midazolam.

REID I thought it was, I thought it was 20 ...

DC YATES I might well be wrong.

REID ... and exceptionally in elderly people, 10 milligrams and I mean this is obviously, I mean I don't know what it said back in 1999.

DC YATES Yeah.

REID I think it's actually, it's, look it's not, I think that it's mentioned at the front of this under, under another section Midazolam is a sedative, an anti epileptic, dosage for a very restless patient, it is given in a subcutaneous infusion dose of 20-100 milligrams over 24 hours.

DC YATES Mm, mm. Thank you doctor, answers that doesn't it. Any questions you want to ask in relation ...

DC Code A No I don't think so and it's 33 minutes, or 35 minutes Chris.

DC YATES Is it?

DC Code A Yeah.

DC YATES I won't go onto the next then. What we'll do now then doctor is we'll take a break for ...

REID Okay.

DC YATES ... half hour or so I think. Get a bite to eat, stretch your legs and then continue. The time by my watch is 1216 hours and I'm turning the recorder off.

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RECORD OF INTERVIEW

Number: Y25U

Enter type: FULL TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 08/08/2006

Time commenced: 1307 Time concluded: 1349

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

Interviewer(s): DC2479 Chris YATES / DC Code A

Other persons present: Mr CHILDS - Solicitor from Radcliffes, Le Brasseur in London

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded, I am Detective Constable 2479 Chris YATES from Hampshire Major Crime Department. My colleague is?
DC Code A	DC Code A
DC YATES	I am interviewing Doctor Richard Ian REID. Doctor could you please give your full name and your date of birth?

REID — Richard Ian REID, date of birth Code A

DC YATES — Thank you. Also present is Mr CHILDS who is Doctor REID's solicitor. Could you please introduce yourself?

CHARLES — Oh yes Will CHILDS from Radcliffes, Le Brasseaur in London.

DC YATES — This interview is being conducted in an Interview Room at Fareham Police Station, Hampshire. The time is 1307 hours and the date is Tuesday the 8th of August 2006. At the conclusion of all the interviews I'll give you a notice explaining what will happen to the tapes as we've finished them all. Again I'll remind you doctor that you are still entitled to free legal advice, you have Mr CHILDS here with you. Have you had enough time to consult with him?

REID — Yes thank you.

DC YATES — If at any time you want to stop the interview to take advice just say so and we'll stop the interview in order for you can do this.

REID — Thank you.

DC YATES — Again I'll point out that you've attended voluntarily, you're not under arrest and so at any time you wish to leave you are free to do so. Again I'll caution you, 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 and anything you do say may be given in evidence. Do you understand that caution?

REID — Yes.

DC YATES — I broke it down earlier,...

REID — Yes.

DC YATES — ...but you're happy with it are you?

REID — Yes I'm happy about it.

DC YATES — Again the room can be monitored. If that red light's on it's being monitored, it should be Detective Inspector GROCOTT listening in. If we, we've taken a break for some lunch and to stretch our legs and everything. Can we just confirm that you haven't been asked any questions about this matter while the tapes have been off?

REID — No.

DC YATES — I think, unless you've got anything you want to ask Code A we'll pick up on a new topic, which is Diamorphine.

Code A — Yeah.

DC YATES — I want to ask you about the drug Diamorphine, okay, and the easiest way to start it is what is Diamorphine?

REID — It's an analgesic. Um, it's a member of a group of drugs called Opiates, which are strong painkillers.

DC YATES — Okay. What other kinds of analgesic can normally be used prior to taking Diamorphine?

REID — Um well one can use, um, by referring to the Analgesic Ladder you'd be starting things like Paracetamol and then moving on to things like Codeine, or extra Codeine and Paracetamol, um, and then drugs which are sort of Opiate related like Tramadol, um, but most of these other groups of drugs are called non-steroidal anti-inflammatory agents and then finally there's the Opiates themselves, which are known as Morphine and Diamorphine etcetera.

DC YATES — And where does Diamorphine fit within the Analgesic Ladder?

REID — At Stage, at sort of Stage (3) if you like.

DC YATES — At the top?

REID — The stronger level, the strongest level of painkiller.

DC YATES — Okay. In the case of Mr PACKMAN then, what was the range that Diamorphine was written up to?

REID — Diamorphine?

DC YATES Yeah.

REID It was 40 to 200.

DC YATES That's right. If you want to refer to it it's Page 171 doctor if you want to find it. And why was the Diamorphine range written up with such a gap between 40 and 200?

REID Well I think, as we've said before, it's to, um, allow nursing staff to use their discretion should the initial starting dose not control the patient's symptoms.

DC YATES I mean we've also spoken about Midazolam haven't we a little bit earlier on?

REID Yes.

DC YATES Is it right to say with things like Midazolam are quite often used in conjunction...

REID In conjunction with, in conjunction with Diamorphine yes...

DC YATES Yeah.

REID ...in syringe drivers.

DC YATES Yeah. So the range being written up for one is quite obviously would be a range written for two. So the

questions might seem a bit repetitive but we'll try and deal with Diamorphine. Again though would you, personally, have allowed a nurse to start at the higher range?

REID No.

DC YATES No. And your expectation is...

REID Absolutely.

DC YATES ...that they start at the lower range?

REID Absolutely.

DC YATES Right. Again, I asked this about Midazolam as well, how is it ensured that the patient was reviewed by the Clinical Assistant before Diamorphine was administered?

REID (Pause)

DC YATES So how can you ensure...

REID Did you say Midazolam or Diamorphine?

DC YATES Of Diamorphine. How can you ensure that the patient's reviewed by, how did you ensure that the patient was reviewed by the clinical assistant before Diamorphine was administered?

REID (Pause) Well I would...

DC YATES Diamorphine was written up on the 26th wasn't wasn't it?

REID Yes it was.

DC YATES And on this occasion it looks like it was actually started on the 30th...

REID That's right.

DC YATES ....of August...

REID Yes.

DC YATES ...1999, so there's a gap of four days.

REID Yes.

DC YATES In the pro-act, is this a pro-active prescribing then, it was written up on the 26th?

REID Um, yes I suppose it is. Um, well in a sense there would be a, but only in the sense that the continuation of (pause), the patient had been written up for Oramorph...

DC YATES That's right.

REID ...as a regular prescription and this would be sort of pro-active in the sense of the patient was no longer able to take medication...

DC YATES Orally.

REID ...orally, or the pain wasn't controlled, this would allow Diamorphine to be introduced.

DC YATES Okay. And in the case of this patient, which was it? The patient couldn't take the medication orally or what?

REID I can't, I can't say if it's just not practical.

DC YATES Well I think we know that he could, he could eat because he was eating.

REID They say he was able to take something in small quantities.

DC YATES Yeah. Then why is 'pro-active prescribing policy' then needed if a doctor is going to see the patient at least once a day, or be available to see the patient at least once a day.

REID Well it isn't, it isn't.

DC YATES It's not required?

REID (Silent)

DC YATES And we've already covered the 'pro-active prescribing policy' and I showed you the document, which was drafted by you after this case was (inaudible).

REID Yes.

DC YATES Where could we find, or where would you find the instructions to nurses on how much they should increase a drug by? So in the case of a patient on 40 milligrams of Diamorphine shall we say, which isn't covering the pain, where is the guidance for nurses on how they should increase...

REID You mean in, in this case?

DC YATES In this case.

REID Well there isn't any.

DC YATES Was there any, was there any guidance at that time on that on how a nurse should increase...

REID I'm, I'm not aware of any written guidance.

DC YATES Because it's all right now sort of like several years on, seven years on, we understand I think the (inaudible) is increase it by half isn't it?

REID About 50% again.

DC YATES So what checks then, or safe guards were put in place to prevent overdosing?

REID There was none.

DC YATES But again for Mr PACKMAN why was Diamorphine prescribed? Or are you just only in a position to assume?

REID I can only assume.

DC YATES From the records?

REID Yeah.

DC YATES Because it's not recorded anywhere is it?

REID No.

DC YATES (Pause)

REID I mean just,...

DC YATES Yeah.

REID ...just sort of very briefly on the sort of, um, the safe guards, um, and I think I've said before that, um, when nurses administer, um, Diamorphine, two nurses have to go to the controlled drug cupboard so in a sense there is, it will take two nurses to make an...

DC YATES — An error.

REID — Yeah an error, or a rash decision.

DC YATES — Yeah. (Pause) By the time that Mr PACKMAN was receiving Diamorphine was he in a terminal phase of his life in your view?

REID — I, can I just look at my (inaudible)? (Pause) It's, it's difficult to say because of, uh, by not keeping, um. What Doctor BARTON has written on the 28th is: 'Remains poorly but comfortable. Please continue Opiates over the weekend,' which would, to me, imply that this man is seriously ill.

DC Code A — Right. But there is a difference between being seriously ill and terminally ill isn't there?

REID — Well it's a sort of correlation and, um, that was written on the 28th and the Diamorphine, the Diamorphine was started on the 30th, a couple of days later,...

DC Code A — Yeah.

REID — ...so it's possible his condition could have deteriorated and, um,...

DC Code A — Sorry but I was just making a point that if, if anything, if you end up having to go to court over this,...

REID Yes.

DC Code A ...these interviews could be played in front of a jury,...

REID Yes.

DC Code A ...yeah, or the transcripts could be shown...

REID Yes.

DC Code A ...to the jury,...

REID Yes.

DC Code A ...or extracts from them and I just want to make it clear that 'seriously ill and terminally' ill are different aren't they? I mean a person can be seriously ill, but be treatable?

REID Yee...

DC Code A Or am I...

REID Oh yes, yes, yes, your right yes.

DC Code A Yeah.

REID I'm sorry I'm just,...

DC Code A Yeah.

REID ...I was just really trying to look back through the 'nursing record' to see if there's any, anything within that which would, um, make me believe that he was terminally ill.

DC Code A Terminally ill. I'm not trying to trip you up,...

REID No, no, no I appreciate that.

DC YATES ...I'm trying to be fair to you because I don't want you to, if you do come in front of a jury, I don't want you to say something now which is not what you intended to say you know.

REID Yeah.

CHILDS Or not what he meant?

REID Yes.

DC Code A Yeah.

REID Yeah.

DC Code A Carry on

REID No. I think it's difficult to say from the notes that he was terminally ill at that stage.

DC Code A — Okay. But would you expect normally to see an entry in the notes as to justification for the drug being used?

REID — Yes. Because there is a switch from oral medication...

DC YATES — Yeah.

REID — ...to Diamorphine.

DC YATES — Yeah. Now I know it can vary from patient to patient, but what would you consider to be an excessive dose of Diamorphine?

REID — Well it would depend, it would depend on the patient whether they're Opiate-naïve etcetera.

DC YATES — Yeah. And, as we've mentioned before, size may or may not come into it?

REID — Uh-huh.

DC YATES — Hydration?

REID — Yes.

DC YATES — And renal problems...

REID — Yes.

DC YATES — ...and all sorts of factors can come into it.

REID Yeah.

DC Code A Can we just talk about Opiate-naïve doctor and again this is, we need people who don't know anything about drugs to be able to understand that and Opiate-naïve is for people who have...

REID Never.

DC Code A ...never had...

REID Yes never had a...

DC Code A ...any Opiates such as Morphines and Oramorphs...

REID Yeah.

DC Code A ...and Diamorphines. And at what stage would they cease to be Opiate-naïve, as soon as you give them...

REID Oh I, I honestly,...

DC Code A ...a Morphine or is it over a period of time?

REID I honestly have no idea, you'd have to ask, you know, an expert on this, it's what they Pharmacology. I suspect it would vary from patient to patient,...

DC Code A Yeah.

REID ...but I have no idea.

DC Code A — Do you see the point I'm making, if say for argument sake Mr PACKMAN had been on...

REID — For a few months or something like that?

DC Code A — Yeah. Or for three or four days and then he had gone onto Diamorphine,...

REID — Yeah.

DC Code A — ...would it have been different if he had been on Oramorph for three or four months and then gone on to Diamorphine?

REID — (Inaudible – mumbles)

DC Code A — Is there a time scale involved in what I'm saying as well as the absence of the drug?

REID — I just don't know. I mean what I, what I would say is that, um, he was receiving 60 milligrams of Oramorph a day, um, if we use the sort of half, maybe we should use the half of the third conversion factor then you're talking about sort of 20 to 30 milligrams,...

DC Code A — Uh-huh.

REID — ...but if his symptoms weren't controlled on that then 40 milligrams would seem to me to be a reasonable starting dose.

DC YATES And there is a chart in the BNF isn't there doctor that assists for the transcribing of drugs?

REID Yeah. Whether that was there in 1999 I don't know.

DC YATES Well I believe it was,...

REID Okay.

DC YATES ...but there is now anyway, so. We mentioned the Wessex Protocols before and you've made it quite clear that 'you weren't aware of them then' is that right?

REID Uh-huh.

DC YATES So what were the guidelines, what are the guidelines for the prescription of Diamorphine for a man, for somebody like Mr PACKMAN and Mr PACKMAN's condition?

REID Well it's a combination of judgement as to whether they need Diamorphine and then it might be in the BNF to guide you, (hiccups) pardon, guide you on what dose you use.

DC YATES He was on Oramorph, 60 milligrams a day I think it was was it?

REID Yes it was, yeah.

DC YATES I think it's the first half-a-dozen pages of the BNF is that chart. What would that say he should have?

REID Well I think it would be 20 wouldn't it?

DC YATES I think so but.

REID (Pause) Uh, um, (pause) I think it's 60 milligram that's 30 milligrams twice a day, they say 20 milligrams over 24 hours.

DC YATES So the dose is doubled?

REID Yes. What I mean I think I remember back from that time there was: 'Is the conversion factor a half or is it a third?' If the conversion factor is a half then one's talking about may go to 30 milligrams of Diamorphine,...

DC YATES Uh-huh.

REID ...and if the pain wasn't controlled then that's just a third step up, so I don't think it was as clear as that back in 1999.

DC YATES Okay. Did you ever advise Doctor BARTON regarding the prescribing regime in respect of Mr PACKMAN?

REID No.

DC YATES Okay. Why not?

REID Because I wasn't asked to.

DC YATES All right. So is it something that you hadn't noticed on this occasion that the variance, you know variable doses and the...

REID Well I, I can't recollect whether I noticed or not.

DC YATES Well do you think had you noticed them you may have said something?

REID No well I should have done.

DC YATES (Pause) How do you know that this prescribing regime didn't lead to a worsening of Mr PACKMAN's condition?

REID (Pause) Um there was documentation in the nursing notes,...

DC YATES Yeah.

REID ...they just seemed to be requiring increasing doses to keep his pain under control, um, and when I saw him on the 1st, um, he seemed to me to be comfortable and I think I said 'he was drowsy', that means sometimes, you know, to get people's pain under control they will be drowsy, so I certainly didn't feel that he had been, well my, my interpretation, of my notes at that stage, was I didn't feel he had been overdosed with Diamorphine.

