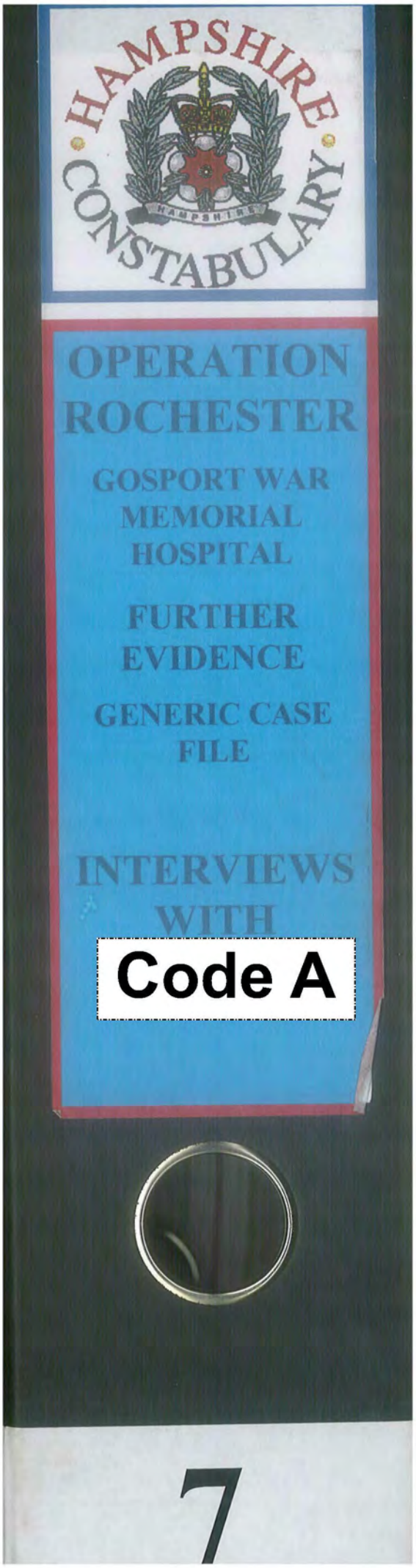
Code A


HAMPSHIRE CONSTABULARY
OPERATION ROCHESTER
GOSPORT WAR MEMORIAL HOSPITAL
FURTHER EVIDENCE
GENERIC CASE FILE
INTERVIEWS WITH
Code A
7

GMC AND Code A INDEX OF FILES RECEIVED FROM HAMPSHIRE POLICE ON 18 JANUARY 2007.

1. Index of all evidence obtained
2. Generic Case File
3. Generic Case File (exhibits)
4. Generic Case File (exhibits)
5. Generic Case File (further exhibits)
6. Generic Case File further evidence re: Code A
7. Generic Case File further evidence - interviews with Code A
8. Code A Volume 1
9. Code A Volume 2
10. Code A Additional Evidence
11. Code A Hospital Medical Records
12. Code A Volume 1
13. Code A Volume 2
14. Code A
15. Code A
16. Code A
17. Code A
18. Code A
19. Code A
20. Code A
21. Code A
22. Code A
23. Code A Volume 2
24. Code A - further evidence
25. Code A police interviews with Code A
26. Code A Hospital Medical Records
27. Code A Volume 1

Code A - organise copies.
Take off index of files
Dividers marked.
Summary.
Tape 1
" 2
" etc
We'll need copies for defence, Counsel + DS (3) may need expert too ??

GMC AND Code A INDEX OF FILES RECEIVED FROM HAMPSHIRE POLICE ON 18 JANUARY 2007.

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29. Code A Hospital Medical Records
30. Code A Hospital Medical Records
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32. Code A Volume 2
33. Code A Hospital Medical Records
34. Code A Hospital Medical Records
35. Code A Volume 1
36. Code A Volume 2
37. Code A Hospital Medical Records
38. Code A Hospital Medical Records
39. Code A Volume 1
40. Code A Volume 2
41. Code A Hospital Medical Records
42. Code A Hospital Medical Records
43. Code A Volume 1
44. Code A Volume 2
45. Code A Hospital Medical Records
46. Code A Hospital Medical Records
47. Code A Hospital Medical Records
48. Code A Volume 1
49. Code A Volume 2
50. Code A Hospital Medical Records
51. Further evidence re: Code A
52. GP Records for Code A
53. GP Records for Code A
54. Copy Extracts from Patient Admission Records
55. Extracts from controlled drugs record book dated 26 June 1995 - 24 May 1996

56. Code A file: 1 of 2

57. Code A file: 2 of 2

58. Code A Medical Records

59. Code A Further Medical Records

60. Code A Further Medical Records

61. Code A (Police) - Witness Statements file

62. Code A (Police) - Transcripts of Interviews file

63. Code A (Experts' Reports and Medical Records)

64. Code A (Eversheds) file: Experts' Reports and Medical Records

65. Clinical Team Assessments for Code A

66. Clinical Team Assessments for Code A

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27. Code A Volume 1

READ THIS.

GMC AND BARTON INDEX OF FILES RECEIVED FROM HAMPSHIRE POLICE ON 18 JANUARY 2007.

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Operation ROCHESTER.

Additional Evidence Summary.

Code A

Series of tape recorded interviews with Code A in presence of Code A Code A under caution 0921hrs – 11600hrs 4.7.06 in respect of Generic Matters Gosport War Memorial and Queen Alexandra Hospitals.

Keypoints:-
Interview Tape1.

Code A qualified in 1974, his initial training was conducted in various hospitals in Scotland. After performing Senior Registrar duties in Portsmouth and Southampton Hospitals he was appointed as a Code A Code A in 1982.

In March 1998 he took up his current role as **Code A** at Queen Alexandra Hospital, Cosham, he also had the additional responsibility of Code A

His role as Code A did not cover General Practice but covered the community hospitals in Fareham, Gosport etc. His role was to provide medical advice and guidance to the Trust Board. He was also the Code A Code A in the Trust.

In 1998/99 he was working half and half as **Code A** His Code A responsibilities were to Ann Ward (QA), Dryad Ward (GWMH) and clinics at Dolphin Day Hospital and QA.

Interview Tape 2

Dryad Ward would take patients over 65 who were frail and or had multiple medical problems, slow stream rehabilitation.
His leave entitlement was 6 weeks of which he would all of it, nobody covered his ward rounds during his absence. Code A a Code A for Daedalus Ward would have been available should Code A had needed her advice.

As the turnover of the ward (Dryad) was quite low locums were not used as cover.
Code A performed a weekly ward round on Dryad Ward, on Monday afternoons. Code A accompanied him on alternate Mondays as she also attended Daedalus Ward for Code A round. If Code A was away she would forego the Dryad round. His round lasted about 4 hours, he would spend approximately 12 minutes per patient depending on their conditions. New patients would take longer.

He worked at least 60 hours a week. Clinical Assistants were not in training though they were under the supervision of the Consultant.

Regarding admissions to Dryad most patients would have been seen at QA by one of the Elderly Medicine Consultants and assessed as appropriate for rehabilitation. There were 20 beds on Dryad Ward.

Medical notes were easier to write at Gosport compared to QA as the patients problems were previously well established, they were not 'so medically sick'. He wrote his own notes.

He did not sit down and have regular appraisals with Code A
In 1998/99 Dryad Ward was for continuing care, assessment for continuing care and Daedalus was for rehabilitation.

Interview tape 3

Code A role as the Code A was to provide 24 hour cover to the wards and to see new patients that came in and attend to any problems. Code A Code A was not aware of the Code A Job Description, he had never seen it. He felt that Code A did more than he would have expected in her role in some ways regarding the time she spent at the hospital.

Code A was satisfied that Code A had adequately met the requirements of her job description. He agreed that it was probably the Consultant's responsibility to supervise this.

Patients on Dryad Ward were more medically stable than those on Daedalus, thus she would spend more time there as there were more problems.

Daedalus Ward took patients for rehab, i.e. they would be going back home whereas Dryad took patients for continuing care and whose prospects of getting better were not good.

He had no concerns about either the nursing or medical care.

Patients could be returned to the QA if they became unwell. However if they were unlikely to recover or they were too ill to transfer they would be looked after in a palliative way. Code A usually made those decisions. QA was under huge pressure for beds at that time. It was almost "Well let's send the least suitable patients there" "Well there might be a chance that they might get

back on their feet, but it doesn't really look very likely so we'll send them" It's difficult to understate how much pressure there was from QA to fill beds in community hospitals. In an ideal world they would probably have gone to Daedalus Ward. Consequently the turnover of Dryad increased.

Interview Tape 4

On ward rounds typically Code A would talk to nursing staff, read medical notes, prescription charts and if appropriate examine patient. Sometimes conducted with Code A every other week with Code A and usually with Senior Nursing Staff. Notes would be made if a change in management etc was needed. The purpose of these was for handovers so that others would know what's been happening.

He was not aware of the Wessex Protocols in 1999. Similarly The Palliative Care Handbook. He is not a palliative care expert.

He had not heard of the analgesic ladder in 1999, though it's principles were practiced then. Patient's levels of pain are assessed by communication, non verbal clues and clinical observation. The Portsmouth Health Care Trust's policy 'for assessment and management of pain' came about as a consequence of the original GWMH complaints. There was no such policy at Dryad before this.

He was not aware of any policies for prescribing strong opiates at the time. He admitted that when diamorphine was prescribed the prescribing doctor had responsibility for the patient but ultimately it was the consultant in charge.

It would be very unlikely for Code A to have any communication from the hospital about a patient prior to him seeing them on the ward round. In other words a patient could be on the ward for 6 days before he was aware.

Patient notes did not always accompany patients on transfer, though they should have always gone with the patient. It was an option to contact the ward they had come from.