DC YATES Okay. (Pause) Now we've mentioned with the Midazolam before, and obviously it does apply to Diamorphine, there was no justification documented in the medical notes is there?

REID No.

DC YATES I'm going to say why is this, or should there have been?

REID Well, um, there should have been a note to the effect that Mr PACKMAN was in pain and distressed, um, and that would, you know, we could quickly have justified the use of a combination of Diamorphine and Midazalom.

DC YATES Okay. I understand that you're doing this not from memory but from the notes.

REID Yes.

DC YATES But from the notes when would you consider that Mr PACKMAN actually entered the terminal phase of his life?

REID I mean I would say he was terminal when I saw him on the 1st of the ninth.

DC YATES The 1st of the ninth.

REID Yeah definitely.

DC YATES And why did you consider that?

REID — Um I think, um, (pause) oh for a number of reasons, the fact that, um, he did seem to be in pain that was taking, you know, um, a fair dose of Opiates to bring his sort of pain and distress under control. The fact that, um, he was passing sort of, what we call 'melina stools' and he was haemorrhaging from his gut, um, and overall the whole picture just seemed to me as someone who was terminal, terminally ill.

DC YATES — So from what you just said what did you suspect was wrong with him for that time then?

REID — Not, Not.....

DC YATES — I know he's obese, I know he's obese.

REID — Well multiple things

DC YATES — You've mentioned bleeding stools and...

REID — Yeah he's got, he's got huge pressure sores on this buttocks, these would all at least be superficially, um, infected. We know that, um, people who are ill, um, let's say in ITU or people like him who have got extensive pressure sores, um, are at risk of getting ulcers, um, in the stomach from the stress of the illness and being unwell, um, it's very difficult to treat bleeding ulcers particularly if you're as large as, uh, Mr PACKMAN was, would you actually get him onto an operating table for example, um,

so I just felt the picture was, I think I, I know the picture was pretty hopeless at that stage.

DC YATES — As you mentioned the stools etcetera, just from looking at the stools could that give you an idea from whereabouts he's bleeding?

REID — Well, well yes it can. I mean if it's melina stools it's usually the upper part of the bowel you're bleeding from.

DC YATES — And is that more difficult for, on what to treat or?

REID — Um both of them,...

DC YATES — They both are.

REID — ...they're difficult to treat I'm not an exp, but I'm not an expert in that.

DC YATES — (Pause) So yes on the 1st of September you put: 'Rather drowsy but comfortable, passing melina stools, abdominal huge but quite soft, pressure sores over the buttocks etcetera, remains confused with TLC,' and then you stopped the Frusemide and got Doxazosin ?

REID — Yeah.

DC YATES — Why was that?

REID — Well stopping the Frusemide because his oral intake was very poor so he just might be dehydrated which can add to his distress. The Doxazosin I mean I can't, can't be sure, um, but I mean I would, it may just have been because he was sort of drowsy and not taking much by mouth, but I felt that his prescription was sort of almost irrelevant...

DC YATES — Uh-huh.

REID — ...given, given his poor state.

DC YATES — Okay. So you actually sort of met him, what change had taken place in the patient to reach this conclusion? And you've made a note on the 1st of September about what you've seen. Have you made a diagnosis as such? Have you actually, if you have where of what is wrong with this man?

REID — Well the fact he's passing bleeding stools means that he's almost certainly bleeding from an ulcer, um, in his stomach or duodenum and problem related stress from being, you know,...

DC YATES — And were you qualified to diagnose this?

REID — Well I mean the only way of definitively diagnosing the leaking ulcer is to take a look down inside and see, so it was a sort of presumptive diagnosis based on the evidence you're faced with.

DC YATES — Entirely, yeah.

REID Faced with.

DC YATES And was this your responsibility to make these diagnosis, diagnose?

REID Oh yes

DC YATES Did you refer the patient to any other consultant?

REID No. I mean at that stage I felt he was beyond (pause) recovery.

DC YATES Code A?

DC Code A What you're saying is he wasn't...

REID I thought he was terminally ill.

DC Code A Yeah. There was no treatment available with a cure?

REID Yes.

DC Code A And on the 1st of the 9th in the absence of anything else written there you were confident that everything that was prescribed to him, all the care that was being taken of him, the medical plan in place such as it was, you were happy with that, all that?

REID — Yes. I mean I think, um, I mean I don't know what I thought at that time because, um, based on the notes, um, but recognising that one has about ten minutes per patient. What you have to do is if you like: 'What's, what's the, what's the pressing problem or issue?' And it seemed to me that this man was dying and should be made, and should be made comfortable. What I can't say is whether, you know, we looked at what had gone on say in the sort of ten days before ,but all this time I've heard from the nursing staff and Doctor BARTON was present what had actually been happening and I'm taking that that into consideration. I mean and also there's a thing in the nursing records that poor diagnosis had been explained to his wife...

DC Code A — Wife.

REID — ...etcetera and, you know, that would have been relayed to me and, you know, that would of again would of sort of informed so.

DC Code A — If I take you back to the entry on the, it's on Page 54 or 55 sorry, 55b, the 26th of August by Doctor BARTON: 'Couldn't see, pale, clammy, unwell suggest query myocardial infarction,...

REID — MI, yeah.

DC YATES — ...treat stat Diamorph. Alternative possibly GI bleed,...

REID Yes.

DC Code A ...but no...

REID Haematemisis.

DC Code A ...Haematemisis

REID That means vomiting up blood.

DC Code A Yeah. So she's considered two possibilities...

REID Yes.

DC Code A ...of what's ailing him. You make no mention of MI.

REID Yeah.

DC Code A Well myocardial infarction is heart attack isn't it?

REID Yes it is, yeah.

DC Code A Was that not a consideration, were you happy that this extra thing was going to be a GI bleed?

REID Um I mean he could have had a myocardial infarction at the time Doctor BARTON saw him,...

DC Code A Yeah.

REID ...because we know of, I mean he could have, he could have had both and we know certainly if you're losing blood and becoming anemic then that puts an extra strain on the heart so he could have had a heart attack as well, but it seemed to me that the issue which was causing this man to deteriorate was the fact that he was bleeding and not, not his heart.

DC YATES (Pause) Code A anything else?

DC Code A Only one thing doctor...

REID Yeah.

DC Code A ...and that was that at the start of this tape, towards the start of this tape DC YATES asked you a question and you replied, I think your reply was: 'Can't say,' all right and he was asking something about why something was prescribed or, and I think you said: 'Can't say.'

REID Oh was it about the Doxazosin was it?

DC Code A It might have been yeah, and why can't you say?

REID (Silent)

DC Code A Is it because...

REID Because I haven't written, because I haven't written down the reason why.

DC Code A — Yeah, yeah. It's okay that's just a simple thing to clear that up yeah.

DC YATES — Well while we're actually on the entry on Page 55, the 26th of August of Doctor BARTON's, last line is: 'I am happy for nursing staff to confirm death'. What does this mean?

REID — Um it would imply to me that Doctor BARTON felt, I could imply that Doctor BARTON felt that at that stage the patient was terminally, um, terminally ill,...

DC YATES — Uh-huh.

REID — ...um, (pause) that's what it could imply.

DC YATES — And why is there a need to record that in that way?

REID — Um well usually, um, in the case of an expected death the nursing staff will confirm death and then let the doctor know in the morning that death has occurred, whereas if it's an unexpected death the doctor would be called out during the night.

DC YATES — I mean is there a difference then between confirming and verifying or certifying death?

REID — Um well certifying death, um, to me verifying and confirming are the same sort of thing it's a sort of, the nurse is actually saying: 'This patient has died.'

Certification is a doctor filling out your death certificate saying the patient has died and giving the reasons why.

DC YATES — Okay.

DC Code A — Can we expand on that Chris?

DC YATES — Go on.

DC Code A — Your entry on the 1st of the 9th says: 'For TLC'.

REID — Yes, uh-huh.

DC Code A — You're saying that: 'I'm happy for nursing staff to confirm death,' was an indication that Doctor BARTON was expecting death.

REID — I would, well...

DC Code A — That's the interpretation I get.

REID — That's the interpretation I would put on it.

DC Code A — Yes so on the 26th Doctor BARTON is expecting Mr PACKMAN to die and that gives the nurse the authority to confirm the death?

REID — Yes.

DC Code A — Yes?

REID Yes.

DC Code A If Doctor BARTON wasn't expecting the death,...

REID Yes.

DC Code A ...then the nurse had a duty to call a doctor in?

REID That's my understanding.

DC Code A Yes that's how I understand it as well, and that's my understanding of your explanation of it.

REID Yes.

DC Code A Okay. So your entry on the 1st of the 9th says: 'For TLC' doesn't it?

REID Yes.

DC Code A What does that mean?

REID Tender, Tender loving care. In other words it's for, it's an indication you want someone to palliative care.

DC YATES Yes. And in a layman's term, when a nurse reads 'TLC' she knows that a doctor is saying: 'This patient is dying,'...

REID Yes.

DC Code A ...more or less isn't it?

REID Yes, yes.

DC Code A Okay. When Mr PACKMAN came into QA on the, what was it the 6th of August...

REID It was the 6th or something like that.

DC Code A Wasn't it yeah. He was written up as 555 wasn't he?

REID I remember seeing: 'Not for 555.'

DC Code A Sorry that's what I mean 'not for 555'.

REID Yes.

DC Code A So it's the 13th of August wasn't it...

REID Yes.

DC Code A It was the 6th of August when he came in right.

REID All right, okay.

DC Code A And if you were to go back to those records, Page 47 I think is the 6th of August and consistently during his stay at Queen Alexandra Hospital he's written up 'not for 555'...

REID Yes.

DC Code A ...several times hasn't he?

REID Yes.

DC Code A Certainly on the 6th, I think on the 7th,...

REID Yes.

DC Code A ...on the 13th,...

REID Yes.

DC Code A ...and I believe on the 20th as well, that's Page 53 by the way.

REID Yeah.

DC Code A And another entry says 'not suitable for CPR'.

REID Yes.

DC Code A Yeah?

REID Yeah.

DC Code A And that's the same thing isn't it?

REID Yes it is.

DC Code A Can you explain what that means?

REID What 'not for 555'?

DC Code A Yeah 'not for 555' and 'not suitable'.

REID It means someone's not, not to be resuscitated in the event of their heart or breathing stopping.

DC Code A Yeah. Now I've had this explained to me by a doctor previously who says that with all clinical decisions you have to balance things out don't you, there is a cost implication, a time implication. Why would the decision have been made for Mr PACKMAN to be 'not for 555'?

REID Well I'm, I'm only surmising.

DC Code A Yeah going on your notes, yeah.

REID I think for, um, because I'm going to guess that the person thought the chances of sort of CPR being successful were low,...

DC Code A Uh-huh.

REID ...that would have been presumably because of his gross obesity it would be difficult to undertake it not, not really likely to be effective, um, and I think probably also by the

fact that, I think as I said before, the gentleman whose been struggling to keep mobile at home is finally no longer mobile was developing pressure sores resulting from gross arthritis of his knees, highly likely that this man's going to get out of hospital and, you know, would it be appropriate to attempt CPR, um, in that situation.

DC Code A — Now how does that affect his care and treatment while he's with QA then, he's been written up as 'not for 555'?

REID — Well it, that, that order applies only to the events of your heart or breathing stopping, it doesn't apply to any other treatment, which could be offered.

DC Code A — Yeah. So it doesn't stop, it doesn't stop the doctors...

REID — Treating, treating other things.

DC Code A — ...investigating the patient...

REID — No.

DC Code A — ...trying to find out what's wrong with them and trying to treat and cure whatever is wrong with them?

REID — Yes that's right.

DC Code A — Yeah?

REID — Yeah.

DC Code A — And as we go through the pages starting from Page 46, 47, 48, 49, 50, 51, 52, 53 up until the day he was admitted into Gosport on the 23rd, there are various entries by doctors aren't there...

REID — Yeah.

DC Code A — ...talking about the treatment he's been getting...

REID — Uh-huh.

DC Code A — ...and tests on him for various things, yeah, and so they're being active in his treatment aren't they?

REID — Yes.

DC Code A — Ant the 'not for 555' has no effect on those doctors looking at what was wrong with Mr PACKMAN,...

REID — No that's right.

DC Code A — ...including yourself at that stage because you looked at one stage didn't you?

REID — Uh-huh.

DC Code A — Right. And when you saw him you actually, were suggesting Daedalus, Gosport...

REID Dryad.

DC Code A Dryad straight away weren't you?

REID Uh-huh.

DC Code A When he comes to Gosport on the 23rd does it mention 'not for 555' there at all?

REID No it doesn't.

DC Code A Not on the 23rd sorry...

REID No.

DC Code A ...the 26th it doesn't mention it there?

REID No it doesn't.

DC Code A Sorry it was the 23rd it's when Doctor RAVI yeah, it doesn't does it?

REID No.

DC Code A Doctor RAVI doesn't put it in his does he?

REID No.

DC Code A And Doctor BARTON doesn't put it in hers does she?

REID No.

DC Code A No. But she puts on the 26th 'I am happy for nursing staff to confirm death'.

REID I mean it would have been normal practice unless circumstances have changed to continue with a previously made decision like that,...

DC Code A Yeah.

REID ...so for example Doctor RAVI yes and it should, it would have been him, you know, we should put it down but the way we would operate is if it's been said 'not for 555' at Queen Alexandra...

DC Code A Yeah.

REID ...then the patient would not be for 555 at Gosport unless there had been some sort of medical transformation...

DC Code A Because that statement is reviewable isn't it?

REID Oh absolutely yes.

DC Code A And could change if the patient...

REID It could change if the patient's condition improved.

DC Code A — Can I ask you to look at Page 62. And if I ask you to look at an entry dated the 26th of the 8th, what is Page 62 it's another nursing summary page isn't it?

REID — Yes, uh-huh.

DC Code A — Yeah. Can you read that through for me, I'll tell you when to stop, you'll know when to stop of course.

REID — A fairly good morning, no further vomiting, Doctor RAVI contacted re Clexane, advised to discontinue and repeat haemoglobin today and tomorrow, not for resuscitation.

DC Code A — Now who has written that entry doctor?

REID — Um it's Sister HAMBLIN.

DC Code A — So Sister HAMBLIN has put on there 'not for resuscitation' hasn't she?

REID — Yes.

DC Code A — Now where has she got that from then?

REID — Well she may have got it from Doctor, um, RAVI.

DC Code A — But Doctor RAVI doesn't put that anywhere does he?

REID — Um, well it says 'Doctor RAVI contacted', which was three...

DC Code A — Do you know why Doctor RAVI would have been contacted for the Clexane when Doctor BARTON around and about because she had seen him the same day hadn't she?