He did not recall either himself or Code A ever giving patients intravenous infusions. ECG's were carried out on occasions when he or Code A Code A requested them. He couldn't remember anyone having blood transfusions on Dryad Ward.

GWMH was not set up for common medical emergencies, patients would be sent to QA.

He did not remember seeing the 'Operation Policy, Dryad Ward Continuing Care' before (CSY/HF/7). Fundamentally it was the same procedure as when he started.

He remembered that he spoke to Code A on one occasion about her prescribing 20 to 80 milligrams of diamorphine to an unknown patient.

Interview Tape 5

In 1999 Consultants were not regularly appraised, they were regarded as independent medical practitioners and therefore did not need supervision. If somebody had concerns about a Consultant's performance any complaint would probably have gone to the Chief Executive. Code A actually introduced the annual appraisal system for Consultants.

Code A did not have an appraisal system. If she had any problems with the organisation or patients she could seek help from either of the consultants, the hospital manager or the Chief Executive.

Code A had no supervisory responsibility for the nursing staff.

Nurses set up syringe drivers and he had no reasons to think they were doing anything other than appropriately. If nurses had reason to, they could speak to appropriate medical or nursing staff regarding prescriptions written up by doctors, similarly with general advice surrounding patient treatment etc. He did not recollect anybody challenging prescribing practice.

He said that though he and Code A would be responsible for prescribing syringe drivers nurses might suggest it as an option.

He said that regarding increasing the dose of diamorphine via syringe drivers the guidance was much clearer now, for instance after 24 hours now you would increase by 50%, and then write up a sixth of that for breakthrough pain. In 1999 he would use the BNF advice. The size and age of patients would also influence prescribing. He would use the BNF especially for conversion because that's where the potential for error was.

In general he said that implementing a syringe driver should be written in the medical notes depending on how significant the change in relative dosage was.

Interview tape 5

Code A explained the prescription chart format etc. He said that he did not recollect when Code A started her proactive prescribing, he was only aware of it when he was shown some of the patient notes during the investigation. He recalled that she wrote variable doses. He thinks he was first aware of this early in his time at GWMH.

He described proactive prescribing as prescribing something in the absence of pain and variable where someone was in pain but the nurses are given discretion. He had not seen any policy or guidance as to how large the variance could be. He said that Code A had no authority as such, it was

her decision, and she was free to do it though it was not good practice with regards to opiates. She did not speak to him about it.

He said 20 to 40 milligrams was acceptable practice but not 20 to 200. He said you relied on the nurses to start on the starting dose using discretion and common sense.

Regarding patients in pain and who had kidney or liver failure he would check with the BNF before prescribing opiates.

He was shown a copy of CSY/HF/27 'Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion'. He remembered seeing the recording charts but not the rest of it. He read the document but did not recognise it. He was not aware that the nursing staff were using this at GWMH. He denied that he had drawn the policy up.

He explained the difference between certifying and verifying death. He said that Code A or her partners would be responsible for death certificates, he would not know a patient had died nor would he be notified.

He agreed that people who had had surgery or an accident within 12 months of death should have that death notified to the coroner. He did not normally see death certificates nor medical causes of death.

He would be happy for a doctor to write in the notes 'satisfied for nurses to confirm death' when it's clear that the patient is dying.

Interview Tape 6

He said that on admission of a patient Code A would form a view as to the type of care (eg palliative) and so would he. He said that an Elderly Medicine Consultant would have previously written something along the lines of 'Transfer to Gosport for rehabilitation' or 'For further assessment' etc.

He said that even then patients conditions could change at or prior to transfer so that the doctor on admission could change the care. He agreed that this should be recorded.

On admission he would expect the doctor to record a brief resume, what the patient was transferred with and a management plan. He would not expect as detailed a history as if the patient was being examined from off the street at QA.

He said that doctors made medical care plans and nurses made the nursing care plans. He did not have great knowledge of the nursing plans, though they would be using information from the medical staff.

Code A was responsible for the initial clerking. There were no policies for completion of notes. He confirmed that medical notes assisted other doctors who might subsequently be called to see the patient.

He described Code A note keeping as brief but felt that she did record significant changes in condition and management. He said that his busy Mondays did not prevent him from properly writing notes.

He was shown CSY/HF/2 and agreed that the paragraph concerning accurate and contemporaneous notes was relevant to that time.

He did not raise the issue of note keeping to anybody. He said that when it was difficult for him to follow plans, treatments etc (because of poor notes) he would speak to the nursing staff to learn what had happened with the patient. He said that this did not happen regularly.

On initial clerking he would expect to see Code A to have written a main diagnosis, management plan, to have examined the patient if they were unwell etc.

He could not be specific but recalled that the nursing staff said that in Code A Code A absence her partners could be reluctant to come in and see patients.

He could only remember one conversation about Code A having concerns about the pressures of her job, this was in early 2000. This centred around the change in patients being sent from QA and causing a higher turnover. He felt that the medical cover was not enough and that a staff grade doctor was required full time. He hoped that this would persuade Code A to consider her position so that the money used for her salary would go to the staff grade doctor. Asked why he didn't suggest Code A to apply for the role he said that her GP role would be far more lucrative.

He said that telephone or verbal prescribing is an accepted practice.

Regarding Code A proactively prescribing diamorphine, oramorph, hyoscine and midazolam he said he had only seen that once, which was the occasion he had spoken to her about.

Interview Tape 7

He did not feel that Code A kept her notes to the letter of the GMC Guidelines.

He did not discuss her note keeping with her as she was a senior responsible GP and should know the importance of good not keeping, plus he felt that she did record significant changes.

He agreed that there would always be a Consultant from Elderly Medicine available on call, but he could not remember ever being called by Code A Code A

Asked if Code A met the standards of his note keeping he said that there were deficiencies.

He was asked about the protocol again CSY/HF/27. He was also shown a copy of GJQ/HF/39 similar documentation. He agreed that it was documentation emanating from himself including a letter regarding a draft protocol which was sent to Code A and others. He agreed that the two were the same documents but in a different font which was why he had not originally recognised it.

He said that it had come about at the same time as the Code A case and as a consequence of the Code A case. He felt it appropriate to develop a policy for the management of diamorphine by subcutaneous infusion. He said he did not relate it to any particular incident at GWMH.

His first concerns on prescriptions came about with the Code A case in March 2000. This involved Fentanyl to Diamorphine prescribed by Code A Code A He would have prescribed a smaller dose. The protocol was already in an embryonic stage at this time.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Code A

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

Person interviewed: **Code A**

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 0921 Time concluded: 1000

Duration of interview: 39 MINUTES Tape reference nos.
(→)

Interviewer(s): **Code A**

Other persons present: **Code A**

Police Exhibit No: Number of Pages: 22

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This interview is being tape recorded, I am **Code A** **Code A** and my colleague is?
Code A	**Code A**
Code A	Right. We are interviewing **Code A** **Code A** **Code A** would you give me your full name and date of birth please?
Code A	It's **Code A** and my date-of-birth is **Code A**

Code A — Thank you very much. And also present is Code A who is Code A Can you pleas introduce yourself Code A ?

Code A — Oh yes it's Code A Code A in Code A

Code A — Thank you very much. This interview is being conducted in an interview room at Fareham Police Station in Hampshire. The time by my watch is 0921, and the date is the 4th of July 2006 (04/07/2006). At the conclusion of the interview we will give you a notice explaining what will happen to all the tapes. Okay?

Code A — Yeah.

Code A — I will remind you Code A that you are still entitled to free legal advice, Code A is here as your Code A Can you confirm, or not, that you have had enough time to consult with Code A in private, or would you like further time before we start the interview?

Code A — I mean, I mean I've had enough time, but obviously I don't know what's...

Code A — Sure, yeah.

Code A — What you've got.

Code A Yeah fine. So the next bit is, I'll explain that if, at any time, you wish to stop the interview and take further legal advice from Code A just let us know that and we will do that. Okay?

Code A Okay.

Code A Yeah?

Code A Yeah.

Code A Now it's already been pointed out to you twice already this morning that you've attended voluntarily,...

Code A Yeah.

Code A ...you're not under arrest, you've come here of your own free will. If at any time you wish to leave the police station, leave the interview room and leave the police station you're entitled to do that, we can't stop you and we won't stop you.

Code A Right.

Code A Okay?

Code A (Silent)

Code A Now I have to caution you,...

Code A Right.

Code A ...and the caution says you do not have to say anything but it may harm your defence if you fail to 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?

Code A Yes.

Code A Would it help you if I sort of did a sort of layman's...

Code A Yes.

Code A Yeah, okay. It can be broken down into three bits. The first part is that you've got a right not to say anything and we respect that and so anything we ask you you don't have to answer. Okay?

Code A (Silent.)

Code A The second part is a little bit more confusing, but if this matter should go to court if you should be charged, or reported for offences and you go to court it might harm your defence if you wish to rely on something as part of your evidence that you haven't told us, but you've had the opportunity to tell us.

Code A Right.

Code A Yeah. So if we ask you questions today and you choose not to tell us an answer to those questions, but then come out with answers in court it may harm your defence.

Code A Right.

Code A Right, okay. And so in other words a court might draw what they call an 'adverse inference'...

Code A Right.

Code A ...wondering why you didn't mention it during the entire process.

Code A Yeah.

Code A And the third part is that it is being recorded and if it goes to court the transcript of this interview may be available to the court. Okay?

Code A (Silence)

Code A On this occasion the room that we are using is equipped with a monitoring facility and there's a red light that's on which tells us that someone is monitoring at the moment and that will be Code A the chap you met just now.
...

Code A Right.

Code A ...The reason he's doing that is that it enables us to carry out any enquiries that may come about as a result of anything you say to us today expeditiously. No person can hear anything via the equipment when the machine isn't running, so if this tape recorder isn't running that microphone doesn't work. Okay?