REID — I, I, I, no I don't know. (Pause) Right. Only it says the previous day 'passing fresh blood' on that same page, 'query Clexane' because Clexane can, can cause that to happen. Um a verbal message from Doctor BEASLEY to withhold and review with Doctor BARTON in the morning now. Well I don't know whether that happened or, or not, I mean maybe it didn't happen and Doctor BARTON wasn't available Sister HAMBLIN chose to contact Doctor RAVI.

DC Code A — Okay. We'll go down, change the course slightly again. You mentioned that when they put down, when a doctor puts down 'not for 555' and that it doesn't stop a doctor investigating...

REID — That's right.

DC Code A — ...the cause of this person's discomfort...

REID — Yes.

DC Code A — ...once brought into hospital etcetera, etcetera, when a doctor writes: 'I am happy for nursing staff to confirm death',...

REID Yes.

DC YATES ...and when a sister writes: 'Not for resuscitation'...

REID Yes.

DC Code A ...does that affect the way that patient is then cared for?

REID No.

DC Code A Does that not have an implication on the way the patient is cared for?

REID Well it shouldn't, it shouldn't have.

DC Code A Because what we're saying there is at that stage on the 26th Doctor BARTON is assuming that the patient is close to death.

REID Going to die. Yes.

DC Code A Yeah. And that's backed up by the nurse, the sister by writing: 'Not for resuscitation'. Yes?

REID Yeah. Well what it would do is it would make you, um, circumspect about how far we'd investigate or treat it's got to influence that decision if you felt that someone was terminally ill.

DC Code A — Because from the 26th onwards was there any investigation into that patient's illness?

REID — No there wasn't.

DC Code A — Okay. Chris.

DC YATES — But bearing in mind as well that, I think it's on the 26th when Doctor BARTON wrote that note 'query MI, also other possibility GI bleed'. Well we were speaking about it. What investigations have been done for either?

REID — Well he had, he had a full blood count...

DC YATES — He had a full blood count yeah. Anything after the MI?

REID — No.

DC YATES — ECG?

REID — No.

DC YATES — What would the reason be for not doing that?

REID — The reason might be that it's unlikely to influence the patient's management, in other words you do an ECG it confirms that someone's had a heart attack, it's not going to, it's unlikely that you're going to initiate or stop any treatment just on the basis of the ECG,...

DC YATES Uh-huh.

REID ...say for example with a heart attack some people may get what we call heart furring and become very short of breath and what you do is listen to someone's heart and chest and if you hear some fluid give them Frusemide, which this chap was on. An ECG itself I think is unlikely to have changed the management of Mr PACKMAN. The only thing I can think of which, um, sometimes you can get abnormal rhythms of the heart developing if you've had a heart attack, um, you can sometimes pick it up just by feeling someone's pulse, um, ECG's a much better way. Um some of these abnormal rhythms could be treated, um, in Gosport but a significant number couldn't be because you need sort of continuous monitoring and given drugs which have to be very closely supervised etcetera, so I don't think an ECG on it's own would necessarily have a big impact on Mr PACKMAN's management.

DC YATES Okay. Well I think we will be coming back to that a little bit later anyway.

Code A One other thing 'not for 555' has TLC and, happy for nursing staff to confirm death, are they similar statements?

REID Um not for 555, it simple means not for resuscitation,...

DC YATES Not for resuscitation.

REID ...but any other treatment could be given as it's thought appropriate,...

DC YATES Right.

REID ...but TLC to my mind would mean 'not for 555' and 'not for the, um, and for treatment of symptoms only'.

DC YATES So it just repeats the circle I expect.

REID Yeah.

DC YATES 'Not for 555'?

REID It doesn't, it's strictly in, not for (inaudible) ...

DC YATES Yeah, yeah.

REID ...doing heart massage in the event of chest,...

DC YATES Yeah that's 'not for 555'.

REID ...it could be the heart or breathing is stopping.

DC Code A But 'TLC' would mean?

REID Well 'TLC' would mean, by implication to me would mean definitely not for 555...

DC YATES Yeah.

REID ...and not for active treatment other than symptom control, in other words palliative care.

DC Code A Yeah, yeah. So if someone is marked up 'not for 555' and doesn't have heart problems there is a chance that they're going to make a recovery from whatever it is as long as you find it and treat it?

REID Well you would certainly 'not for 555' means you're just not going to resuscitate, but if they've got a urine infection, or chest infection,...

DC Code A Yeah.

REID ...a heart attack even, you know you would, you would treat that, um, but you wouldn't attempt to re-start the heart if it stopped.

DC Code A But 'TLC' means just?

REID Symptom control.

DC YATES Symptom control.

REID Palliative care.

DC YATES The person is dying?

REID	Yes.
DC YATES	Make them comfortable, and happy for staff to confirm death for that?
REID	That would imply to me,(TAPE MACHINE BUZZES) That would imply to me that someone is close to the end of their life.
DC YATES	Right.
DC YATES	We'll change the tapes over, so the time is 1359 hours and we'll turn the tapes over.
REID	1349 (laughs).
DC YATES	1349 yeah.
	INTERVIEW CONCLUDED – TAPES CAME TO SUDDEN END

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y25V

Enter type: FULL TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 08/08/2006

Time commenced: 1357 Time concluded: 1440

Duration of interview: 43 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC Code A YATES

Other persons present: MR CHILDS, SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This is a continuation of the interview with Dr REID. The time is 1357, everyone's checking now. Dr can you just confirm that it's the same people are present?
REID	Yes.
DC YATES	And can you confirm whether you've been asked questions or not about this matter while the tapes have been off?
REID	No.

DC YATES — Thank you very much. The tape ended and everyone's stretched their legs and had a quick comfort break but we were talking about the, well the different terms of 555, TLC and 'Happy for nursing staff to confirm death'. On the 'Happy for nursing staff to confirm death', what would be the normal practice that would be followed by nurses upon the death of a patient if they were going to ...

REID — Certify.

DC YATES — ... verify death.

REID — Sorry to verify it rather?

DC YATES — Yeah.

REID — As I understand it is what they would normally do is record it in the nursing notes that you know, something like the time, patient not breathing, no pulse felt, no heart sounds, heard, died, 0350am or whatever it was.

DC YATES — Right, okay. Right and we had covered actually why in that statement, 'Happy for nursing staff to confirm death', was written a number of days prior to ...

REID — Yeah.

DC YATES — ... the patient's death.

REID Yeah.

DC YATES But during, in that entry by Doctor BARTON on the 26th of August she made, or suggests two possible things that have happened to …

REID Mr PACKMAN.

DC YATES … Mr PACKMAN which is the MI …

REID Yes.

DC YATES … and the GI bleed.

REID Yes.

DC YATES So if we then move onto the death certificate, we've got a copy of the death certificate which Code A will find in a sec but death certificates anyway, they're a formal legal requirement aren't they?

REID Yes.

DC YATES Okay and they can only be undertaken and written out by a medical practitioner?

REID Yes.

DC YATES Okay and are there specific guidelines that should be followed?

REID — I remember you showing me something ...

DC YATES — As to when death should be referred to the coroner and ...

REID — Yes, yes there are yes, yeah.

DC YATES — ... those sort of things. Okay so we can actually seek an explanation or try and find out your understanding of this process. We have the death certificate of Mr PACKMAN it's been given a reference of CSY/HF/22. Take it out the folder cos, it might, the exhibit label might be obstructing some of it. Who completed that death certificate?

REID — Doctor BARTON.

DC YATES — Okay and what procedure would be followed when certifying and recording the death of a patient by a doctor?

REID — Well completion of this certificate and giving this, not necessarily the doctor doing this but the certificate being handed to relatives and told to register with the registrar and if it was one of the indications referring it to the coroner with it being within a year of operation etc.

DC YATES — Yeah, okay. Who informs the registrar or the coroner?

REID — Coroner, usually what happens is the doctor phones up the coroner's office.

DC YATES Yeah.

REID And he usually speaks to the coroner's officer and then decides what needs to happen and in the case of the registrar it means the relatives have to take the notice of death to the registrar.

DC YATES Right so in the case of Mr PACKMAN then is it the doctor that completes the form that decides on the cause of death?

REID Well yes if you, if you, I mean the requirement is that if you know the cause of the death then you complete the certificate. If you don't know the cause of death then you refer it to the coroner.

DC YATES Yeah well the cause of death is given on that as ...

REID Myocardial infarction.

DC YATES ... right. There are two possibilities of what Mr PACKMAN was suffering with. One was a GI bleed one was MI.

REID Mm, mm or both.

DC YATES Or both, right. Nothing seems to have been investigated on either because, certainly in your opinion he was at a terminal phase of his life, although ...

REID Certainly when I saw him he was.

DC YATES ... yeah and that was on the 1st of September and he died on the 3rd of September didn't he?

REID Yes.

DC YATES Well the 1st of September you've seen him and would I be right in assuming from your notes that you're actually thinking actually he's bleeding?

REID Yes, yeah.

DC YATES And there's no, certainly no reference in your notes about a heart problem.

REID No.

DC YATES I'm just wondering then why and what evidence there is to suggest that he should be certified as dying of ...

REID Myocardial Infarction.

DC YATES ... yeah.

REID There is, well there's not a lot of evidence, we know that they've collapsed as described by Doctor BARTON in a note, could be due to myocardial infarction. There's also reference in the nursing notes to Mr PACKMAN having some pain in his throat.

DC YATES Mm, mm.

REID Now, although typically heart attacks are pain in the chest ...

DC YATES In the chest.

REID ... you can experience pain in the throat from a heart attack. So there's a possibility that Mr PACKMAN could've had a heart attack.

DC YATES Right could you also get a thing of the throat from a GI bleed?

REID I think that's unlikely, more likely to be abdominal pain.

DC YATES No indigestion type, no indigestion type feelings or ...

REID Well yeah indigestion can be either, can be either GI bleeding or it could be a heart attack.

DC YATES ... okay, right.

REID Pain in the throat not a bleed.

DC YATES Okay. Do we have MCCD?

DC Code A Sorry Chris what one?

DC YATES Is that it?

DC Code A — No I can't, remember which...

DC YATES — MCCD. Now on this medical certificate, the cause of death, which I think is abbreviated sometimes as an MCCD, there's a box on the right, for approximate interval between onset and death.

REID — Yeah.

DC YATES — And that's, they're talking about whatever killed him, five days. He died on the 3rd of September, we're saying it's the 28th of August.

REID — Yeah.

DC YATES — If, if these forms have been completed correctly and Doctor BARTON truly suspected that ...

REID — Myocardial ...

DC YATES — ... Mr PACKMAN was suffering with myocardial infarction ...

REID — ... yeah there'd have been seven days.

DC YATES — ... it should have been seven days. On the 28th, all that's been written is 'Remains poorly but comfortable'.

REID — Mm.

DC YATES — How much credence is put into filling in these forms? I mean, or certain boxes of these forms?

REID — Well I mean I certainly take them very seriously.

DC YATES — Well yeah I think they should be taken seriously but I can't, well when we look at these forms separately away from it all etc, they don't tie in with what's been written. So we just ask for an explanation as to why that could be, and you're shrugging your shoulders so. Is there anything you want to ask on death certificates Geoff?

DC Code A — Well just expanding on all that really because we went through this before when one of the nurses put there that pain not controlling symptoms and ...

REID — Diamorphine not controlling symptoms?

DC Code A — ... yeah, that's it, yeah and if you start reading this from after he'd got admitted to ...

REID — Dryad.

DC Code A — ... Gosport War Memorial Hospital, actually ...

REID — No it doesn't mention it at all.

DC YATES — ... given any clue at all about what is wrong with Mr PACKMAN.

REID — Well I mean Doctor BARTON's note of the 26th says about that particular, about the pre myocardial infarction, the pre GI bleed.

DC Code A — Suggests GI yeah.

REID — Both of which could cause people to become, you know very distressed and uncomfortable.

DC Code A — Yeah but not a lot else there really is there?

REID — No there isn't.

DC YATES — Is the, is an MIA, medical emergency?

REID — Um well yeah, yes is the short answer to that um, particularly now that what I call clot busting drugs available, so there's something you can do to limit the size of the heart attack. Before they had the anti clot busting drug one was really just treating symptoms and complications.

DC YATES — Right well I have to ask you now and when did these clot busting, clot busting drugs ...

REID — Come in?

DC YATES — ... yeah.

REID Right.

DC YATES Were they around in 1999?

REID Yeah.

DC YATES They were?

REID They were, not as widely used as they are now. The major downside of clot busting drugs is they cause bleeding. So in this situation you wouldn't entertain ...

DC YATES Is it that ...

REID ... the idea of using a clot busting drug.

DC YATES ... and again as a layman, Warfarin and things like that are blood thinning drugs, is that right?

REID That's right.

DC YATES Is that not a clot ...

REID No that's completely different.

DC YATES ... it actually breaks the clot does it?

REID Yes it does, Warfarin just prevents clot.

DC YATES — Yeah, okay. So I, and I can understand that then if a clot busting drug was used and a person is suffering from a bleed then it's just exasperating the other.

REID — You're potentially causing death from bleeding.

DC YATES — And is the GI bleed ...

REID — Yes.

DC YATES — ... in other words

REID — Oh yes, yeah.

DC YATES — But nothing was done about either?

REID — No.

DC YATES — Okay. Geoff. Geoff.

DC Code A — Yeah sorry, I'm just thinking, I'm just reading it now. So when were you aware of the possibility of the GI bleed then doctor?

REID — Well when I saw him on the 1st of September and he was definitely having a GI bleed then.

DC Code A — Yeah, okay.

DC YATES — So just expand on that, so you said he was definitely having a GI bleed on the 1st of September when you saw him?

REID Yes.

DC YATES So it was a medical decision that you made because of his other problems ...

REID Yeah.

DC YATES ... that you were not going to treat it?

REID That's right.

DC YATES Had you decided that you were going to treat it would that have meant a transfer?

REID Yeah, yes there's nothing ...

DC YATES And he would have been transferred?

REID ... yes.

DC YATES Okay. Right just, some of this stuff we will recap on in a minute as larger groups and try and take things chronologically but just, but you know supervision, what supervision did you provide for Doctor BARTON?

REID Well I was available if she wanted to talk to me.

DC YATES So it was a more ...

REID Informal.

DC YATES ... call when required, informal as opposed to hands on supervision?

REID Yes.

DC YATES Were you happy with that level of supervision?

REID Yes.

DC YATES Were you happy with the level of training that Doctor BARTON and others received in order to perform their duties?

REID Yes I was. I was never made, Doctor BARTON never made me aware that she was, I say, deficient in or could have benefited from training in, you know any areas where, you know she's provided, had to provide care to her patients.

DC YATES If she had made you aware of any deficiencies in her training how were you able to address that?

REID Well she didn't but if she had done ...

DC YATES Yeah.

REID ... there's a number of ways. You know we could either, I mean if it's a fairly simple clinical problem just sit down

and talk about it but if it's, say an area of management of heart failure we could've seen about maybe offering her a course.