Code A Right. So what you're saying is that, is it D?

Code A Code A

Code A Code A is listening into this....

Code A Yes. I will do most of the talking today, but Code A will almost certainly be taking notes as we go along...

Code A Right.

Code A ...and he will be asking you some questions as well at some stage I should think.

Code A Right.

Code A Operation Rochester is an investigation being conducted by Hampshire Constabulary and it started in September of 2002, so it's already been running for the best part of 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 no decision has yet been made as to whether any offence, or

offences have been committed, but it's important to be aware that the offence range that we're investigating run from potential murder right the way down to assault. Okay?

Code A (Silence)

Code A Part of the ongoing enquiry is to interview witnesses who were involved in the care and treatment of the patients during that period. Now you were the Code A Code A for the Gosport War Memorial Hospital during part of the time that these deaths occurred, so your knowledge of the working of the hospital, the care and the treatment of the patients is very central to our enquiry. The interview today will be what we term as a 'generic interview' in that we wish to talk about yourself, your qualifications, your training as well as the policies and procedures pertinent to the Gosport War Memorial Hospital during this time period. Now the groups of questions will come under particular topic headings and we will endeavour to try and explain the topics at the start of each stage. Okay?

Code A (Silence)

Code A And do you think you are quite comfortable with,

Code A Yeah.

Code A As comfortable as can be

Code A (Pause) So the interview, as I just said will be generic and it's not patient specific. Okay?

Code A (Silence)

Code A During the interview we will ask you questions about several topics such as your qualifications and the role of the consultant, that sort of thing.

Code A Uh-huh.

Code A When we start on your topic area we will tell you what it is and the reasons why we want to ask those questions about that particular subject. Now the first topic area to cover is about your qualifications. ...

Code A Right.

Code A ...The reason we want to speak about these now is that it's not only, it's a good point to start off with but we need to establish exactly what your qualifications are as a doctor and how experienced you are etcetera. Okay?

Code A Yeah.

Code A Can you tell us when you qualified as a doctor?

Code A 1974.

Code A Thank you. And where was that?

Code A Glasgow.

Code A And where did you do your pre-registration training?

Code A Um I did six months in a town called, well the Royal Alexandra Infirmary in Paisley, Scotland. Yes that's the first six months, and the second six months was at Stirling Royal Infirmary, Stirling, Scotland.

Code A Yeah. And that's Junior House Officer as well then yeah?

Code A These are both what are called the 'Pre-registration House Officer'. Yeah.

Code A Yeah. And where did you train as a Senior House Officer?

Code A Um I did, um, there were several posts, um, the first one was, can I just look back to...

Code A Yeah sure.

Code A ...(inaudible) over here. There's the Senior House Officer in Obstetrics and Gynaecology at Paisley Maternity Hospital, Paisley, Scotland and that was from August 1975 to January 1976, and then following that, um, I did training as a Senior House Officer in Geriatric medicine at the Victoria Geriatric Unit in Glasgow from February 1976 to July 1976, and following that I was a Senior House Officer

in Cardiology at the Glasgow Royal Infirmary in Scotland from August 1976 to April 1977. Um so that covers the Senior House Officer.

Code A Uh-huh. And where were you the Registrar, where did you train as a Registrar?

Code A Uh yeah in Kilmarnock Infirmary, Kilmarnock, Scotland and that was from May 1977 to to July 1979.

Code A Thank you. And then Senior Registrar?

Code A Yeah, um, I became a Senior, well it's, one was appointed to what was called a Wessex Rotation, um, which involves spending different periods of time in different hospitals...

Code A Yeah, yeah.

Code A ...and for me it was Portsmouth and Southampton...

Code A Yes.

Code A ...and that was from August '79 to July 1982.

Code A And then the next stage of your career was to become a Consultant?

Code A A Code A at Southampton General Hospital and that was from August 1982 to March 1998.

Code A And from '98 to present?

Code A Yeah from, in April 1998 I was appointed as Code A Code A and along with that I was the Code A Code A of, well at that time was Portsmouth Health Care Trust.

Code A Uh-huh. And so that's covered all your hospital appointments really hasn't it...

Code A Yes.

Code A ...from when your career starts?

Code A Yeah.

Code A Why did you want to become a Consultant then?

Code A (Pause) Um, (laughs)...

Code A (Laughs) It's forty-five minutes the tape.

Code A Um, well I mean the choice one's faced with is either, either becoming a, in general terms becoming a G.P. or become a Consultant. I mean in fact I had been going to, um, become a G.P.,...

Code A Oh right.

Code A

...um, but, um, for sort of personal reasons, um, when I was sort of a Senior Registrar, um, I was sort of married before that, my marriage broke up and I thought, you know, 'I don't want to go into a sort of small town and be a G.P. I'd rather sort of have a bit of a social life (laughs)', um, so I stayed in hospital and I'd really quite enjoyed my time in Geriatric Medicine,...

Code A

Yeah.

Code A

...um, at the Victoria Geriatric Unit and so that was when I applied to, um, become a sort of Senior Registrar in Geriatric Medicine down here, and I also felt I wanted a change from the West of Scotland.

Code A

Yeah.

Code A

(Pause) And in kind of some ways General Practice and Geriastrics is sort of quite similar; they're very sort of broad based.

Code A

Okay. And how did you get the, you answered a role; there was an advert in the papers, or in the magazines, or something like that?

Code A

Yes I mean the medical journal carries advertisements.

Code A

As the Consultant what was your first position that you were initially employed in?

Code A In Southampton in Geriatric Medicine.

Code A In Southampton?

Code A Yes.

Code A Okay and then when did you come over to the Queen Alexandra then?

Code A That was in April 1998.

Code A That's nicely covered your career background. Code A Code A what is the organisational set up of the hospital, the Queen Alexandra?

Code A You mean which organisation does it belong to?

Code A Yeah go on, because we know that it changes over the years...

Code A (Laughs)

Code A ...doesn't it?

Code A When I came to Portsmouth in 1998, um, the non primary care / community care was covered, in Portsmouth was covered by two organisations the Portsmouth Hospital's, um, NHS Trust as it was called and Portsmouth Health Care Trust. Now Portsmouth Hospital Trust ran most of the, um, beds, if not all of the beds at St. Mary's Hospital

and most of the beds in Queen Alexandra Hospital other than the beds which are used for the Department of Elderly Medicine. The Department of Elderly Medicine, um, was part of Portsmouth Health Care Trust, which, um, was responsible for running St. James's Hospital, mental health services, um, community paediatrics, um, district nursing, health visiting, school nursing, um, so it was almost everything that was sort of not acute hospital and not strictly G.P.

Code A

Yeah, okay. So when did all that, and when did all that change then? Because what they called, what does it come under, what does it come under now?

Code A

It's East, it's East Hampshire Primary Care Trust,...

Code A

Yeah.

Code A

...um, now run, um, elderly, the elderly medicine beds at Queen Alexandra Hospital. I mean I should also have said that, um, Portsmouth Health Care Trust ran all the community hospitals so that was Havant War Memorial, Petersfield, Gosport War Memorial, um, I'm sorry I can't remember your last question you asked me.

Code A

We were just trying to find out when it all changed over ...

Code A

When it changed?

Code A

...to its current positioning.

Code A

Uh I can't remember when the last reorganisation was whether it was 2002 maybe. So I went to Portsmouth, Portsmouth Health Care Trust was dissolved and basically split into three organisations Portsmouth City Primary Care Trust, Fareham and Gosport Primary Care Trust and East Hampshire Primary Care Trust.

Code A

Yeah so that's covered that, so it's covered, that's how it's changed since 1998 basically then?

Code A

Yes.

Code A

Yeah okay. And what about your department.

Code A

Elderly Medicine?

Code A

Yeah.

Code A

Well the Elderly Medicine Department had beds, um, in Petersfield Hospital, at that time St. Christopher's Hospital in Fareham, which is no longer there and Gosport War Memorial Hospital as well as St. Mary's Hospital and Queen Alexandra Hospital. Um we also had, you know, day hospitals at Petersfield Hospital, at Gosport and both at Queen Alexandra Hospital and St. Mary's Hospital.

Code A

Okay, yeah. And you say 'St. Christopher's isn't there anymore' is it?

Code A That's right.

Code A Is Petersfield still running?

Code A Yes.

Code A Yeah. And you've still got the beds at St. Mary's.

Code A Yes.

Code A Yeah okay.

Code A I mean the configurations changed but...

Code A Yeah. And did these care trust changes affect your department much or?

Code A One, well (pause) no and, and this is before I, I came to Portsmouth and the decision had been made that elderly medicine would be part of Portsmouth Health Care Trust, so in some ways it was very useful having all the departments, you know, all the beds in Queen Alexandra and St. Mary's plus Gosport all, all being managed by one organisation,...

Code A Yeah.

Code A ...I mean that created some tensions with Portsmouth hospitals because they would like to have run the beds in,...

Code A Yeah, yeah.

Code A ...there are beds in Queen Alexandra Hospital.

Code A Fine thanks for that. How many doctors were working in your department from 1998?

Code A Let's say in 1998. Consultants?

Code A I mean, I mean I can't, it, it's changed so often but I mean there'd be I think nine or ten consultants, not often were full time...

Code A Right, yeah.

Code A ... I don't know they might have had, um, (pause) I think they might have had four Registrars or Specialist Registrars (pause), um, I am, you know, I'm guessing, well I'm not it's an inspired guess eight, eight Senior House Officers, two Pre-registration House Officers and we had, um, G.P.'s working for us as Code A like Code A Code A

Code A Yeah.

Code A ...at the War Memorial and we had a doctor doing a similar role in Petersfield and we had a practice covering St. Christopher's Hospital.

Code A So they didn't have their own Clinical Assistant, they had a practice that covered the same role?

Code A Yes and two of them took a lead role if you like.

Code A Yeah, okay, thanks for that. What's your current role within the department?

Code A Now I'm a straightforward Code A if you like...

Code A Okay.

Code A ...as of the 1st of June.

Code A From the 1st of June?

Code A Yeah.

Code A Is that a job change or?

Code A Yes.

Code A Oh have you just dropped a title, were you Code A Code A?

Code A I was Code A

Code A Oh right.

Code A ...um, of, um, what are called Secondary Care Services within East Hampshire Primary Care Trust and Fareham and Gosport Primary Care Trust. Well I'd actually did it for Portsmouth City Primary Care Trust for a year, or a couple of years, this is when Portsmouth Heath Care Trust was dissolved...

Code A Uh-huh.

Code A ...and then Portsmouth, I think after a couple of years Portsmouth City P.C.T. appointed their own Medical Director and I was left as Code A for what we call 'secondary care', in other words I had no, my role didn't cover general practice but, um, it covered the sort of community hospitals which were Fareham and Gosport P.C.T. and East Hampshire P.C.T.

Code A You decided to cease that role or?

Code A Yeah, yeah, well I was asked to cease it (laughs)...

Code A Oh right (laughs).

Code A ...because there's another re-organisation, um, well it's happening, we're in the midst of that happening now because Fareham and Gosport P.C.T's will no longer exist from the end of, um, September I think it is...

Code A Another change?

Code A ...I was going to be a Hampshire wide P.C.T. excluding Portsmouth City and Southampton City.

Code A So there will be just the three Health Care Trusts in the future Hampshire, Portsmouth and Southampton?

Code A Um not quite, um,...

Code A No. I didn't think it would be that simple.

Code A ...as of the 1st of October there will be Portsmouth Hospital Trust,...

Code A Yeah.

Code A ...there will be the Hampshire P.C.T., there will be Portsmouth City P.C.T., but what I didn't also say was that, um, Mental Health Services, um, are now run by Hampshire, what's called Hampshire Partnership Trust and that was established when Portsmouth Health Care Trust was dissolved, so around about 2002 / 2003. It used to be called West Hampshire NHS Trust, but it's changed its name to Hampshire Partnership and over the past year there's been sort of, um, fits of service from both Fareham and Gosport and East Hampshire PCT which have gone to Hampshire Partnership Trust or, I don't think anything's going to Portsmouth Hospital Trust yet, but we are about to be taken over by Portsmouth Hospital Trust the elderly medicine service.

Code A — But within the department when you were a Code A were you the head of the department?

Code A — No I wasn't head of the department. The head of the department in 1998 was Code A (pause) and he was head of the department until about a year ago.

Code A — Okay. Would that have been his title as well?

Code A — He was, um, Code A .

Code A — Code A

Code A — ... Code A was his title. Now I was the Code A for the Trust, which covered elderly medicines, psychiatry, the whole works and he was the Code A for the department.

Code A — With that title a layman just assumes that you were the headman.

Code A — No. So I was not the Medical Director of Gosport War Memorial Hospital,...

Code A — No.

Code A — ...I was like any other consultant at Gosport Memorial Hospital.

Code A Can you explain what your role was as Code A then?

Code A Yes. I was a member of the board, the Trust Board, and so my role was to provide, if you like, medical advice and guidance, um, to the Trust Board. Um, I was also, if you like, I was also a, um, the Senior Medical Professional in the Trust so that if, um, there were disciplinary issues, um, which haven't been resolved within a department, um, I would deal with these (pause), and there are always policies and procedures, create a medical flavour for the whole, um, Portsmouth Health Care Trust, my role was not policies within the Department of Elderly Medicine although the policies could have applied to...

Code A Yeah.

Code A ...Elderly Medicine.

Code A It looks quite a broad, a broad role...

Code A Yeah.

Code A ...compared to your role as the Code A Code A

Code A Oh yeah, yeah, yeah, it's huge. I mean that took up most of my time.

Code A Did it?

Code A Yeah.

Code A We might go back to that and ask some more questions later on.

Code A Yeah.

Code A So since you qualified as a Consultant, have you had any further professional qualifications since then?

Code A No.

Code A No?

Code A No no further qualifications. I mean one obtained additional qualifications to become a Consultant.

Code A Yes. Go through those then doctor if you would?

Code A Um, well, um, what, well the training requirement is what's called Membership Of The Royal College Of Physicians...

Code A Yeah.

Code A ...and that's what called, um, an entry qualification, it's an entry qualification to what's called Higher Specialist Training so, um, before you, as things were it's changed since, before you could become a Senior Registrar, um, you had to have possession of Membership Of The Royal

College Of Physicians, um, so having got that I then decided to pursue Geriatric Medicine and the higher specialist training programme is the Senior Registrar post and then on successful completion of, it's nominally a four year training period and then you, um, could apply for Consultant jobs at that time, it's changed since then.

Code A It would have done.

Code A (Laughs)

Code A So for instance a Member Of The Royal College Of Physicians, I read the statement that you gave a while ago and you said that that was in 1978,...

Code A Yes.

Code A ...is that when you applied, or is that when you've completed?

Code A That's, no it's an exam.

Code A This is sitting an exam.

Code A It's an exam.

Code A Yeah.

Code A Um well it's a mixture of written and seeing, you know we exam seeing patients...

Code A Yeah.

Code A ...and making diagnoses and treatment plans, so that's, it was an exam, you pass an exam.

Code A If you pass the exam that gives you the membership?

Code A Yes.

Code A And then you'd have to continue to train...

Code A Yes.

Code A Right.

Code A And you have to compete for posts, it's not a, it's not a guarantee of...

Code A Yes.

Code A ...getting a specialist training job, it's an entry qualification to...

Code A To be able to apply?

Code A To be able to apply yeah.

Code A I'm with you, yeah. Am I right in thinking that you're a member of some other (pause), a Fellow Of The Royal College of Physicians,...

Code A Oh yeah, um, that...

Code A ...Glasgow?

Code A Yes that's, um, that's, um, (pause) that's, that's different, um, it's arc and it's arcane, um, but you have to be proposed to become a Fellow Of The Royal College Of Physicians, um, I think almost everyone is and you usually have to have been, had your MRCP for, but usually people have been in the consultancy for three or four years and then their colleagues will nominate them to become a fellow, but it's not, um, it's not a training qualification as such it's a sort of, I suppose a mark of seniority...

Code A Experience of...

Code A ...but that, that doesn't really mean anything.

Code A So have you, you haven't got any more qualifications then since those we just talked about,...

Code A Yeah.

Code A ...but have you undertaken any other training in the field of medicine since working at Q.A.?

Code A No.

Code A Apart from obviously the general.

Code A Not in medicine I haven't, no.

Code A No. But you've done something else in something else?

Code A Well I've been, I mean I was sent away on a three-week management course.

Code A Oh right when?

Code A A long time ago.

Code A Yeah. And your GMC registration number?

Code A Code A

Code A Okay. And under that registration what do you understand as being your responsibility under that registration?

Code A Um to, um, well the GMC...

Code A Yeah.

Code A ...produces guidance, you know, of the duties expected of a doctor. I mean for a long time that was, you know, remained unchanged, but it's been, in the past, um, few years that's been sort of fairly regularly, um, updated.

Code A Any major changes in that then?

Code A Oh um I think making it very clear that ones sort of first responsibility is to patients.

Code A Yeah. Has anything in particular brought that change or?

Code A Um well I think probably lots of, um, um, unhappy, um, events that have, you know, hit the national press...

Code A Yeah, uh-huh.

Code A ...over the years where, um, it was perhaps felt that doctors were, um, you know, not, um, doing as much as they should for patients.

Code A Okay. Now as the Code A in the Code A role obviously has it changed since you've taken, since you've ceased doing Code A , or are you doing the same job as a Code A as you were when you first joined?

Code A More or, more or less the same.

Code A Yeah, okay. So what are you contracted to do as a Code A then?

Code A I mean I'd have to go back to...

Code A Sessions.

Code A Oh yeah right okay, right. Um, um, it's, um, well it's changed again since I made this first statement. ...

Code A Yeah.

Code A ...I'm contracted at the moment to, um, what I call 11PA's, and now PA is a programmed activity. Now a programmed activity is a session, a normal session of four hours work.

Code A One session is four hours?

Code A Yes.

Code A Or one PA is four hours?

Code A Yes. Um I should perhaps also, um, just for completeness sake that, um, from the 1st of June I've also agreed to do some additional work although not as a sort of PA for Portsmouth City Teaching Primary Care Trust.

Code A And do you still have on call responsibilities?

Code A Yes, yes. And, and, and they're, they're recognised within that 11PA's.

Code A That's all part of that?

Code A Yes.

Code A Oh right. And so if you had a, if you're on call tonight for instance...

Code A Yeah.

Code A ...is that one PA one session?

Code A Oh no if only (laughs).

Code A No?

Code A No. Um it, it's to search the time you spend working. So if I, when I go in on a Saturday and a Sunday morning as part of a ROTA, um, that's totted up over a year and then, you know, the number of hours on average per week that is,...

Code A Uh-huh.

Code A ...it becomes, I mean it's .75 of a PA's is equivalent to actually going into hospital and working at weekends. We get a separate payment, um, for, um, on call which I think is about, and it depends how onerous your on call is but I think it's about, something between 1 and 3% of your salary. So if I'm on call tonight I get a, for doing that a 1 in sort of 8 or 10 places, I get it back next year at 2% or something like that, it's something like that, I mean I couldn't tell you exactly.

Code A And you do weekend responsibility as well you're saying?

Code A Oh yes.

Code A How many is that?