DC YATES — Courses, yes.

REID — But I mean almost certainly Doctor BARTON would be doing these as part of her post sort of keeping up to date as a GP. So a lot of her skills doing that would be applicable, directly applicable to her job in the hospital.

DC YATES — Right. If you had had concerns about Doctor BARTON or any staff or any workload issues that they were suffering or you were suffering from, how would you report that? Who would you go to?

REID — It depends what the issue actually was.

DC YATES — Well if we take a medical issue first.

REID — Yeah if she'd been sort of struggling with the management of a patient?

DC YATES — Yeah.

REID — Well I'd have discussed you know what you should do ...

DC YATES — Who could you go to?

REID ... oh who would I go to. Well I mean what I would've done if she'd said she was struggling with something I would sit down with her and say, well how do we think you, we could address this and then take action from there. I mean study leave was available to you know pay for Clinical Assistants to go on courses if they wanted. We did have a regular programme, education programme in the department for Clinical Assistants, which I understand Doctor BARTON used to attend sort of fairly regularly.

DC YATES If, if you were to have concerns about any member of staff though that wasn't being addressed or you weren't able to address by sitting down with them or sending them on courses.

REID Yeah.

DC YATES IE, they weren't taking any notice for instance ...

REID Yeah.

DC YATES ... did you have a next step that you could go to to assist you to deal with a problem?

REID Not really I mean I think what I would've done was say discuss the issue with one of my colleagues, like the lead consultant David JARRETT and say, look I've got this problem here and I'd discuss with him as how he might deal with it. The alternative then, depending, you know if it was a problem with nursing staff then I'd obviously say,

you know speak to a senior nurse manager about it and in extreme sort of circumstances I might have spoken to the Chief Executive but other than David JARRETT there wasn't anyone to go to.

DC YATES — Did you have any concerns about the Gosport War Memorial Hospital in 1999?

REID — No.

DC YATES — Right. Did you raise any issues in regard to training within medical or pharmaceutical in 1999?

REID — Did I raise any issues about training?

DC YATES — Yeah.

REID — No.

DC YATES — Okay.

REID — I mean I would've been, I would've been happy for my mother to have been admitted and treated in the War Memorial Hospital.

DC YATES — Code A?

DC Code A — No.

DC YATES What I'll do now if I can is Doctor BARTON has made statements and given them to us on other days and actually just pick up just a few points within those statements and ask what you consider and what your thoughts are on the matter and she made a generic statement the first time which is about her, obviously her training as a GP etc and the workload she had and her work at the hospital and she stated in this specific statement that, well she indicated that by 1998 the demands on her time were such that it impacted on her ability to make notes and then in a specific statement relating to the care of Mr PACKMAN she said '... if anything had become even more difficult by 1999' and she felt obliged to adopt the policy of proactive prescribing. Why would it be more difficult in 1999 and I appreciate you got there in 1998 didn't you?

REID Yes but it doesn't take very long to write notes. I mean I think that, I mean I got there in 1999 my understanding is that the turnover had, of the patients, had gradually increased.

DC YATES But as you say it doesn't take long to write notes?

REID No.

DC YATES I, I think I've already asked you actually, when and how did she complain? When and how did she complain about this?

REID — Well I don't remember her complaining to me. I mean I can't you know put my hand on my heart and say she didn't mention that she was busy or stretched but not in a sense of the workload as coming down and sitting down and saying my workload is far too great. Sorry what was the question, ask me again?

DC Code A — When and how did she complain?

DC YATES — Did she complain?

REID — I mean I don't remember her complaining to me. One of my colleagues reminded me that, in fact I think she wrote a letter to him, Dr JARRETT, in I think early 2000 but I ...

DC YATES — That would've been in early two, I think that was, was that about the time she actually retired or resigned I should say?

REID — I think so yeah it was not long after that.

DC YATES — Yeah.

REID — And I mean I know, well from discussions with you I mean I'd completely forgotten about it she tried to re-negotiate or re-negotiated her contract with the sort of personnel department but I wasn't involved in that at all.

DC Code A — Sorry, when was that? When was that?

REID — I have a feeling that was in, I can't be sure, but my feeling was that was probably the Autumn of 1999 but I'm, you know I wouldn't like to ...

DC YATES — In what way was she trying to re-negotiate the ...

REID — ... well get more money.

DC YATES — ... okay.

DC Code A — So she wasn't looking to leave the post?

REID — Not that I'm aware no, not that I know of, no.

DC Code A — Not to your knowledge

DC YATES — Well we've discussed the notes and we can see that the nurses write notes regularly but whether they're full enough you're a better judge than I am but at least they do record things regularly.

REID — Yes.

DC YATES — And they have to see each and every patient pretty much.

REID — Yes.

DC YATES — So if a nurse can afford the time is there a reason why a doctor can't?

REID — As I said I mean I think if there is a significant you know interaction with a patient then that should be recorded. Even if it was just, you know probably urinary infection, you know give antibiotic.

DC Code A — Just going on on that subject another exhibit (coughs), excuse me, CSY/HF/23, it's a calendar print out ...

REID — Right.

DC Code A — ... for the relevant period and it shows that the date of 23rd of August, if I just show you that, the 23rd of August was when Mr PACKMAN was admitted to Dryad.

REID — Mm, mm.

DC Code A — Yes and then it shows Doctor BARTON's first entry on the 26th, Doctor BARTON's second entry on the 28th ...

REID — Mm, mm.

DC Code A — ... and on the 3rd when Mr PACKMAN died, on the Friday yes, I've written in red ink there 'Mrs MORRIS to Haslar ...', this is all coming from the admissions book for the ward okay?

REID — Mm, mm.

DC Code A — So a patient called Mrs MORRIS left the ward and went to Haslar.

REID Mm, mm.

DC Code A So that actually shows that patients could go to other hospitals for further treatment, doesn't it, yeah?

REID Yeah.

DC Code A On the 17th a Mrs KILSBY was admitted and then on the 24th the day after Mr PACKMAN, Mrs MORRIS was admitted back to the ward again.

REID Right.

DC Code A Yeah, now the only purpose of showing you this doctor is to say, does that look like a ward that is, cos obviously new patients take up more time than ...

REID Yeah.

DC Code A ... an existing patient, don't they?

REID Yeah. Yeah.

DC Code A Yeah and so for the period that Mr PACKMAN was there in fact no new patients were admitted at all?

REID Yeah, mm, mm.

DC Code A — And was that, is that an indication that the ward wasn't that busy?

REID — Well certainly it was an indication at that time that it wasn't that busy but as you're aware Doctor BARTON also looked after Daedalus Ward ...

DC Code A — Yeah.

REID — ... and I mean I don't know what, you know the turnover in Daedalus Ward was greater than it was in Dryad Ward so I don't know how busy that was at the time cos that could clearly have effected her workload.

DC YATES — I mean we know that Doctor BARTON was contracted to five session per week and more so in one of her statements she says that it was actually increased in 1998 to five sessions but her contract from way back, she was contracted to five sessions per week but in your opinion as a consultant in 1999, at that time was Dryad Ward understaffed and overworked or ...

REID — Medically or nursing wise?

DC YATES — ... well medically first.

REID — Um, sorry just what was, did I think it was overworked medically or overstaff?

DC YATES — Well first of all was Dryad Ward understaffed?

REID Medically?

DC YATES Medically.

REID I think that would depend on what was going on on Daedalus Ward. I mean it's my understanding that turnover started to increase from 1999 onwards but without having you know the facts there I couldn't, you know I can't say that's actually the case. See I'm not clear how different things were in 1999, say from 1996 I just don't know.

DC YATES If Dryad Ward was understaffed as the consultant for Dryad Ward would you have been aware?

REID Well I think the nursing staff would have reported to me that they weren't getting sort of, if you like, adequate you know from Doctor BARTON. In fact it was quite the reverse the nursing staff were indicating that Doctor BARTON was very assiduous and coming you know usually coming in two or three times a day etc, so.

DC YATES And had you received adverse reports would you have ...

REID I'd have tackled it.

DC YATES ... you'd have tackled it?

REID Yes.

DC YATES — Now a lot of Doctor BARTON's stuff, statements actually use the words she anticipates that she would have reviewed Mr PACKMAN on the basis with regards prescribed drugs for him, for instance on the 24th of August and if you go to the prescription sheets you can see she has actually prescribed drugs on the 24th but not made notes in the medical notes. Again she, she states that she would visit patients up to three times, or visit the ward sorry up to ...

REID — Three times a day, yes.

DC YATES — ... three times a day. So it would be morning, afternoon and possibly every evening. Now Code A s just shown you Mr PACKMAN was admitted to Dryad Ward on the 23rd of August, just shown you on the calendar. Was assessed by Dr RAVIDRANE on that day.

REID — Yeah.

DC YATES — And the next entry is on the clinical notes whereby Doctor BARTON on the 26th and 28th ...

REID — Yeah.

DC YATES — ... in 1999 and then you personally reviewed him on the 1st of September and that's nine days after he's admitted. Disregarding what Mr PACKMAN was suffering from, we'll cover that in a bit why wouldn't you have queried why over a period of nine days there's only been three

entries on the clinical notes for a man with, as you state, a poor prognosis?

REID — Well I mean I was conscious that Doctor BARTON was working hard. In terms of the note keeping I think I've already said I'd always felt that when there was important change in the patient's condition Doctor BARTON you know did generally make a record of that, although that might be a sort of fairly brief record and I also, I mean I didn't want to sort of um, you know unnecessarily burden her by saying that every single interaction with the patient had to be recorded because I'd recognised that she was, you know she was working hard.

DC YATES — I mean even in our line of work people can work extremely hard but be heading in probably what is the wrong direction, that is the duty of the supervisors or any of us that have any responsibility for guiding people, sort of put them on track and point them back in the right direction.

REID — Yes, yeah.

DC YATES — Is that one of your, was that one of your duties?

REID — Yes, yeah. I mean with hindsight I think I can say I should've spoken to Doctor BARTON about her note keeping.

DC YATES — But as I say a gap like that, it actually appears that she hasn't seen the patient for nine days, doesn't it?

REID Well it looks like that.

DC YATES Yeah.

REID Six days.

DC YATES Six days is it? Yeah six days. So it's just, not just lack of notes, there's not any reference to Mr PACKMAN's general condition. There's no comment re care plans or drugs.

REID No.

DC YATES So why was this lackadaisical approach allowed to happen ...

REID Well doc..., ...

DC YATES ... and allowed to continue?

REID ... yeah well Dr RAVINDRANE had made a sort of, you know fairly sort of detailed notes, you know on the initial medical clerking and then after that sort of initial notes what I would just expect would be to sort of details, you know when they're being, as I say important change in the patient's condition had occurred. So I wouldn't expect Doctor BARTON to sort of reiterate stuff that had already been, you know recorded in the notes and as I've said

already I mean I'd always felt that when there was an important change Doctor BARTON did write it down.

DC YATES — Okay. Right well we know that Doctor BARTON was called to see Mr PACKMAN on the 26th of August and we know it must've been after six o'clock (1800) in the evening cos there's an entry on page 168 if you want to check, which shows she gave a verbal order at that time to Sister HAMBLIN for Diamorphine.

REID — Mm, mm.

DC YATES — And that's a few days or so after he was admitted and I know you reviewed the patient on the 1st of September. Where would the patient's medical records be at the time, from the time of his arrival at the hospital would you have all the medical records from the QA as well?

REID — They should be there, yeah.

DC YATES — So for you to, when you review a patient, in particular obviously Mr PACKMAN, but how would you review a patient? What would be your process?

REID — Well as I say I'd speak to the nursing staff.

DC YATES — Yeah.

REID — And look at their medical records, speak to the patient and take things from there.

DC YATES — But how far would you go into the medical records yourself?

REID — It would depend on, you mean go back in the medical ...

DC YATES — Yeah.

REID — ... I mean I'd look at the last sort of entry that was in the, in the notes and depending that, what that told me I would speak to the nursing staff about what had happened or if it related to, possibly related to something that had happened in the past I would go back through the notes ...

DC YATES — Back through that.

REID — ... and I'd look at blood results and or whatever.

DC YATES — So with a lack of notes you would find yourself having to go elsewhere, so to speak, other than the medical notes to find out the information, is that correct?

REID — Yes.

DC YATES — So you may well have to go to the prescription sheets, have a look at the nursing records, speak to the nurses.

REID — I'd look through the, I'd obviously, I'd look at the prescription sheets anyway and I'd always speak ...

DC YATES So as a matter of course, yeah.

REID ... to the nurses so I mean I can't remember it sort of adding, you know to the burden of work.

DC YATES Right. How often did you conduct your rounds?

REID Weekly.

DC YATES Weekly and that was every week was it?

REID Well sometimes there was a bank holiday or if I was on leave or something, cos a Monday being a, I missed some because of Bank Holidays but usually what I'd try to do is catch up on another day and look.

DC YATES Okay.

DC Code A What day did you say you normally conducted your round sorry?

REID Normally a Monday.

DC Code A Cos I think this was a Wednesday.

REID It may have been, I suspect there's, it was August Bank Holiday.

DC Code A Ah, ha.

REID On that would be there.

DC YATES Yeah.

DC Code A Yeah.

DC YATES So if there's a Bank Holiday you'd still get your round in that week ...

REID Well I'd try to.

DC YATES ... albeit a different day.

REID I mean I couldn't say that I managed it every time but I used to try and do that.

DC YATES What, you've got the notes in front of you page 168, this is just to explain something really, which, I just want to get straight. Is it 168?

DC Code A Yeah it is 168.

DC YATES Yeah, once only in pre-medication drugs, there's two entries for Diamorphine ...

REID Yes.

DC YATES ... on the 26th and 28th, is that because they're for once only on that day?

REID Yes.

DC YATES So the 26th is the verbal message from Doctor BARTON?

REID Yes.

DC YATES And who signed that?

REID Oh I think it's, I think I mean I can't, it's not very clear it looks like Jill HAMBLIN's signature.

DC YATES Right and possibly another signature next to it. Shouldn't that be countersigned eventually by the doctor?

REID Yes it should be.

DC YATES Right and the same on the 28th, it's a one off yes?

REID Yes.

DC YATES Now, Page 169, cos this one doesn't necessarily, no it doesn't. Right on the 26th of August the nurse has contacted Dr RAVI who's the, I think he's the local consultant geriatrician, I thought you said he was the Senior Registrar?

REID He's a Senior Registrar but if I were away on holiday he would ...

DC YATES He acts up does he?

REID ... he'd almost act, act, it probably wouldn't be official acting up but he'd be ...

DC YATES He'd cover you?

REID ... yeah.

DC YATES Is that still a training post, Senior Registrar?

REID Yes, yes.

DC YATES So it's like the final, final ...

REID Yes.

DC YATES ... stage of training?

REID Yes.