Code A Um it's approximately, um, I think it was, it's 1 in 6, um, going on to the wards at Queen Alexandra and being on call for the rest of the week. Sorry 1 in 12 I should say.

Code A 1 in 12?

Code A Approximately, somewhere between 1 in 10, or 1 in 12 it fluctuates a bit depending, because with some consultants leaving and what have you.

Code A Right yes.

Code A Um so 1 in 12 I do that and I am on call for the weekend and on call 1 in 10 of 12 week days, but I also go in another 1 in 12 to work on the Medical Assessment Unit and that's seeing patients who have come in as an emergency, um, on a Saturday and a Sunday morning and that's takes sort of four or five, um, hours to do, but once that's over there's no on call commitment. So if you like I'm in at weekends roughly 1 in 5 or 1 in 6.

Code A Sure. Now so is yours a full time National Health Service contract then?

Code A Yes.

Code A Yeah. And that's a typical contract is it for a Consultant?

Code A Yes. The minimum is, well the normal is 10, but a lot of people are doing more than that.

Code A Yeah. So the programmed activity or session has that changed then recently?

Code A Um it changed with the new consultant contract, which was introduced in 2003 I think.

Code A And was it 3½ before that?

Code A It was yeah, it was what were called 'sessions' and a session lasted 3½ hours.

Code A Yeah. And was a session, would that have been the same for, a G.P. session would have been 3 ½ hours as well would it,...

Code A Um.

Code A ...or was that a common figure or not?

Code A Sort of, well nominally.

Code A Yeah.

Code A I mean what, what often happened was that G.P.'s, if you like the currency was sessions in terms of paying people, so you might pay a Clinical Assistance or pay a G.P. four sessions worth of pay to provide twenty-four hour

responsibility because you're recognising that there weren't working all these hours. Does that make sense?

Code A — Yeah, yeah. So do you have any other responsibilities within the hospital in addition to your consultancy now?

Code A — Well I mean I've, as I've said just taken on an advisory role at Portsmouth City as a teacher.

Code A — (Inaudible) is it you say?

Code A — No, no, it's, um, they call it a Teaching Primary Care Trust because,...

Code A — Oh.

Code A — ...because the university's down in Portsmouth,...

Code A — Yes.

Code A — ...it doesn't, it's nothing to do with, no it's not teaching.

Code A — Oh right, okay. And do you have any other responsibilities outside of the Q.A.?

Code A — At the moment?

Code A — Yeah.

Code A — Well I'm working down in Gosport again.

Code A Oh are you?

Code A Yes.

Code A Right. What, as a?

Code A On Dryad Ward.

Code A Oh right, okay. When did you start that again then?

Code A Uh (pause), um, (pause) it's either September or October last year.

Code A Oh right. And what's your commitment to that?

Code A Um one ward round, or one session a week, one PA a week.

Code A Now that covers the present time. So back in '98 what were your responsibilities outside of the hospital then, outside of Q.A. then?

Code A In 1998?

Code A Yeah '98 / '99 that time.

Code A Our Consultant time-tables changed, um, not on a, perhaps every nine months or so, so I could probably, one of our secretaries is very diligent and keeps them all so I might be

able to find exactly what I did back in 1998, but as I remember my contract was basically half time as Code A Code A and half time Code A Um I was certainly looking after Ann Ward in Queen Alexandra Hospital and I was also, um, I had an outpatient clinic I think in Queen Alexandra Hospital and I had I think a session in Dolphin Day Hospital at Gosport when I first came in 1998, but not working on the, directly on the wards.

Code A Yeah. When did you start working on the wards then?

Code A Well it was in 1999, I mean somewhere in the Spring of 1999...

Code A Yeah.

Code A ...but I can't...

Code A I think it was February wasn't it?

Code A I admit it was either February or April I can't, I can't remember.

Code A Yeah that's fine. I mean we say February I think because we've actually taken it out of the statement you supplied to the police,...

Code A Yeah, yeah.

Code A ...we haven't got it from anywhere else.

Code A No.

Code A So you had responsibility to Dryad Ward?

Code A Yes.

Code A Yeah for about a year?

Code A Yes.

Code A Yeah. And did you also cover for Code A on Daedalus?

Code A Yes. Um I mean it was really only covering if there was a major problem.

Code A Yeah. Such as they weren't available for something?

Code A Well yeah if there was some sort of crisis really.

Code A And what about if Code A wasn't available to do her weekly ward rounds…

Code A It wasn't done.

Code A It wasn't done.

Code A We'll probably cover that more in a minute.

Code A Yeah we'll do that again in a minute. Can you explain, I think you've probably already given the answer in a way but can you explain how you became responsible for a ward at the Gosport War Memorial Hospital?

Code A Um well as I say every so often, um, Code A and one of the, um, um, we've got a, she's not a secretary like a sort of administrative person who looks at all the sort of the, who deals with all the medical staffing issues in the department. They would sort of sit down and re-jig the time tables.

Code A Uh-huh. So we've established that you were on Dryad Ward, and what type of ward was Dryad Ward (TAPE MACHINE BUZZES)... That little buzzer indicates that the tape is coming to an end. What we'll do, is everybody happy to continue?

Code A Yeah.

Code A Yeah just carry on.

Code A Shall we stop there Code A and turn them over?

Code A Yeah turn them over.

Code A The time is 1000 and I'm turning the machine off.

INTERVIEW CONCLUDES – TAPE MACHINE IS SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Code A

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 1002 Time concluded: 1042

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

Interviewer(s): Code A

Other persons present: Code A

Police Exhibit No: Number of Pages: 25

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the interview of Code A Code A Doctor can you just confirm that we just stopped briefly just to change the tapes over?
Code A	Yes.
Code A	Yeah. And the personnel in the room still stayed the same?
Code A	The same, yes.

Code A And we haven't spoken to you during that interim period?

Code A No.

Code A Thank you. We were just talking about Dryad Ward, oh sorry the time is 1002, we were just talking about Dryad Ward, what sort of ward was Dryad?

Code A I mean as I remember at that time it was a continuing care ward that, I mean, uh, I can't, I mean I just, I mean there might have been some patients there who would go home who might have improved over a long period of time, so there might have been one or two what I would call, um, we got what we used to call 'slow stream rehabilitation' sort of patients at the start of it.

Code A Okay. We will probably go back to that again later on as well and so thanks for that. And what sort of age groups are we talking about there then?

Code A Anyone over, it could be anyone over sixty-five with, who had, usually patients who suffered multiple, who were frail and or had multiple medical problems.

Code A While you were engaged in that work from '99 onwards, what was your annual leave entitlement whilst working at the hospital?

Code A Six weeks.

Code A Six weeks. And do you recall what leave you did take while you were there?

Code A No. I certainly took my full quota.

Code A Sorry?

Code A I would have taken the full quota.

Code A Yeah, okay.

Code A But what I can't say that the leave year runs from April to March, so I mean it might have been, you know, five weeks during the time, I just, I don't know.

Code A No, yeah. And how was your role covered when you were on annual leave then?

Code A Well there's only Doctor, well Code A did the routine day-to-day care and, you know Code A was, you know, if I wasn't there then she was usually around, but I mean there wouldn't be anyone to do the ward rounds.

Code A Right. So what would (pause), if you weren't, say for argument, what would you, typically how long would you be away about two weeks?

Code A About a week or two weeks.

Code A A week or two weeks. So say for arguments sake you had a period of summer leave there...

Code A Yeah.

Code A Yeah.
...and you were away for two weeks,...

Code A Yeah.

Code A ...what involvement, if everything, ran...

Code A Smoothly.

Code A ...smoothly, what involvement would Code A have had with the ward?

Code A None.

Code A None at all?

Code A No.

Code A And what would cause her to have any involvement in the ward?

Code A By Code A if she was very concerned about a patient, or I mean let's say if there were, uh, relatives who, um, had spoken to Code A and wanted to speak to a Consultant then she might do that stuff.

Code A I mean do you want me to say a bit more about that?

Code A Yes please go on.

Code A Yeah. Well, um, it's always very difficult, um, when someone's on leave: "What do you do about it, do you bring in a locum?" Um, and certainly I know that before I came to the department we had employed locums who were, um, you know, so bad that they were dangerous and, um, so I mean I sort of, I can't see it written down on a bit of paper but there was certainly a sort of very conscious decision that for short periods of absence, um, we would not normally employ locums because they often created more risk than they actually produced, ...

Code A Yeah.

Code A ...and it was felt that in particular somewhere like, um, Dryad Ward the turnover was quite low certainly at the start of that period, um, and therefore not an awful lot, you know, happened and there usually wouldn't be, um, a great call for either, you know, me to go and see Code A patients or visa versa.

Code A So you didn't use locums at all then?

Code A I've no recollection of there being a locum in Gosport in the time I was there I couldn't, you know,...

Code A No.

Code A ... say absolutely not but I have no recollection of it.

Code A And you were performing ward rounds at the Queen Alexandra Hospital?

Code A Yes...

Code A Yeah.

Code A ...at the same time.

Code A Yeah. And how often would your ward rounds be at the Q.A.?

Code A At least twice a week.

Code A And what wards would they have been?

Code A There was an Ann ward.

Code A And what sort of ward, what sort of...

Code A Well it's like, sorry it's an acute elderly care ward, but almost certainly I would go in at other times, um, I mean sometimes I would go in almost every day,...

Code A Yeah.

Code A ...you know, because, um, well we often had sort of problems with staffing there, um, you know the junior staff, um, off ill, patients there might not be a, you know, Registrar around because they were off doing clinic at St Mary's so you'd often have to pop round to the ward and see what's going on and sort out the problems there.

Code A And that was twice a week your ward round there?

Code A Yeah. I would be on the ward at lease twice a week.

Code A Yeah. And what about that Dryad Ward, what were your ward rounds there?

Code A Once a week.