DC YATES Right now he advised that the Clexane to be discontinued didn't he?

REID Yes.

DC YATES And that Mr PACKMAN's haemoglobin to be checked ...

REID Yes.

DC YATES ... on the 26th and the 27th of August.

REID Yes.

DC YATES Now the haemoglobin level on the 26th August, I think that's page 205 and I'm going to have to ...

REID Yeah it came back as ...

DC YATES ... Take this slowly.

REID ... it came back as 7.5 or something I think.

DC YATES Yeah.

REID 7.7, 205.

DC YATES Yeah. Put my glasses on, poor photograph. 7.7 is it, yeah. Right so the 26th of was 7.7 ...

REID Mm, mm.

DC YATES ... and that's been initialled, yeah?

REID Mm, mm.

DC YATES JAB which indicates that Doctor BARTON has seen the result?

REID I think that's Doctor BARTON's signature, yeah.

DC YATES Now when did you see the result of this test?

REID Well I don't recollect seeing it at all. I mean I may have done on the 1st of September but you know I've no recollection of it.

DC YATES Had you seen it would you have initialled it to say you've seen it or ...

REID No.

DC YATES ... is it just the doctor?

REID No, it's to make, really to make, they like doctors to initial every result that comes back cos it means that there's documentation that someone's seen the result.

DC YATES Yeah. Oh right so if you hadn't seen it were you going to be aware of the fall in haemoglobin?

REID I might, I mean I might not have been aware, I mean it depends what, cos I just don't know what I did on the 1st of September.

DC YATES Okay but certainly from your notes of what you said earlier you were pretty convinced that he was suffering with a GI bleed?

REID And that would confirm that.

DC YATES And that would've confirmed it. Okay did you discuss this matter with Dr RAVI or Doctor BARTON?

REID Oh I don't, I don't, no I don't, well I don't recollect having any discussion cos it was a Wednesday afternoon, Doctor BARTON wouldn't have been there and I don't recollect having a discussion with Dr RAVI.

DC YATES So although there is a fall was a further blood test done at all?

REID Doesn't look as though it was.

DC YATES Right would that have been normal to have a further blood test to see if there was a continual drop or not?

REID I think it comes back to the issue would a further test influence your management. Would you change your approach to treatment?

DC YATES And I've pretty much got my head round that now because if you, the answer to a lot of my questions now you've given and you're saying that your diagnosis of Mr PACKMAN on the 1st of September was the man was dying?

REID Yeah.

DC YATES He had a GI bleed, you weren't going to treat him for it, just to make him comfortable ...

REID Yes.

DC YATES ... and palliative care ...

REID Yes.

DC YATES ... and pass away peacefully.

REID And therefore there's no point in doing more tests.

DC YATES Right.

REID It might be interesting to do but it's not going to do the patient any good.

DC YATES Do no favours, no. Okay so, and really that's your stand point on that then isn't it ...

REID Yes.

DC YATES ... is the 1st of September ...

REID Definitely.

DC YATES ... you were damn sure what was wrong with the man.

REID Absolutely.

DC YATES That, accompanied with his size, and the other problems he had ...

REID Yes.

DC YATES ... he was dying.

REID Yes.

DC YATES And that's why nothing was done ...

REID Yes.

DC YATES ... and why he wasn't moved to an acute ...

REID Yes.

DC YATES ... okay. Geoff do you want to?

DC Code A No.

DC YATES Is that, having read the notes that Doctor BARTON made on the 26th wasn't it, back on page 55 I think it is ...

REID Yes.

DC YATES ... from reading those are you assuming that Doctor BARTON was probably thinking along ...

REID Yes along ...

DC YATES ... along the same lines although she wasn't sure it was a GI bleed or an ...

REID ... yes.

DC YATES ... MI?

REID Yes.

DC YATES What would actually make you go towards a GI bleed as opposed to an MI on your diagnosis?

REID Well again it's just from the notes, the fact, and his haemoglobin had dropped from 12 to 7, I mean that's huge, that's absolutely huge and that was done, what three, four or five days before I saw him and he clearly had been continuing to lose blood. So it wouldn't surprise me if his haemoglobin had been 3 or 4 when I saw it, in other words he'd catastrophically ...

DC YATES So it was a considerable bleed?

REID ... I think so, yeah and there's several references to passing black stools and if you notice them you're bleeding quite a lot.

DC YATES Now obviously there are other things that can cause bleeding from the anus haemorrhoids and things like that. Is it significantly different?

REID — Yes because it's what we call myolena, which is, it's not, it doesn't look like blood, it's black and it's black because the blood loss has occurred in the upper part of the gut. The stomach acid changes it and it becomes black. So I think we talked about it earlier that black, there are a lot of causes of black stools. Iron tablets can give you black stools but other than that you're bleeding. It means you're having a big, really a big, you know GI bleed from the upper part of the stomach.

DC Code A — And that's a very basic thing even an inexperienced doctor to ...

REID — Yeah.

DC Code A — ... to diagnose isn't it?

REID — Yeah.

DC Code A — Yeah.

REID — Nurses will pick that up.

DC YATES — And that brings us back then to the death certificate, even nurses can pick that up, yet the nurse can certify that you're dying of myocardial infarction or heart attack?

REID — Yes I mean it's more than likely he died of a GI bleed than a heart attack.

DC YATES I think another, again, Mr PACKMAN's being treated with Diamorphine, one of the side effects of Diamorphine is constipation isn't it?

REID Yes.

DC YATES Yet we've seen earlier on he's actually had problems with diarrhoea ...

REID Yes one ...

DC YATES ... I think on two occasions wasn't it?

REID ... yeah I mean one wonders if, although it doesn't directly say, that the diarrhoea was actually what I call myolena stools, cos it's usually pretty soft sort of stuff.

DC YATES Mm but that's another indication when, when, you wouldn't be surprised if a patient's constipated, it is actually the opposite?

REID Yeah can, yeah can I just clarify cos what you can get with Diamorphine and constipation is if you get very constipated, it essentially acts like a sort of plug in your bowel, you can't shift it, get it out and what starts to happen is more liquid motion actually seeps down round the edges and the patient's present with diarrhoea but if you actually examine them they're actually constipated.

DC YATES Constipated.

REID And the treatment is to relieve the constipation.

DC Code A So via medication?

REID Well any medicine, probably a combination of enema's and softening, stool softening agents.

DC YATES Right at the QA Hospital his only analgesic was Paracetamol?

REID Yes.

DC YATES Is a GI bleed particularly painful?

REID Well it could cause abdominal ...

DC YATES Bloating?

REID ... distension but certainly what it can do is make people feel really ill and unwell and there is some reference in there ...

BUZZER SOUNDS INDICATING THE END OF THE TAPE

REID ... there is some reference in there to him having, you know intermittent abdominal pain.

DC YATES Yeah.

REID I mean one certainly wonders was that because he was bleeding from blood distending bowel or from, probably from having an ulcer it's certainly a possibility.

DC YATES Okay the tapes just ended there and it's not a bad place to stop so the time is 1440 and I'll turn the recorder off.

GMC100748-0267

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y25W

Enter type: FULL TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 08/08/2006

Time commenced: 1502 Time concluded: 1545

Duration of interview: 43 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC2479 YATES

Other persons present: MR CHILDS - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	Okay this is a continuation of the interview with Dr REID. The time is 1502 hours. Dr as I say there's been a short break while the tapes have been changed etc. Have you been asked any questions about the matter ...
REID	No.
DC YATES	... while the tapes been off. Excellent. It's the same people present?

REID Yes.

DC YATES Right. If I can refer you to I think it's page 55 (inaudible), in fact we'll go to page 54. This is Dr RAVINDRANE.

REID Hmm, mmm.

DC YATES Just very quickly, it's the 23rd of August.

REID Hmm, mmm.

DC YATES And that is the day that Mr PACKMAN comes to the War Memorial ...

REID War Memorial yes.

DC YATES ... hospital.

REID Yes.

DC YATES And he's checked and the initial assessment is done by Dr RAVINDRANE.

REID Hmm, mmm.

DC YATES About six lines down he's got a query malina?

REID Yes.

DC YATES Right. So on the 23rd August there is a suspicion that there's a possibility ...

REID Yes.

DC YATES ... there. In fact on page 52 I think it is ...

REID Yes it's been queried.

DC YATES ... 13th of August it's queried as well.

REID Yes.

DC YATES Okay. So it's in everyone's mind ...

REID Yes.

DC YATES ... that there is that possibility?

REID Yes.

DC YATES Right. We've already covered that a GI bleed is life threatening.

REID Yes.

DC YATES And it is a medical emergency.

REID Yes.

DC YATES Is a GI bleed treatable?

REID Ye ... with difficulty.

DC YATES With difficulty.

REID It ... with a GI bleed you can you know just bleed profusely or you can just trickle like slowly. And people trickle very slowly there's you can have you know days, weeks to investigate what the cause is and treat. Bleeding ... first of all you have to ... well the treatment is to try and establish where someone is bleeding from if they're really you know bleeding a lot. And that involves what's called endoscopy which is looking down into the stomach and seeing if you can find the source of the bleeding. Usually the source can be identified but sometimes a source isn't identified. There can be different sources of bleeding, I mean some patients the stomach may just be sort of oozing blood generally. In other cases it maybe see an obvious ulcer and sometimes it will actually see an artery in the ulcer spurting blood and via the endoscope if you see that you can try cauterising it to stop the bleeding. Sometimes what they see is a clot adherent to an ulcer and they don't want to dislodge the clot for fear of sort of cause further bleeding so they leave things be. At the same time as not having done that you can start people on ... there's drugs which heal ulcers but the evidence that they have much effect when you're actively bleeding is not good but they're generally given anyway in the hope that they might do something. But people who are, as this chap was, dropping

in haemoglobin 5 grams in the space of two days that's a significant bleed and that you know potentially could be difficult to treat, and given his particular circumstances you know the fact he was so large would make it even more difficult.

DC YATES — Okay.

REID — So it is not ... and what sometimes tend to happen if bleeding is continued people then have to go to theatre to have a partial hysterectomy have part of the stomach removed. So treatment is not easy.

DC YATES — Yeah I'm with you. And possibly with as you say somebody as large as Mr PACKMAN.

REID — That's gonna make it more difficult.

DC YATES — Okay. But we have had a mention as far back as the 13th of August ...

REID — Yes.

DC YATES — ... or a query, again on the 23rd August ...

REID — Yes.

DC YATES — ... of Dr RAVINDRANE, that's 10 days.

REID — No I think what he was referring to was ...

DC YATES Yes.

REID ... a previous episode.

DC YATES It brings it to the fore again though.

REID Yes.

DC YATES Yeah. And for a Dr to then pick the notes up as Dr BARTON would the next day possibly although her notes aren't for a couple of days, surely she'd read the notes made by Dr RAVINDRANE?

REID Well I'd have thought she would have done.

DC YATES It's there for all to see.

REID Yes. And I think it really depends on how the patient actually presented to Dr BARTON. I mean she's clearly considered it cause she said that he hasn't been vomiting up blood.

DC YATES Okay. And that's Haematemisis.

REID Haematemisis yes.

DC YATES Vomiting blood. Is that always the case with a GI bleed?

REID No.

DC YATES So ...

REID It doesn't exclude it.

DC YATES It doesn't exclude it. Okay. Now we know some of the other symptoms that can indicate a GI bleed which are the black loose stools.

REID Yes. That will often not happen, they sometimes can ... will take two or three days to come through the system.

DC YATES Okay.

REID Depends how quick they're bleeding.

DC YATES Would other symptoms ... could other symptoms possibly be pale, clammy, unwell?

REID Very consistent with GI bleeding.

DC YATES Okay. Now there's some nursing notes on page 62 dated the 25th of August I've marked down. Passing fresh blood PR, query clexane, verbal message from Dr BEASLEY to withhold.

REID Yeah. Sorry ...

DC YATES That's at 1800 yeah?

REID Yeah.

DC YATES Dose and review speaking to Dr BARTON I think it is in the morning.

REID Yes. I mean that would be ... be unusual to pass fresh blood from an ulcer in your stomach unless you're absolutely pouring and you'd be very ill. So I think that that comment of passing fresh blood is unlikely to be this GI bleed. It could be but I think it's unlikely. Now what I'd sort of forgotten about was that this patient was on clexane and the likelihood of you bleeding is increased by while you're on clexane. And I mean it's possible that this chap could have had say piles and unknown and bled from the pile because of being on clexane. It could have been from another GI bleed but I think that's a bit unlikely if he wasn't that unwell.

DC YATES Okay. So there's a possibility he's not that unwell but there's a possibility of a GI bleed has been brought up now for ...

REID Yes.

DC YATES ... 12 days.

REID Yeah.

DC YATES So come the 26th of August I think it's on here as well, unwell at lunchtime.

REID Yes.

DC YATES Colour poor, complaining of feeling unwell. Seen by Dr BARTON this afternoon, await results of the haemoglobin, further deterioration, query indigestion, pain in throat, not radiating, vomited again ...

REID Hmm, mmm.

DC YATES ... this evening, verbal order from Dr BARTON, diamorphine 10 milligrams stat.

REID Mmm.

DC YATES And that was given at six o'clock. Metaclopramide 10 milligrams given.

REID I mean that could have been consistent with having a heart attack you know. And you know again if you thought if someone had been having a GI bleed at that time you would have indigestion, vomiting they might have brought up blood. So you know it's been ... I think to think of an MI as well was perfectly legitimate.

DC YATES So that's what I'm just trying to establish though cause there's mentions of a possible ... a possible bleed which is the 13th of August, well initially on the 13th of August. You've got the vomiting and there are further mentions of loose stools. Now that brings us up to the 26th and Dr

BARTON actually writes the notes ... I think Dr BARTON may well have seen Mr PACKMAN before that but on the 26th she actually writes some notes. And that's back to page 55 again where she's querying a GI bleed okay. Now from what you've just told me now yes there was a query on the 13th of August, nothing really repeats itself before Mr PACKMAN gets to the War Memorial with Dr RAVINDRANE is just really repeating the incident on the 13th of August.

REID — Yes that's right.

DC YATES — And he arrives on the 23rd doesn't he?

REID — Hmm, mmm.

DC YATES — So ... and all these other things that I've actually brought up, the passing fresh blood and vomiting you said actually it still doesn't necessary indicate that he's having a huge bleed.

REID — Hmm, mmm.

DC YATES — Now that (inaudible) said it on the 26th of August he was possibly might be bleeding but he's alright.

REID — On the 26th he's ...

DC YATES — He's possibly bleeding.

REID Yes.

DC YATES But he's ... he's not on death's door yet.

REID Not ... possibly not. I mean it's difficult to say from ... say from this.

DC YATES Well on the 1st of September then we'll take you to your entry Dr and you've made your notes six/eight lines. You're quite convinced reading your notes now that you realised this was a GI bleed?

REID Yes.

DC YATES You're unsure whether you would have seen the haemoglobin. If you had seen the haemoglobin you said ...

REID It's a definite ...

DC YATES ... it's obvious ...

REID ... GI bleed yeah.

DC YATES It's a huge loss now. What's been done since the 26th of August and the 1st of September though? The test results have been back, all these indications that he might be having a GI bleed, what's been done?

REID Well other than read his symptoms nothing. The thing is what can you do in this situation. Well if someone was in

QA what you think about is now should we start thinking about transfusing someone. We can't transfuse people in the War Memorial Hospital because there isn't a doctor on site all the time and for a blood transfusion you're required to have a doctor on site in case people develop allergic reactions to the blood. So being in the War Memorial is sort of bad news if you like in terms of being able to transfuse someone. So you then have to make a decision well should we think about transferring the patient for transfusion and the issue then becomes well is that the ... is that the right thing to do, you know in other words if things are so bad that you think the patient's not likely to survive or not survive the journey or if the patient doesn't wish to go and would they ... as I say they survive the journey. So that's the sort of decision that has to be made whether a transfer back is appropriate or not. And from Dr BARTON's note it certainly ... appear that she's considered that possibility, should the patient be transferred back because he's become unwell but she's felt that he wasn't fit ... or what she's written is wasn't fit to be transferred back.

DC YATES — Yeah and ... yeah I mean that entry is plain to see. But what evidence is there to support that entry?

REID — Well I think it has to be a judgement you make at the time and there's nothing written to support that statement.

DC YATES — No there's not anywhere. So it's not just Dr BARTON's poor notekeeping on this occasion there is no evidence that

I can see, unless you can correct me, that would support Dr BARTON's statement that the patient's not well enough to transfer.

REID — One would think twice about transferring someone who's having a heart attack.

DC YATES — Mmm.

REID — Because we know that you know stress and anxiety could potentially make things worse. But ... so that may have been part of the thinking behind her decision but I can't say because there isn't a note as to why the decision was made.

DC YATES — And I accept that Dr BARTON has put or suggested a myocardial infarction an MI.

REID — Yes.

DC YATES — As well as a GI bleed. But the evidence that's available in the form of these notes of people that have been treating Mr PACKMAN it actually all points towards to a GI bleed doesn't it?

REID — Well there's only been a question raised about it before.

DC YATES — Mmm.

REID There was the fresh bleeding from the rectum which you know I'm not sure that's really of any significance in this to be fair. The haemoglobin count was only done that day.

DC YATES Yeah.

REID And I mean there's notes to the effect that they were unable to ... whether Dr BARTON was aware of that result when she you know wrote these notes and when the nursing notes were written up, I don't know.

DC YATES Hmm, mmm.

REID Because I mean I think if she'd been aware of that she would have ... she might well have thought differently.

DC YATES Okay. So black stools overnight on the 13th of August at the QA.

REID Yeah.

DC YATES I appreciate Dr RAVINDRANE's just repeated that.

REID Yes.

DC YATES Or brough it forward onto the notes. The entry on page 62 and there's the note dated the 25th August passing fresh blood and vomiting.

REID Hmm, mmm.

DC YATES — An entry on page 62 of those notes dated the 26th of August, unwell at lunchtime.

REID — Mmm.

DC YATES — Colour poor, complaining of query indigestion, pain in throat, not radiating, vomited again this evening. So that's probably pushing on past possibly when Dr BARTON got there.

REID — Hmm, mmm.

DC YATES — But we're not too sure of that yeah. The indication to me again as a layman are that from what we've been told and what we've read is it's still pushing towards a GI bleed?

REID — Pain in throat would be unusual of a GI bleed unless ... I mean if you bleed very severely then you can get the heart can ... you can get heart pain. I mean the other thing to say the 13th of August isn't the only time that black stools is ...

DC YATES — No.

REID — ... mentioned on the notes. Now usually if you're passing black stools and having sort of significant you know bleed, your blood count drops and one of the things that Dr TANDY was at pains to do was to check that Mr PACKMAN's haemoglobin was okay before he went to the War Memorial.

DC YATES Hmm, mmm.

REID Which she did and it was. So that raised the question from me I'd have thought if someone had been bleeding from the 13th through the to the 24th passing black stools you'd have picked it up by a drop in the blood count before then. So I think the ... although it's been considered a lot it's a bit strange really that if he was bleeding ... well if he was bleeding beforehand the white ... sorry the haemoglobin count would have dropped.

DC YATES Hmm, mmm.

REID He'd bleed significantly. So it's a bit of a ... it's a bit of a puzzle really.

DC YATES Okay. But even so then that's actually pushing more towards then on the 26th of August he was stable. He was a big man, he was a fat man with sores, he was immobile, morbidly obese.

REID It says he was unwell complaining of feeling unwell, cold, clammy.

DC YATES So he's arrived ... he's arrived at the war memorial ...

REID Sorry this is what date?

DC YATES Well he's arrived at the war memorial on the 23rd.

REID Right.

DC YATES Round about that time there's been a haemoglobin check there's been fall so if there is a bleed it's gonna be almost as insignificant.

REID (Inaudible).

DC YATES If he's bleeding at all, is that right?

REID Yes.

DC YATES And now on the 26th of August he's pale, the Dr's been called in to see her ... to see him, he's pale, clammy, unwell. Okay two possible diagnoses, one of them being a GI bleed.

REID Hmm, mmm.

DC YATES So ... but at that stage then he's not ... I mean when you say you saw him on the 1st of September you said you looked at him and thought ... what you were presented with to put it bluntly the poor man had had it, he was going to die.

REID Yes.

DC YATES Was that the case on the 26th of September?

REID — I mean I can't ... I can't say for sure but with Dr BARTON having written, what was the term, you know unwell, cold, clammy etc.

DC YATES — Yeah yeah.

REID — I am happy for nursing staff to confirm this. Certainly it raises the possibility to me that Dr BARTON thought he was seriously if not terminally ill at that time.

DC YATES — Right. I just still find it very difficult to understand how ... how your patient at the Gosport War Memorial Hospital is actually in a worse position than a patient in the street or at home. The transfusion part I accept but if the patient can't be treated at hospital and it is a medical emergency surely they should be transferred to somewhere where they could be treated.

REID — If that's what the patient and the family you know agree as ... and the Dr thinks that's the right thing to do.

DC YATES — Okay. So the family should be aware that ...

REID — I'd have thought the family should have been aware if there was a very significant change in this man's condition.

DC Code A — Well before we go on from that, when he came in on the 23rd of August, tell me whether you agree or disagree, that he was obese, he had arthritis in his knees, he had ... he was immobile.

REID Mmm.

DC Code A Pressure sores and constipation.

REID Hmm, mmm.

DC Code A Was he in a life threatening condition when he came in to Gosport War Memorial Hospital on the 23rd of August?

REID In the sense of life threatening was he likely to die in the next sort of 24/48 hours? No.

DC Code A He'd gone to Gos ... sorry go on.

REID But I think that he was on ... he was on the slippery slope because of having all the things we've just gone through. The outlook when you're as overweight as that, you've got pressure sores, you can no longer move off the bed, is poor. And I can't tell whether it's gonna be you know one week, one month, six months but things do not look good when you're in that position.

DC Code A Well we discussed earlier on when we talked about this ... when we first started talking about this case today and you were you ... you weren't aware that he had had a fall, but that was why he'd ended up in hospital, he had a fall at home and he was then immobile but he was immobile. It was in the ... it's in the Q.A. notes ... sorry I'll find it for you in a minute Dr but it's in the Q.A. notes, it's at the ...

it's in a ... on his entry into hospital. And I think you thought he was just immobile didn't you?

REID (Inaudible). I can't ... I don't recollect seeing anything (inaudible).

DC Code A It's at the top of a page.

REID Page 42.

DC Code A Is it thank you. There you go. Fall at home, unable to mobilise, obese, 2 x ambulance crew called to assist. So he'd had a fall at home. If when that ambulance crew had arrived at his home and he is now in the condition that we find him in on the 28th, 29th, 30th of August ...

REID Hmm, mmm.

DC Code A ... what would you expect that ambulance crew to do to him?

REID Well they would ... if there's something wrong they'd probably try to get him into hospital unless he or his wife said that that was not what they wanted to happen.

DC Code A Is there any evidence that his wife didn't want him to get further treatment?

REID Well what I'm aware of from the notes is that his prognosis has been ... probably was discussed with his wife.

DC Code A — Yes.

REID — And that she agreed with the ... what care he was having at the War Memorial

DC Code A — Was she told that he had a GI bleed?

REID — I don't know.

DC Code A — Is there any evidence that he was told ... she was told that he had a GI bleed?

REID — There's nothing ... nothing ... well.

DC Code A — Is there any evidence in those notes Dr that it was carefully explained to her what exactly was wrong with her husband? And in actual fact was she there because my understanding is that she herself was under the surgeon's knife at the Q.A. hospital at the time.

REID — My under ... well I thought that she was going in to have surgery the day that he died. Mrs PACKMAN ... on the 1st of the 9th it says Mrs PACKMAN was visited this afternoon is aware of her condition. She's being admitted to E1 Ward tomorrow for surgery.

DC Code A — Yeah. So on the 2nd of September she was in hospital herself wasn't she?

REID — One presumes so. I mean on the 27th of August cause we've got the wife has visited this afternoon is aware that condition could deteriorate again. Still remains poorly.

DC Code A — But when ...

REID — 26th of August 1700 hours Dr BARTON here for Oramorph, wife seen by Dr BARTON explained Mr PACKMAN's condition and medication used. That was the day he deteriorated. So that's the 26th of August at 1700 hours. So one would assume Dr BARTON had explained what she felt was wrong with Mr PACKMAN and discussed his future treatment.

DC Code A — Well you mention the 26th of August ...

REID — It's page 62.

DC Code A — Yeah sorry no I'm looking for another ...

DC YATES — Await results?

DC Code A — Yeah, yeah.

DC YATES — So await results have been .

DC Code A — Yeah you covering that?

DC YATES — I will be yeah.

DC Code A — Okay we'll leave that for a minute Dr cause that will come up in a moment.

DC YATES — Well accepting that Mrs PACKMAN's been made aware of the poor prognosis of her husband ...

REID — Hmm, mmm.

DC YATES — ... would it have been explained ...

REID — Well it said Mrs PACKMAN's explained Mr PACKMAN's condition.

DC YATES — Yeah. Would they have ... would it have been explained actually that apart from being morbidly obese etc there are things that can be done for a GI bleed but it would involve transfer to another hospital. Will those things ... will they be explained?

REID — Well they should be.

DC YATES — Should be. Again it's just not ... nothing's documented. If you look at page 62 as you're on it.

REID — Mmm.

DC YATES — And it's ... this one's from Gill HAMBLEN and it's Sister HAMBLEN. Fairly good morning no further vomiting. So he's obviously been vomiting. Dr RAVI contacted re clexane, advised to discontinue or repeat.

REID Haemoglobin.

DC YATES Haemoglobin today and tomorrow. Not for resuscitation. Unwell at lunchtime, colour poor, complaining of feeling unwell. Seen by Dr BARTON this afternoon. Await results of haemoglobin. Further deterioration. Complaining of query indigestion pains and throat not radiating. Vomited again this evening, verbal order from Dr BARTON diamorphine 10 milligrams stat, same given at 1800. So if you go to the prescription sheets you can see on the 26th August, you won't see it quite so clearly but you'll see it is different handwriting, 1800 diamorphine, and that's Gill HAMBLEN's.

REID Yes.

DC YATES And it's easy for me cause it's actually written in blue

REID Hmm, mmm.

DC YATES Now Dr BARTON obviously attends yeah.

REID Hmm, mmm.

DC YATES And you'll see on page 171 I expect it will be half way down oramorph.

REID Hmm, mmm.

DC YATES Now that's been written up ... that's been written up by Sister HAMBLEN again but it's been signed by Dr BARTON, dated by Dr BARTON. Now it's a bit more plain to see on my copies cause it's the original.

REID Yeah I think I can see what you're ...

DC YATES Yeah it's different hand writing, different pen. All the times have been put in and that's never ... never been administered has it?

REID No.

DC YATES Right. Straight away then Dr BARTON's come in she's signed that, she's now written up diamorphine on the 26th, midazolan on the 26th.

REID Yeah.

DC YATES Oramorph again twice, one's 10 milligrams one's 20, and the hyoscine.

REID No the hyoscine wasn't ....

DC YATES No the hyoscine was later. The two oramorphs on page 172, medazalam, diamorphine and then the oramorph that was written up as a result of a verbal request. All written up on the 26th. Right the diamorphine we can see underneath the 26th of August it's actually not given till the 30th and the 31st.

REID Yes.

DC YATES Yeah. Okay. Midazolam well that appears to be given on the 26th of August.

REID Prescribed on the 26th of August.

DC YATES According to these notes given on the 26th of August.

REID Yes. Having said that I mean you know I take your point but what it seems to have happened to me is if you look at the signatures under diamorphine and Midazolam then obviously you go from the first one where it's written on the 30th.

DC YATES Yeah.

REID The signature at 1445 looks to be the same signature as is given for Midazolam.

DC YATES It is.

REID And then on the 31st the same.

DC YATES I think ...

REID So I think that these ... the medazalam was not given on the 26th of the 8th it was actually given on the 30th, 31st, the 1st ... the 1st and 2nd.

DC YATES And I think you're right, this is what I was going to come on to. But it doesn't say that and it's just shown, it's a bit of a Fred Carno circus here now, it's a bit of a Fred Carno circus going on here.

REID Yeah.

DC YATES It's all over the show. You've got a sister actually writing things in, sister's putting the dates in etc she hasn't put the dates in properly. All these drugs have been written up, diamorphine, Midazolam, the oramorph three times oramorph's been written up on that day.

REID Yeah.

DC YATES Nobody seems to know what they're doing there, they're just ... it's not professional is it?

REID Well that's it.

DC YATES It's not professional.

REID I would say that's poor ... poor practice.

DC YATES It is very poor. So it makes you think does anyone know what they're doing there? I mean also on the 26th of August this patient Mr PACKMAN is going downhill or he's started to feel unwell. By the 1st of September he's ... he's going to die you say when you saw him, there's no

doubt in your mind. But what was being done in the 5 days previous? It's all over the show, the notekeeping we've said abysmal, notekeeping and on the prescribe ... on the prescription sheets it's abysmal. And failing that I thinking probably one of your more junior house officers will pick up things like GI bleeds and that. It hasn't been picked up. There is no evidence here that has actually been picked up and dealt with. Now there is a duty of care to the patient Dr BARTON has it but you too have it don't you?

REID Yes.

DC YATES Now was that duty of care actually complied with, did you actually provide that duty of care to Mr PACKMAN?

REID Well I think I did.

DC YATES What did you do about this, about the whole scenario?

REID Well when I came on the 1st of ...