Code A Once a week.

Code A On a Monday afternoon.

Code A Okay. And did you mention in one of those statements that you made earlier that you actually, did you ever do any ward rounds on Daedalus?

Code A I have no recollection of ever doing a ward round on Daedalus Ward.

Code A Obviously I was talking about in the absence of Code A Code A

Code A Yes, yeah, yeah.

Code A I think we've covered that haven't we because you said 'it would be something remarkable to get her to go in'.

Code A Yeah, yeah.

Code A What about sick leave then Doctor, have you ever taken extended periods of sick leave for anything?

Code A Um yes I had a shoulder operation last, a year ago in January.

Code A So it's quite recent, yeah.

Code A But not at that time.

Code A Not at that time. Right the next question was, what cover was provided during your absence, but I think we've covered that as well haven't we? There's no cover for...

Code A There's no cover.

Code A ...when you're on leave or...

Code A No.

Code A No. Presumably, say for arguments sake something untoward had occurred to you and you had a forced lay off

with a broken leg or something and you're off work for four months

Code A That, that...

Code A ... is that something that would have been...

Code A That would have been different.

Code A Yeah.

Code A I mean would have, we would have to have considered engaging a locum at that time...

Code A Yeah.

Code A ...and, um, I mean it usually would have been sort of, Code A would have made the decision.

Code A Uh-huh.

Code A Am I right in thinking if there is any, or if there was any problems on the ward it's a phone call to the elderly medicine?

Code A Yes.

Code A So would that be if you were away for two weeks and let's say for arguments sake whoever was doing the ward rounds whether it be Code A or somebody else, there

was someone that they, when you weren't there there was someone they could contact?

Code A

Yes. I mean, well Code A, um, Code A Code A was sort of very assiduous in her duties, I mean she came in every morning at sort of seven-thirty (0730), um, well I suppose I've seen her occasionally but somebody told the nursing staff that she came in every morning without fail and she would obviously invariable come in in the afternoons too, so the nurses have sort of had lots of opportunity to, um, you know present problems that have arisen. What, what I can't say is, because I just can't remember, is say, because if I remember correctly Code A also had her ward round on Monday afternoons so Code A would sort of join us on alternate weeks. Now I think that what probably happened is that say when Code A was away I would probably have said: "Oh you go on to Daedalus Ward," rather then sort of check the round with me because like I say, you know, it's better to have one, some Doctor rather than sort of no cover at all,...

Code A

Yeah.

Code A

...so that sort of thing would happen.

Code A

Okay. So no local cover was arranged at all?

Code A

No.

Code A How would you describe your workload at that time then?

Code A I mean it was, it was very heavy. I mean I would be working six, at least sixty hours a week. I would be in before eight (0800) in the morning and often you're not home until that time at, or after that time at night.

Code A Yeah. So that's regular twelve-hour shifts there?

Code A Yes.

Code A Yeah. And how did you cope with that do you think?

Code A (Laughs) Um, well I mean it wasn't easy, um, funnily enough I quite enjoyed working hard, um, I mean there's a sense in which that, um, sometimes you felt that you were in the wrong place (laughs), you know you were down in Gosport and there was a problem up in Q.A., or you were up in Q.A. and there was a problem down in Gosport.

Code A Yeah. And that's a geographical site problem really?

Code A Yes.

Code A Yeah.

Code A Yeah.

Code A Have you got any questions Code A?

Code A There are a couple I would just like to just go back over Doctor. I mean were mistaken and we thought you were the head of the department because you were a Code A Code A, but it was Code A ?

Code A Yeah.

Code A Can you just explain as best you can, obviously I know you said 'you can't remember exactly how many Consultants...

Code A Yes.

Code A ...there were and things like that', but at the top of the tree obviously in elderly medicine you've got Code A Code A I mean how does it sort of filter down from there?

Code A Yeah I mean it's, it's quite, it's quite difficult in a way. I mean everyone likes to assume themselves as being equal...

Code A Uh-huh.

Code A ...and certainly as you practice as an individual Consultant you're all equal, um, and not all Consultants would recognise this at that time, well I think Consultants in our department would, but Code A was, um, Lead Consultant in terms of, if you like, the administration,...

Code A Right.

Code A ...all the input to administration departments, it's not to say that, you know, he could go and tell another consultant what to do clinically it's more around the Administration Department how cover was arranged, where people worked,...

Code A Yes.

Code A ...the new development of policies, that sort of thing.

Code A Right I've got that then, so you've got Code A and the Consultants. I'm probably using the wrong term when I say 'beneath',...

Code A Yeah.

Code A ...but the next level down is the Registrars.

Code A Yes well Senior, well at that time the Senior Registrars and then Registrars.

Code A But are they under the guidance of the Consultants there?

Code A They're under, I mean I think, I'm not, I'm not sure just how where clearly the responsibilities would been seen back at that time,...

Code A Yeah.

Code A ...um, but I think most people would accept that if a Registrar was working for them, they were responsible for their actions,...

Code A Yeah.

Code A ...not, not, so Code A wasn't responsible, I don't think say with regards say Code A responsible for the actions of all the Registrars and Junior Staff in departments that would be the Consultants.

Code A The Consultants it would be. And where does the Clinical Assistant fit in here?

Code A Right. Well a Clinical Assistant is a different type of post completely, it's what called a 'career post', in other words it is not a Doctor in training so it's not like all the other grades Registers, Senior Registrars,...

Code A Yeah.

Code A ...it's sort of like career post and I mean although, and most, um, Clinical Assistants, um, were appointed, you know, working in hospitals or in sort of secondary care base services and outpatient clinics and usually, um, working in a department where there was a consultant.

Code A Right. I mean we're going to cover the whole thing about the Clinical Assistant a little more in a little bit of time, but do they sit equal to the Senior Registrars, or...

Code A No it's just completely, it's completely different really...

Code A Right. I understand the Registrars...

Code A ...and the Senior Registrars are still in training.

Code A Training yeah.

Code A Um I mean Clinical Assistants could, you know, I mean there were some people in full time jobs as Clinical Assistants who wouldn't be much short of the experienced Consultant, and there were others who would be, you know, a G.P. who had maybe had, you know, did two sessions in an ENT clinic, they'd just go and see the sort of simpler cases in an ENT Clinic,...

Code A Yeah.

Code A ...or would be covering say St. Christopher's Hospital...

Code A So they've got a good standing?

Code A Yes.

Code A They've got an equal...

Code A Yes.

Code A ...standing so to speak?

Code A Yeah. They're not Doctors in training,...

Code A They're not Doctors but are they...

Code A ...so you'd expect them to be able to take a fair degree of responsibility.

Code A Are they still under the guidance of a Consultant?

Code A Um usually they were working in a department. I mean I would, I'm just not clear of what the employment law is, but I mean I think most people would regard them as sort of working, you know, under the supervision of a Consultant.

Code A Okay. And just one other thing is you've mentioned in the last tape actually that 'you attended a management course some time ago',...

Code A Yeah.

Code A ...what was that about?

Code A It was about, um, and I can't remember what it was entitled, um, it was called 'A Senior Management Programme' and it was at Keele University and it wasn't

for Doctors, there were a couple of Doctors on the course, but it was for, you know,...

Code A General management?

Code A Yes.

Code A Non-specific?

Code A Non-specific, we had black people from the Nigerian Electricity Board and Indian Coal Board and...

Code A Yeah, right. Yeah that's fine. One more thing we were talking about, only can you just explain you mentioned 'Registrars, Senior Registrars and Specialist Registrars' earlier,...

Code A Right.

Code A ...can you just explain for the benefit of ...

Code A What's happened, I can't remember the date it happened...

Code A Yeah.

Code A ...but the Senior Registrar and Registrar grades were combined and they became one grade called 'Specialist Registrar' and that would have happened about 2000 I think,...

Code A Uh-huh, yeah.

Code A ...about that time, so.

Code A Thanks.

Code A Finished with that Code A

Code A Yeah.

Code A Right Doctor the next part we are hoping is to give you an opportunity to explain, amongst other things, your role, the role of the Consultant, which we've covered quite a bit already I think, what that entails and how much of your working day was taken up. What were your responsibilities as a Consultant, what was your job as a Consultant?

Code A Well it would be to, um, look after any inpatients who were under my care, to do outpatient clinics, um, to, um, do clinics in the day hospital, um, obviously provide on call sort of out of hours cover at weekends and during the week.

Code A Yeah. And when we talk about, I mean through this enquiry we've picked up a bit of knowledge about hospital workings etcetera, etcetera, and for instance on wards, general wards and surgical wards etcetera you'll have a Consultant and he works with a team?

Code A Yeah.

Code A Yeah. Did you have a team working with you?

Code A Um yes on, on Ann Ward I did,...

Code A Yeah.

Code A ...um, and that would have been me, there was either a, there was either a Registrar, or a Senior Registrar at that time, um, and it was a Pre-registration House Officer, so a very inexperienced...

Code A Yeah.

Code A ...person on the ward but first job.

Code A Pardon?

Code A The first or second job out of medical school.

Code A Yeah, yeah. So a Registrar is still a training role isn't it?

Code A Yes.

Code A Yeah. So your Consultant would be your main man?

Code A Yes.

Code A Yeah. Regarding the patients, yeah?

Code A Yeah.

Code A And then you'd have a junior Doctor and then a more Senior Doctor and then yourself as a Consultant?

Code A Yeah there's three of us.

Code A Yeah, yeah. And that was in Ann Ward?

Code A Yes.

Code A Yeah. But the War Memorial wasn't like that was it?

Code A No. There was just Code A

Code A Yeah. How does that, can you just explain how that comes about how, why the War Memorial Hospital operates in a certain, in a different way to say Ann Ward?

Code A Well it's probably just a sort of an accident of sort of...