DC YATES September.

REID ... September in the time given to me, I mean what I've said was that I have to look at you know what's the ... if you like, the most pressing problem ...

DC YATES Hmm, mmm.

REID ... that I've seen. And to me this was a man who was having a GI bleed with multiple problems who is dying and I felt the most important thing was that was palliation.

DC YATES Hmm, mmm.

REID And I can't remember the prescription charts whether I looked at them or not. I mean I have to say that I just can't remember. But we've got documentation here from the 26th of August that Dr BARTON has discussed Mr PACKMAN's medical condition with his wife on a number of occasions.

DC YATES Mmm.

REID And therefore my assumption is from that that his future management plan has been discussed and agreed with his wife.

DC YATES I think most people or the majority of the public believe what a Dr tells them. The Dr is all knowing when it comes to patients and you go to hospital and you feel rest assured the Dr will, to the best of his ability, sort you out and make you better. I think that's the general presumption of the public and relatives assume the same. Dr BARTON could have explained all sorts of things to Mrs PACKMAN ...

REID Hmm, mmm.

DC YATES ... but what did she do about caring for Mr PACKMAN the patient?

REID Well I mean what I can't ... I mean I don't know what discussion Dr BARTON had with Mrs PACKMAN, what she actually discussed.

DC YATES Okay. Well ignore that, ignore what the discussion with Mrs PACKMAN ... but what did she do for you know ... I know what you're saying is did she ask Mrs PACKMAN's permission to do things etc.

REID Well I mean Dr BARTON may have felt at that stage as I did on the 1st I don't know, that Mr PACKMAN was terminally ill and the most important thing was to relieve his symptoms, that palliative care was what was needed, and that it was not appropriate to do anything else because his outlook was so poor.

DC YATES Why on the 26th of August was his outlook so poor, he was pale and he was clammy?

REID It seems that's what she ... that's what she may have felt on the 26th of August.

DC YATES Now you've arrived at the hospital 5 days later, 6 days ... 5/6 days, but on the 1st of September anyway.

DC Code A Five.

DC YATES ... five days. And you've been presented with a patient who you are saying is ... the man is going to die.

REID Yes.

DC YATES He is ... the bleed has gone too far.

REID Yes.

DC YATES He was too big, morbidly obese ... he's going to die. Looking through the notes as you're ... as you're doing your round and as you are examining this patient you must have picked up the fact that ... what has happened since this man's been here, what has been done for him. And it actually looks as though ... it looks as though it's very little doesn't it.

REID Well I think I've said it all already that you know I examined the patient I felt he was terminally ill. I'd have heard from the nursing staff that there'd been discussions with Mrs PACKMAN about how her husband should be managed and my assumption would have been that whether he should be treated, transferred had not really been discussed with him. And therefore there was no need for me to do anything more than that.

DC YATES No but ...

REID If that ...

DC YATES But looking back on what had been done before cause the overall responsibility for the care of that patient Dr fell with you.

REID Yes.

DC YATES So looking back from the 1st of September, at the moment I'm not quibbling or arguing with what you were presented with, you say that's what you saw, that's what you thought then fair enough. But what had happened beforehand?

REID Well I mean it may have been inappropriate because it's ... there's no record of the discussion with Mrs PACKMAN about what was or wasn't discussed, it's ... and I can't make a judgement on that. About whether it was appropriate or not.

DC YATES So having ... having looked at the notes yourself at the time but even now, actually having looked at the medical notes where the patient has deteriorated so rapidly really, would you not have brought this up with Dr BARTON and said look where are your notes, have you seen the patient each day. The nurses say you have, but where are your notes?

REID I would have spoken to the nursing staff.

DC YATES Yeah but why isn't a Dr that is charged with looking after one of your patients on a day to day basis performing her job properly.

REID Well I mean ...

DC YATES Why is she not keeping adequate notes.

REID I mean ... I mean I can't say in relation to the care of this patient. I mean as I said before if Dr BARTON wasn't on my round on a Wednesday afternoon, I'd have sort of been relying on the nursing staff to tell me what had happened and to look at what had been recorded in the notes.

DC YATES But there's been very little recorded in the notes.

REID Absolutely.

DC YATES So what did you do about that?

REID Well I didn't ... I mean I don't remember that I took any further action about it. But I said I did speak to Dr BARTON about variable dose prescribing... whether it was this patient or whether it was ... I can't remember.

DC YATES Okay. Were there any guidelines or protocols or practices in existence that would specifically prevent or encouraged then re transfer of patients to acute units? Were there any guidelines at the hospital?

REID I don't know of any, I mean there may have been some but I just don't know.

DC Code A — No political shenanigans or ... that would encourage you not to send a patient to an acute ...

DC YATES — Bed spaces and things like that. On page 172 which are the prescription sheets the oramoraph at the top, is that my eyes or is there a range 10 to 20?

REID — 10 to 20?

DC YATES — Cause I've lost my glasses. I'm not used to them. It says a range available, am I right in thinking that the record doesn't show actually what dose was given.

REID — It looks like that.

DC YATES — Is there an explanation for this or is it just poor record keeping again?

REID — Well I'd say that's just poor record keeping.

DC YATES — And I know I've asked this ... what safeguards were in place preventing the inadvertent unintentional administration of these drugs to Mr PACKMAN, too much?

REID — Well there's ... I mean there's none other than the expectation of the nursing staff would start with the lowest dose.

DC YATES But actually if I was to ask you what dose of morphine or oramorph did Mr PACKMAN receive on some of those days you couldn't actually give me an answer could you?

REID I couldn't say for sure no.

DC YATES No. And what exactly was the pain and the distress that Mr PACKMAN was in, the pain or distress?

REID Well ...

DC YATES Or the reason for the oramorph?

REID Well he was ... I mean Dr BARTON said he was pale, clammy, did it say distressed I can't remember? Pale, clammy, unwell. Well if he'd either a GI bleed or MI he may well have been feeling distressed and one would presume that that's the reason for it's prescription.

DC YATES Right. Right 22nd I'll just pull the nursing notes up just to check.

(Sound of buzzer).

DC YATES Alright the tapes just coming to an end the time is 1545 hours and I will turn the recorder over and change it.

(Interview concluded).

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RECORD OF INTERVIEW

Number: Y25X

Enter type: FULL TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 08/08/2006

Time commenced: 1556 Time concluded: 1627

Duration of interview: 31 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC2479 YATES

Other persons present: MR CHILDS, SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This is a continuation of the interview with Dr REID. The time is 1556 hours. Dr REID can we just confirm the same people present?
REID	Yes.
DC YATES	And have you been asked any questions about this matter while the tapes have been turned off?
REID	No.

DC YATES And the break was just to stretch your legs and ...

REID Yes.

DC YATES ... get a breath of fresh air. Okay. I'm actually going to take you back now to the morning of the 27th of August 1999, if I can find my place in a minute. I think it's page 62 I'm after.

REID Page?

DC YATES 63 I expect. Yeah page 63 at the top 27th of August in the nursing notes. It says some marked improvement since yesterday seen by Dr BARTON this AM. To continue oramorph 4 hourly and the same given tolerated well, some discomfort this afternoon especially when dressings being done. Wife visited this afternoon and is aware that condition could deteriorate again, still remains something poorly.

REID Poorly. It's Gill HAMBLIN'S signature isn't it.

DC YATES Oh she's signed it up there yeah. So he appears to have stabilised somewhat on that day?

REID Hmm, mmm.

DC YATES And in addition there probably would have been ample opportunity to have obtained the result of the haemoglobin taken the day before.

REID Hmm, mmm.

DC YATES Why then at a time when Mr PACKMAN could have been transferred more safely wasn't this done?

REID I don't ... I can't answer that.

DC YATES When was Mr PACKMAN's condition discussed with you or the gastroentrologist or medical team on call?

REID It wasn't.

DC YATES No. That's in particular the drop of the haemoglobin from 12 to 7 7. The transferring of a patient from the War Memorial Hospital to the Queen Alexandra shall we say or somewhere there's a gastroentrologist or something like that. It's a bit like if the mountain won't come to Mohammed, Mohammed will have to go to the mountain sort of thing. If you can't get him to a hospital because he's so unwell what's stopping you getting the gastroentrologist to the hospital to have a ... to the War Memorial to have a look at him?

REID Because the principle ... well there's nothing ... there's nothing wrong with asking for that to happen but I mean what could he do when he got there?

DC YATES I don't know.

REID Nothing is the answer cause they want to look down just to have a look down into someone's stomach to see where the bleeding is coming from.

DC YATES But would he have been able to do that at the hospital?

REID No not to the best of my knowledge.

DC YATES Okay.

DC Code A So he would have had to have performed a clinical examination, is it a clinical examination?

REID Well he'd have to have an endoscopic examination.

DC Code A Yeah.

REID To look down and try to identify the source of the bleeding.

DC YATES And that would have to be done at the Q.A. itself would it?

REID Yes.

DC YATES See Dr BARTON states in her statement that Mr PACKMAN's pain would have ... that he was experiencing from his ... could be from his abdomen or his sores?

REID Yeah.

DC YATES But the notes never suggest that the sores were a significant cause of pain do they?

REID Except that bit there on the 27th.

DC YATES The nursing care plan for sleeping, there's an entry on the 29th of August, that records that Mr PACKMAN complained of left sided abdominal pain and a query whether it was related to his bowels. Again it's sort of indicating it's this gastro bleed again doesn't it.

REID Well ...

DC YATES Would you ... would you be suffering with pain in that area after an MI?

REID No, no, no. That would be unusual.

DC YATES I think I'm nearly finished in what I want to ask about Mr PACKMAN. Do you want to have a ... if I just check?

DC Code A Yeah. Going back to that nursing note of the ... it was on Gill HAMBLEN's I think. No Dr when was the syringe driver commenced, it was the 30th wasn't it?

REID Yes.

DC Code A — The nursing note on page 63 the night time one for the 29th slept for long periods oramorph given as prescribed. Then it says this mane,morning 30th ...

REID — Hmm, mmm.

DC Code A — ... complaining of the left abdominal pain.

REID — Yes.

DC Code A — That's a new pain isn't it for Mr PACKMAN?

REID — The problem it says here on the 26th query, probably a query indigestion which could be pain somewhere in the stomach in the abdomen.

DC Code A — It's not specific is it? I mean there's nothing specific in any of the Dr's notes either are they?

REID — No.

DC Code A — So, but it then appears then that when Sister HAMBLEN comes on that day takes over, she makes a decision that although he slept for long periods she makes a decision that he should start the syringe driver, presumably because of the left abdominal pain.

REID — I don't know.

DC Code A — No, but that's what it looks like isn't it.

REID Well ...

DC Code A Condition remains poor. So how can we be certain that the use of the syringe driver was indicated or appropriate?

REID Well you can't cause there isn't a record to the effect.

DC Code A No. And this is a danger isn't it because now you've got a nurse who's decided to start the syringe driver by the looks of it.

REID Yeah.

DC Code A Do you think that's satisfactory?

REID Well I mean it doesn't say whether it's been discussed with Dr BARTON or whatever so.

DC Code A No.

REID It's difficult to say whether it's satisfactory.

DC Code A Regarding the haemoglobin, the fall.

REID Mmm.

DC Code A And you yourself said it was huge.

REID Hmm, mmm.

DC Code A — Yeah. The people who do the tests in the lab they're presumably quite experienced aren't they?

REID — I don't know.

DC Code A — Who would do ... who is it that ... what they called?

REID — I mean in the ... that's the haematology laboratory but I don't know whether it's a junior technician whether it's ...

DC Code A — Yeah okay.

REID — Who does ... who actually does the tests.

DC Code A — Okey dokey. So what's ... what would you expect a consequence of somebody seeing that drop cause they would have known there was a drop from 12 to 7?

REID — Well there's note on the form to say that they tried to contact the ward at the hospital with the result and couldn't get any answers from the switchboards.

DC Code A — Now is it usual for them to contact the ward on results of haemoglobin tests or blood tests?

REID — Only if there is a you know as a result that they're concerned about it.

DC Code A — That's significant?

REID Yeah.

DC Code A Yeah. And ... and they couldn't get through?

REID So they say.

DC Code A So they say. But nobody seems to have sort of checked that through do they, no one seems to have rushed it, despite the nursing note saying, I can't quite find it now, but the nursing note said 'await blood tests'.

REID Hmm, mmm. I think it comes back again to what your plan is for patient and what discussions have been had with Mrs PACKMAN and what your view of the patients clinical condition is, in other words is it so bad that palliation is the order of the day or is there to be some active treatment you know short of no resuscitation.

DC Code A Yeah but that doesn't fit in quite well because I found the comment I was looking for now, the one that's dated the 26th of the 8th on page 62 by Nurse HAMBLEN, Sister HAMBLEN, where it says unwell at lunchtime, colour poor, complaining of feeling unwell, seen by Dr BARTON this afternoon, await results of HB.

REID Yep.

DC Code A — So what's the point of waiting for the results of HB if you've made that decision when all you're gonna do is look after the patient in a terminal phase situation.

REID — Well ...

DC Code A — Cause it looks there as if Dr BARTON's thinking that the haemoglobin tests might show us something.

REID — Well ... well it does but I mean I think it would ... you know the discussion with Mrs PACKMAN is gonna be a pretty sort of key discussion.

DC Code A — So if Mrs PACKMAN says I don't want my husband to be ... I don't want my husband to stay alive but you know Mr PACKMAN's got a condition that you can save him from you ...

REID — My responsib ... the first responsibility is the patient.

DC Code A — Yes.

REID — And if ... first of all if the patient is in a position ... if the patient is mentally capable then it's up to the patient to make a decision about what treatment he or she doesn't want ...

DC Code A — Yeah.

REID ... wants. If a patient is not capable of making a decision and I mean it's not clear whether Mr PACKMAN was or not.

DC Code A Yeah.

REID But then it's up to in law and my understanding is the duty of those caring for the patient to act in what they believe to be the patient's best interests.

DC Code A But is there any indication there about his mental state then?

REID No.

DC Code A Well certainly on the 26th fairly good morning, no further vomiting, complaining of indigestion, pain in his throat. So it seems that he's quite verbal at this stage isn't he?

REID At that stage?

DC Code A On the 26th?

REID Yeah.

DC Code A On the ... so ... so on the 26th it's ... if Dr BARTON had ... let's say for arguments sake that somebody on the 26th from the lab had got through to the hospital ...

REID Hmm, mmm.

DC Code A ... and passed on the message about the haemoglobin ...

REID Mmm.

DC Code A ... what would you expect to have happened?

REID I'd expect there to have been ... well assessment of the patient's condition.

DC Code A Yeah.

REID About whether you know you felt further treatment was appropriate ... whether further treatment investigation was appropriate or not and then a discussion with Mrs PACKMAN or with the patient if the patient was capable of ... well first of all I mean if the patient was capable and I think you also feel that the patient was ... well some patients can be mentally capable but yet you feel that to discuss it with them at the time would be so distressing, upsetting that you feel it would be unethical to do so.

DC Code A And the 27th some marked improvements since yesterday, this is page 63, and this nurse I think it's Sister HAMBLEN again, says wife has visited this afternoon is aware that condition could deteriorate again. How does Sister HAMBLEN know that, how does she ... does she know what the condition is now then?

REID Well I wouldn't ... I mean I wouldn't know what discussion Sister HAMBLEN had had with the patient and what she said.

DC Code A But Sister HAMBLEN is aware that condition could deteriorate again.

REID Well I mean I don't know where Sister HAMBLEN got that information from, I mean be it from a discussion with Dr BARTON.

DC Code A Because there's no indication from Dr BARTON what the condition was is there?

REID Well by condition you mean how ill or unwell someone is and not necessarily diagnosis.

DC Code A But I don't think anyone's actually diagnosed what's wrong with him at the moment have they?

REID Well I mean Dr BARTON said that she thought there was two possibilities.

DC Code A Yeah but we haven't got to that have we because I don't think at this stage ... when did we find out about the haemoglobin test then?

REID I don't know.

DC Code A — Because one would assume if it had been by then Dr BARTON would have written something in the notes wouldn't she?

REID — Yes.

DC Code A — And then either ...

REID — Well Dr BARTON ... Dr BARTON has seen the haemoglobin form but hasn't recorded when she's seen it in the notes.

DC Code A — Well then ... there are two options aren't there, she either acts upon it or she doesn't act upon it for the reasons you stated ...

REID — Yes.

DC Code A — ... and that you formed the opinion that the patient is terminally ill and is now in a palliative care situation effectively.

REID — Yes.

DC Code A — But that's not recorded anywhere is it?

REID — No. I mean the patient's in a palliative condition but it's not inevitably a terminal decline so people can ... and then dip down again.

DC YATES Well just to recap a couple of points then. Why isn't there any reference to the reason behind the prescription of any drug in Mr PACKMAN's notes? Why isn't there a reference to the reason?

REID Well I mean that ... there's an oblique reference to it in Dr BARTON's notes isn't there, in that she ...

DC YATES An oblique reference?

REID Sorry?

DC YATES An oblique reference did you say?

REID Well yes I mean what she said in the ... yeah called to see pale, clammy, unwell, suggest query MI, other possibility acute GI bleed and she wanted diamorphine started presumably because the patient was distressed.

DC YATES Yeah. Did Dr BARTON ever make the correct diagnosis of Mr PACKMAN's ... of Mr PACKMAN?

REID Well I mean I don't know.

DC YATES No we don't do we cause of the notes. On the 1st of September you've reviewed the patient and you've come to a conclusion that he died of a GI bleed or you thought he was dying of a GI bleed. At some stage Dr BARTON has seen the haemoglobin results and she's signed it.

REID Hmm, mmm.

DC YATES And she's made no entry yet again.

REID Mmm.

DC YATES And she's not acted on it in any way.

REID Well she ... we don't know whether she's acted on it or not in terms of having a discussion or what she said to Mrs PACKMAN.

DC YATES Well that's what the notes are for isn't it for her to record ...

REID Yeah.

DC YATES ... what actions been taken for people that have to deal with things later. Reading the notes I am not convinced that Dr BARTON has fulfilled her duty of care to this patient and certainly when we start looking at notekeeping etc it's ... it's worse than poor, it's abysmal. But if Dr BARTON's not fulfilling her duty of care then I've got to ask the question are you? Now we accept, we don't have to ask the question we know you have a duty of care to that patient.

REID Yes.

DC YATES You're the consultant. But do you feel that duty of care was fulfilled?

REID Yes.

DC YATES So do you think the manner in which Mr PACKMAN was cared for adequate?

REID When I saw Mr PACKMAN on as I said already on the 1st of September I felt that he was terminally ill. I've explained that I felt that his prognosis was poor from the moment he entered hospital. He obviously developed sort of complications, medical complications while he was at the war memorial. There is clear, that are recorded in the notes, that discussions have taken place with Mrs PACKMAN about her husband's condition and prognosis. I don't know for sure what was actually said in these discussions but I can't be there in the hospital every second of the day, I have to take some things on trust and there's several references to discussions with Mrs PACKMAN about her husband's condition and the management of it and I have to take that in trust. And that would be one of the factors that would influence my decision on the 1st of September that Mr PACKMAN should be for palliative care.

DC YATES There's one final question I think will be (inaudible). Having read the notes now and in hindsight, in fact a couple of questions, do you think that anything better could be done?

REID Oh better documentation.

DC YATES Better documentation for a start. Also having read all the documentation yourself, and I think you've probably formed the opinion on the 1st of September 1999, but what in your opinion did Mr PACKMAN die of?

REID I think it's likely he died of Gastro-Intestinal bleed

DC YATES I think it's more than likely isn't it he died of a GI bleed.

REID I mean I can't exclude him having an MI too.

DC YATES He may have had one yes but he was bleeding, he was bleeding significantly.

REID Yes.

DC YATES And you have said so yourself.

REID Yes.

DC YATES And there is evidence of that, there's evidence of that in the haemoglobin results, there's evidence in that in other things such as the tarry stools.

REID Yes.

DC YATES And so on. I don't see any evidence of myocardial infarction other than he was clammy and unwell and what have, which you also could have been ...

REID (Inaudible).

DC YATES ... which also could have been a GI bleed.

REID Yes.

DC YATES Not the pain in his throat maybe. All that if you were to write a certificate of death today what would you put as cause of death?

REID Well I'd have put in Gastro-Intestinal bleeding.

DC YATES Yeah. But why has it been recorded as an MI?

REID No idea.

DC YATES A heart attack. I haven't got any more questions Code A?

DC Code A No.

DC YATES Right. How long have we got on that tape?

DC Code A Half an hour.

DC YATES What I'm going to do I'm going to call an end to the interview as far as Geoffrey PACKMAN is concerned.

REID Yes.

DC YATES Okay. So I'm not going to turn the tapes off but as I ... I want to actually finish this interview before Geoff asks you some other things. So is there anything you wish to clarify about the interview with PACKMAN?

REID No I don't think so thank you.

DC YATES No. Is there anything you wish to add?

REID No.

DC YATES Okay. At the end of the whole scenario I will give you a notice explaining what will happen to the tapes.

REID Yes.

DC YATES Alright, the time now is 1616 hours. We'll leave the tapes running because Geoff's going to speak to you now about the other patient.

DC Code A Thanks Chris. Right Dr at the start of the day you made some comments about ...

REID Yes.

DC Code A ... Enid SPURGIN didn't you. Can you just refresh us as to what you were getting the points you were getting over at the beginning of the day.

REID I think what it was was this if you like the big picture what this lady's prognosis for mobilising and returning home actually was.

DC Code A Yeah.

REID And she was in hospital I think for a total of about 24 days, during most of that time she seemed to be in pain from her hip.

DC Code A Are you including both hospitals there sorry to interrupt?

REID Yes. Well when I saw her in Haslar she was in pain just on moving her leg in bed. And I wanted to be sure that I'd given you, if you like, the ... my sort of full thoughts about why I thought her prognosis for mobilising ... or remobilising getting back home was so poor. Most of I think we've covered in the earlier interview but I think the particular points that I wanted to emphasise were around if there were sort of either infection or if you like further damage in the hip. That the answer to or the possible ... the treatment options for that were things that could involve you know further discomfort and/or prolonged stay in bed and would be unlikely to restore this woman ... this lady to sort of full mobility.

DC Code A — Okay. Have you finished there?

REID — Oh and the other thing was that there had also been a discussion with her nephew and to the effect that, I mean I haven't got the notes with me, that he felt that if his Aunt were not able to return home and she would have a very poor quality of life, that for her would be a very poor quality of life.

DC Code A — Okay. And as I remember this morning you were ... were you a little bit more elaborate this morning because you were talking about the various things that could have been wrong with her.

REID — Yes and what the treatment options would have been.

DC Code A — And the treatment options were that she ... she would have had to have certainly gone back to surgery.

REID — Hmm, mmm.

DC Code A — Yeah, for if it was to do with the actual hip replacements?

REID — If there's a ... yeah. Or if there was an infection there.

DC Code A — Yeah you talked about two infections.

REID — Well the superficial wound infection.

DC Code A — Superficial wound infection.

REID That's usually easily treated and ...

DC Code A Yeah.

REID ... easily visible. But a deep infection inside the hip often involves taking out the metal work that's been put in with pelvic screw.

DC Code A Yeah.

REID And the orthopaedic surgeon then has to decide does he try and put anything else in its place or does he really just leave a sort ... I mean I can draw it on a bit of paper but essentially you know like the top of ... your femur are all straight bones ...

DC Code A Yeah.

REID ... that neck and they have a ball on it.

DC Code A Yeah.

REID So they basically take off at the neck and the ball and just let the top of the shaft go in to that joint. It's what's called a girdle style operation.

DC Code A Yeah.

REID It results in huge leg shortening and the chances of mobilising if you're not mobilised in the first operation then obviously next to no. And the other option that the socket could have fractured. If that happens you've got to give that a chance to heal, the only way you can do that is by trying to pull the ball out of the socket by putting the patient in traction, which will be for 6 weeks minimum I would have thought, more like 3 months in bed, by which time this lady had lost sort of you know any possibility of getting back on her feet again.

DC Code A Okay.

REID So I just really wanted to make clear that I felt that all the pain that she was having was an extremely bad sign and I couldn't think of anything, which treatment shall we say or any condition which was easily treatable which would relieve the pain she was having and enable her to become more mobile and get back home.

DC Code A Right thank you. You've told us about operations for if it was fractured or ... when you talked about the ... the wound infection ...

REID Yes.

DC Code A ... deep wound infection, how would you have found out whether there was a deep wound infection?

REID Well sometimes it shows in x-ray.

DC Code A — Yeah.

REID — And sometimes it doesn't, it's just a clinical suspicion. One can do more sophisticated types of scan if ... but I mean the first port of call really would have been if this lady had had an x-ray done and ... then to have ask an orthopaedic surgeon to ... to see her. But you know the outlook would not have been good in terms of remobilising and getting back on her feet.

DC Code A — Well I've got a copy of her file in front of me.

REID — Hmm, mmm.

DC Code A — Yeah. If I ask you to have a look at it and I'll give you the page that's relevant to the clinical notes.

REID — Yeah.

DC Code A — Yes. That's a copy of that page.

REID — Hmm, mmm.

DC Code A — Where is what you've just told me and spoken enthusiastically about, where is that evidence on that page that they were possibilities for the pain ... the cause of the pain for Enid SPURGIN?

REID Well I mean the first step would have been an x-ray of her hip.

DC Code A Okay. So there's a mention of a x-ray on the 7th of the 4th yeah?

REID Yeah.

DC Code A Isn't there?

REID Yes.

DC Code A Where's the rest of the ... where's the follow up to that then?

REID Well I mean you told me that you'd sort of tried to find out what had happened to that x-ray and it did not seem to have you know been done. And then by the time I saw this lady you know 5 days later I felt that she was you know by then sort of terminally ill.

DC Code A So that was on the ...

REID 12th.

DC Code A ... on the 12th yeah, and she died the next day.

REID Yes.

DC Code A Yes?

REID Yes.

DC Code A She came into hospital on the 26th.

REID Yes.

DC Code A Apparently according to the notes from Haslar under not a lot of pain paracetomol.

REID According to the notes from Haslar.

DC Code A Yeah.

REID But I mean I'd seen her in Haslar two days before and felt that ... and moving her leg just from side to side her in bed caused a lot of pain. So I find that ... I reckon that's what's been written but you know that was not my ...

DC Code A We'll go back to the point then while we're talking about Enid SPURGIN again today. You've just given those scenarios about possible problems with her hip and her wound and yet there doesn't seem to be any evidence of either yourself or Dr BARTON properly investigating that.

REID Well I would dispute that in terms of the fact that an x-ray which I asked for to be done the first time I saw her ...

DC Code A Yes.

REID ... is the right way to go about that.

DC Code A Okay.

REID We discussed before whether it might have been more timely to have done that at an earlier stage ...

DC Code A Yeah.

REID ... and agreed that it might have been, I can't say because I didn't see the patient during that stage.

DC Code A You only saw the patient on the 7th of the 4th?

REID That's right.

DC Code A Okay. And you asked for the x-ray on the 7th of the 4th?

REID That's right.

DC Code A Yes. But there doesn't seem to be any further ...

REID Well I think by the 12th of April I thought the patient was now terminally ill if you like, the further pursuing that had lost its relevance cause this lady was now terminally ill.

DC Code A Okay. Is there any mention in the records did you have, I believe you had the Haslar records as well didn't you at the time?

REID Well ...

DC Code A They were disclosed to you.

REID Oh yes yes yes.

DC Code A Yes. I haven't got them down here unfortunately at the moment. But is there any mention in the Haslar records about Mrs SPURGIN either being written up as not for 5 5 5 ...

REID No.

DC Code A ... TLC ...

REID No.

DC Code A ... or happy for the nurses to confirm death.

REID Not that I can recollect no.

DC Code A No I don't think there is either. Is there any mention in this record here right that she's not for 5 5 5?

REID No.

DC Code A Or that she's for TLC or that Dr BARTON thinks that she's happy for nurses to confirm death?

REID No.

DC Code A — No. So it's not until the 12th of April that you formed the opinion that she's terminally ill.

REID — Yes.

DC Code A — And that's why on the 12th of April that's your first opportunity to chase up the x-rays?

REID — Yes.

DC Code A — And that's why you're saying you didn't chase up the x-rays?

REID — That's right.

DC Code A — Yes. But what's stopping anybody else looking after that patient from chasing up the x-rays in between that time?

REID — Nothing.

DC Code A — And you've already said haven't you that in hindsight perhaps you should have chased ... you should have asked for ... someone should have asked for those x-rays previously?

REID — Possibly.

DC Code A — It couldn't have been you because you didn't see her till the 7th.

REID Yes.

DC Code A Yeah. The first day you saw her …

REID Yes.

DC Code A … in your calls …

REID Yeah.

DC Code A … is that you asked for the x-rays then?

REID Yes.

DC Code A But nothing else written in those notes covering those points you made is there?

REID Yes … no.

DC Code A No. Okay. Do you want to ask any more questions about that Chris?

DC YATES No.

DC Code A Do you want to say anything else about Enid SPURGIN Dr?

REID No.

DC YATES Okay thanks very much. Well the time is now 1627, is there anything you want to say about anything you've been spoken to today Dr?

REID No thank you.

DC YATES You don't want to clarify anything?

REID No.

DC YATES No. You don't think we got anything mixed up or?

REID I don't think so.

DC Code A No okay. Well we'll turn the machine off and we'll hand you a notice explaining what will happen to the tapes.

(Interview concluded).