Code A Evolution.

Code A Yeah history really.

Code A Yeah.

Code A There were Junior Doctors, well what, the fundamental role of the sort of the Royal colleges, and there's one for Physicians and one for General Practice for Surgeons, is

training that's one of them and awarding specialist qualifications. So the Royal colleges would, um, only approve certain jobs as being suitable for trainees, so the jobs in Queen Alexandra Hospital were deemed to be suitable for trainees and the reason for that basically is because there more, well there's years, there's a Consultant presence most of the time, whereas say down in Gosport, um, maybe down once a week, to put a Junior Doctor in training down there would just be totally, at that time would have been totally inappropriate, um, and, um, I mean, I mean I have no idea how things started off in the War Memorial Hospital when it was first opened, whether it was, you know, entirely G.P.'s looking after their own patients,...

Code A

Yeah.

Code A

...but I mean it may have been that and then it may then have been that the G.P.'s felt not very comfortable about dealing with patients with Consultants cos it was a bit beyond their level of expertise and so someone like, you know, Code A with a practice would be employed to, you know, come in and do ward rounds and provide out of hours cover etcetera so, but it's, there'd have been no process for it, it's just, well that's the way it happened.

Code A

Brilliant, yeah, that's quite useful actually yeah. So how did your department work in relation to the care of the elderly, and particularly with Gosport?

Code A Um well what would happen is that, do you mean in terms of patients?

Code A Yeah.

Code A Most patients would be admitted, usually as an emergency, um, to Queen Alexandra Hospital. Um we would come to our wards, some would be fit to go home and others would perhaps need a period of rehabilitation and so would go to places like Gosport and Petersfield. But we're also, um, we used to, a lot of our work was actually about going to see patients in other wards in the hospital who weren't fit to be discharged home and where the Consultants were asking us: "Would you consider taking this patient for rehabilitation to Gosport because we don't think they're going to get better," whatever, so a lot of, so everyone, if you like, was sort of, they came to Gosport, had almost certainly been seen by one of us either in our own wards, or on some of the other wards in Queen Alexandra or St. Mary's, that's just the way it worked.

Code A Yeah thank you that's great, yeah. So within your department during the '90's, but particularly so during '99, how many patients were you responsible for then?

Code A Um well on Ann Ward I think it was nineteen patients and in Gos, on Dryad Ward it was twenty.

Code A Yeah. So around about forty, thirty-nine / forty?

Code A Yeah.

Code A Yeah. And no other patients anywhere else tucked away?

Code A No.

Code A How was your working day constructed in those days then? I mean I know it was different because you have five days in the week and...

Code A Yes.

Code A So start on a Monday, it's a convenient day to start on but it was the day you went to Gosport wasn't it?

Code A Yeah. Well usually on a Monday I went to Q.A. in the morning...

Code A Yeah.

Code A ...to do a ward round there on Ann Ward because it's much busier there. Weekends, um, are often the time when, you know, because there's not the same level of medical cover so you're more likely to encounter problems on a Monday so it was always very, well I felt very important to, to go to, um, to Queen Alexandra on a Monday morning to see patients on the acute ward,...

Code A Yeah.

Code A ...and its for for the same reason really, but I felt it was, I quite liked going on a Monday afternoon to Gosport because you didn't know what would have happened over the weekend to patients...

Code A Right.

Code A ...because there's a sort of...

Code A Yeah.

Code A And then, um, I'd usually do a ward round on Ann Ward on a Friday morning as well. Um I did a day hospital session down in Gosport but I can't remember, it was a morning, it might have been a Thursday morning, um,...

Code A During that time?

Code A Yeah.

Code A Uh-huh.

Code A Um and then the rest of the time was all office, Medical Director type of stuff.

Code A Yeah.

Code A But my base was in Q.A. so I'd often, even though I didn't have a session on Ann Ward I'd be popping in and out...

Code A Yeah.

Code A ...and support the Junior Doctors there.

Code A You had more patients in Dryad than you had...

Code A At Q.A.

Code A Well not by much though, it was only by one or two wasn't it?

Code A Yeah.

Code A Yeah. So it's reasonably irrelevant really,...

Code A Yes.

Code A ...but why was Ann Ward busier than Dryad?

Code A Oh, um, because of the nature of the patient there. Um I mean Ann Ward was people come with, you know, chest infections, from heart attacks, heart failure, um, and we know that a few days of treatment would get them better and they'd go out, there's a big turnover of patients whereas...

Code A Sorry to interrupt, were they coming from A and E then?

Code A Uh, their G.P.'s, A and E,...

Code A Right, yeah. Yeah that was the first point of contact...

Code A Yes.

Code A ...with your department with that patient?

Code A Yeah.

Code A I've got you.

Code A And then, as I said, it was only after people had been in the Q.A. and not appearing to make progress that they would go to somewhere like Gosport.

Code A And this is why, that's why you had to, well you did two ward rounds at Ann?

Code A Yes and more really.

Code A Yeah. And what was your responsibility, presumably, did you have a Job Description?

Code A (Pause) Ooh it would be very general to provide care to patients. I mean I've probably got a Job Description somewhere,...

Code A Yeah.

Code A ...but I mean it would be along back in 1998 when I was appointed, um, you know two sides of A4

Code A Yeah. Yeah but within the Job Description did it stipulate how many ward rounds you had to do or...

Code A No.

Code A No?

Code A No. That was, that was decided by, by a Code A Code A.

Code A Yeah.

Code A ...you know, so he, he if you like planned the Consultants Time Tables.

Code A Yeah. And that's what you're saying his role was?

Code A Yeah.

Code A How it,...

Code A Yes.

Code A ...in terms of your skills and abilities...

Code A Yeah and by responsibilities.

Code A Yeah, but he had control over...

Code A Yeah he was the person who made the decision.

Code A ...where you worked?

Code A I mean he discussed it with me but he was the person...

Code A Yes of course, yes, yeah. Also the department, am I right in thinking albeit you're all equal, or the department would be run how Code A would like the department to be run?

Code A Yes, yes.

Code A Yeah. But he wouldn't have any interference with your patients?

Code A No.

Code A No. So on a Monday, sorry what time would you have started your ward round at Q.A.?

Code A Oh nine o'clock.

Code A Nine o'clock, and that took you up to when?

Code A One, one probably (1300).

Code A And would you see everybody on the ward?

Code A Oh yeah.

Code A You'd see all the patients?

Code A Yes.

Code A Yeah. And generally how long would that take you to review, or examine a patient?

Code A Well there's twenty patients divided by six, 240 minutes between, twenty patients so that's, about twelve minutes a patient.

Code A Would you do it like that? I mean to get round the ward?

Code A Um well, you would, you would spend more time seeing the new patients,...

Code A Yeah.

Code A ...so the length of the ward round, well it was, it's a bit, dependant on two things really, how many new patients there were coz they always take longer but also I mean you could have some patients who weren't new but they were just very complex and you just need two or three patients who were very complex it took you ages, but I would say the average time was about four hours.

Code A So you then finished there, say one 1 ish (1300)...

Code A And I had to go down to Gosport.

Code A And what time would you be down there?

Code A I usually go down for about two (1400).

Code A Yeah, yeah. And again would you see all the patients again then?

Code A Yes.

Code A Yeah and go through the same...

Code A Yes.

Code A Yeah. And finishing at what time then?

Code A Um well, I mean I'd probably finish the ward round sort of half-past-four to five (1630 to 1700), but there was often relatives to see...

Code A Yeah.

Code A ...so you'd be there after that.

Code A And how long would it take you to write up notes after seeing a patient?

Code A It would depend on what was, it would depend on what was wrong I mean.

Code A Yeah.

Code A Um I mean generally on the wards, um, because someone else has already sort of clerked them in, um, it generally doesn't take, you know, very long to write. You look at the sort of, um, (pause). I mean I think I, I mean I would spend more time at Q.A. doing that because there were sort of new problems, they're inexperienced junior staff, um, so (pause). Writing notes at Gosport, you know, wasn't a major time consideration say compared to writing the notes at Q.A.

Code A And why was that because?

Code A Because the problems were all, um, I generally like to write things myself.

Code A Yeah.

Code A Almost every new patient at Q.A. I would, um, examine, well not quite from top to bottom but, you know, in that sort of order, um, by the time patients moved down to Gosport you know what their problems are, um, they've not come in fresh from a G.P. with a whole load of new problems, it's usually a continuation of existing ones, so for example if someone's had a stroke, nothing else has happened but a stroke and they can't move their right arm

and leg. So they weren't so really medically sick and it's being medically sick that takes up the time on the ward round.

Code A — Sure. I picked up there when you said: "I like to make notes for myself,"...

Code A — Usually.

Code A — ...is that because Consultants often give that responsibility to a Junior Doctor on their rounds?

Code A — They do yeah.

Code A — Yeah, yeah.

Code A — Because on our department it was pretty standard for all of us to write, but if you looked at the rest of Q.A. you would not find that that was the case.

Code A — So when you went to Dryad, you say 'your two o'clock ward round starts',...

Code A — Yeah.

Code A — ...would all your time down there be taken up on the ward round?

Code A — Yes.

Code A Yeah. And then when the ward rounds finished...

Code A See relatives...

Code A Yeah.

Code A ...and do other things.

Code A Yeah and then you go.

Code A Sometimes, well sometimes I go back to Q.A.

Code A Yeah, yeah. So who actually reported to you at the War Memorial when you went down there?

Code A Well I mean Code A would be there usually every other week but, um, you know, I got a lot of the information from the nursing staff about the patients.

Code A Yeah. We've already mentioned the Clinical Assistant. Can you just clarify to us what you saw that role as, the Clinical Assistant's role?

Code A Um, seeing patients, um, you know when they come in to make sure they were okay and writing sort of notes, you know, summarising what their problems were and their reasons for admission,...

Code A Yeah,

Code A ...um, and then attending to medical needs on an as required basis.

Code A Yeah. And what did you expect from the Clinical Assistant then exactly that to be able to do...

Code A Well I mean what I didn't know, um, I expected to know, as I say a summary of why the patient had come, um, and maybe a brief sort of statement and the treatment plan was this patient for rehabilitation, or for continuing care.

Code A And what, in terms of support what did you offer the Clinical Assistant?

Code A What did they get from you in terms of support?

Code A Um, (pause) well I, um, if she was on the ward round she would clearly ask me about problems. Um sometimes, um, if she was on say Code A ward round and she'd come over to ask me about something, um, I was always available, um, in terms of certainly telephone contact if she wanted to discuss something. Um, if you're asking 'did I sort of sit down and have regular appraisals with her?', the answer is 'no I didn't'. Um it certainly, that wasn't, um, (pause) I don't think it was in anyone's consciousness back in 1999.

Code A So your area of speciality was Geriatrics, yeah,...

Code A Uh-huh.

Code A ...within both hospitals obviously?

Code A Yeah.

Code A And your additional responsibility, I think you already said you were a Code A at that time?

Code A Yes.

Code A And were you sitting on, obviously you were on the Board there you were saying?

Code A Yeah.

Code A And did you have any other committees or anything else at that time?

Code A Oh yeah, oh, (laughs) I mean I could produce a list...

Code A Yeah.

Code A ...but it's huge.

Code A Huge yeah.

Code A Um I was, um, there was a small executive team which met, I think we met weekly in the Chief Executive's office, um, but you know thqat I was just a tiny bit of it. As I say I

can produce a list of all the committees I was either chairing, or being involved in.

Code A — And I think...

Code A — Then was that as a Code A ?

Code A — Yes.

Code A — Yeah.

Code A — Or more as a Consultant?

Code A — Most of them were as a Code A some were as a Consultant.

Code A — Because you're going to pick that up anyway as a Consultant aren't you with these committees?

Code A — Yes. Most as a Code A though.

Code A — Yeah. And the next question we've got down there was the demands on your time,...

Code A — (Laughs)

Code A — ...with those roles. ...

Code A — Yes.

Code A ...Now I think you said 'it was roughly half and half' wasn't it?

Code A Nominally,...

Code A Yeah.

Code A ...but in practice it worked out probably I was spending a third of my time clinically and, and two-thirds being Code A

Code A Right. And so we already know that (pause) you were doing the eleven sessions a week then. Did you say 'they were 3½ then?

Code A Yeah. I was working far in excess of that.

Code A Yeah, yeah. Any question around that Code A

Code A No.

Code A No. Right the next role Code A is, again it's an opportunity to explain about the Clinical Assistant...

Code A Yeah.

Code A ...involving this, how people become appointed and how this would impact on their role as a G.P. and that sort of thing through their experience. What was the role of the

Gosport War Memorial Hospital within the local community?

Code A

Right, um, very broadly there were obviously some maternity beds, um, there was also a G.P. ward, Sultan ward where G.P.'s could admit their own patients and look after then and they took full responsibility, no we weren't involved on that ward. Um then there were, there was about forty beds, which were used by old age psychiatry, you know, for elderly patients with depression or dementia, and then we had two wards the Daedalus and Dryad Wards and then, um, in 1998 / 1999 the role of Daedalus was rehabilitation, um, the role of Dryad was continuing sort of care, assessment for continuing care.

Code A

(Pause) You were in the area then, so before you started your work as the Consultant, do you know how the patients from the community were cared for within the hospital before you started there, or had it changed much, or?

Code A

Sorry just start again?

Code A

Before you started...

Code A

Yes.

Code A

...working there,...

Code A

Uh-huh.

Code A ...were there any great changes...

Code A Not at all no.

Code A Yeah. Apart from the fact that you say about Daedalus and Dryad Wards...

Code A Yeah.

Code A taking those...

Code A Yes. But that, that had been the case for a long, as far as I'm aware for quite a long time.

Code A What are the 'bed fund holders'?

Code A Right, um, the 'bed fund holders' I think it was, 'bed fund holders' are G.P.'s, um, and this is to the best of my knowledge, um, who, um, admit their own patients to hospital were paid for doing that, um, I think it was peanuts 25p a day or something like that, but it was so, they were paid a nominal sum for looking after, uh, patients in hospital.

Code A Okay. How does a Doctor become a Clinical Assistant?

Code A Almost certainly there would be, one guessed the post was advertised...

Code A Yeah and...

Code A ...and someone would apply for it.

Code A Now we've already, you've already elaborated on the Clinical Assistant a little bit by explaining that in certain places they can be almost on a par with a Consultant...

Code A If they're very, very, experienced yeah,...

Code A Yeah, yeah.

Code A ...but that would be exceptional.

Code A Exceptional yeah. So it's probably not a role suited to all Doctors is it?

Code A Um, I...

Code A Or is it?

Code A I think all Doctors can be yeah.

Code A Yeah.

Code A Um I mean most Clinical Assistants are probably G.P.'s who are working either in a Dermatology Clinic, or under sort of the supervision of a Consultant, or in an Ear, Nose and Throat Clinic, or sometimes it's orthopaedics. So they're probably people who have had a little bit more experience of that, um, during their Junior Doctor training

so they might have happened, because to be a G.P. you've got to go through training and do jobs in hospital, so you might have spent three months doing ENT and decided you'd quite like to continue doing a couple of clinics in ENT.

Code A

Yeah. Would you need to have a certain experience to become a Clinical Assistant then or not?

Code A

Um well you would, you would probably be looking for people who had, I mean if I was an ENT Surgeon I would be looking for somebody with experience in ENT. ...

Code A

Yeah.

Code A

...um, um, in terms of if I were (TAPE MACHINE BUZZES)...

Code A

It's okay you've got a couple of minutes still.

Code A

Click on?

Code A

Yeah sure.

Code A

Um if we were looking for a Clinical Assistant, if there were such sort of thing today, we'd be looking for someone who had some experience in geriatric medicine, but that wouldn't de, if they didn't have it wouldn't debar them though because a lost of the skills are actually just about, um, making the effort to actually examine older people and

so apply your mind to the problem and these are skills that G.P.'s have got in abundance.

Code A Yeah. Right that's telling us that the tape's coming to an end, shall we just have a quick comfort break for a minute?

Code A Yeah.

Code A Okay.

Code A What's the time?

Code A It is 1042, I am turning the machine off.

INTERVIEW CONCLUDES - TAPE MACHINE IS SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Code A

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 1055 Time concluded: 1135

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

Interviewer(s): Code A

Other persons present: Code A

Police Exhibit No: Number of Pages: 25

Signature of interviewer producing exhibit

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

Code A No.

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

Code A Yes.

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

Code A Yes.

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

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

Code A Yeah.

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

Code A Yeah.

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

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

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

Code A Yeah.

Code A ...tell you about that.

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

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

Code A Uh-huh, okay. And what we've got here is a Job Description for Code A from, – I can't

remember where it was taken from now, it was one that was relevant at the time she took the role on.

Code A Was that back in the '80's was it?

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

Code A No.

Code A No. And so when...

Code A I've never seen it.

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

Code A Yes.

Code A Code A was already...

Code A Yes.

Code A ...doing it?

Code A Yes.

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

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

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

Code A — Yes.

Code A — ...and comparing it with Code A ..

Code A — Yes.

Code A — ...right and Code A would decide where you went and where you worked...

Code A — Yes.

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

Code A (Pause) Um.

Code A Was there one?

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

Code A Yeah.

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

Code A Yes.

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

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

Code A Yeah.

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

Code A Yeah. (Long pause)

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

Code A Yes.

Code A And how often would Code A see the patients then?

Code A Well I'm told that she came in every morning...

Code A Yeah.

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

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

Code A Yeah.

Code A ...and that was...

Code A To the best of my recollection she did that.

Code A Yeah?

Code A Yeah.

Code A You had no problems...

Code A No.

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

Code A I don't recollect any problems with her.

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

Code A Yes.

Code A ...on a Monday afternoon?

Code A Yeah.

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

Code A Yes.

Code A Yeah. And she was doing that?

Code A Oh yes.

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

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

Code A Okay. 'Discharge summaries'?

Code A Oh yeah she did that.

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

Code A Yeah I think that's, it's just a bit of paper that, um, um, well it's got several duplicate sheets and one goes off to records within the hospital, I think one (1) goes off to the Government so that they can compile National statistics,...

Code A Yeah.

Code A ...that's what that refers to long and superseded by something else.

Code A And 'death certificates'?

Code A As far as I'm aware yes she did that.

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

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

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

Code A Yeah.

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

Code A I mean by circumstance that our timetables that Code A Code A and I would arrive at the same time and she could not be in two places at once.

Code A Uh-huh.

Code A Sorry is it worth pointing out that quite a few of these numbers perhaps from one (1) to six (6), tell me if I'm

wrong, but you probably know, you'd know if she was doing this by having looked at the notes rather than physically seeing her doing these tasks, would that be fair to say?

Code A Oh yes I mean...

Code A Sorry.

Code A No that's fine.

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

Code A Yeah.

Code A ...so the presumption is that they've been done.

Code A Yeah.

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

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

Code A Yes well she prescribed as required yeah.

Code A Yeah. And would she...

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

Code A But did you go to those?

Code A They must have had them but I can't, I don't remember them.

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

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

Code A Yeah.

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

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

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

Code A Yeah. And you were quite happy?

Code A Absolutely.

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

Code A I think it's very difficult, um, um, you know given the sort of very limited sort of time that, uh, that, um, Code A Code A sort of, you know, had available.

Code A Okay.

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

Code A Okay. What about the...

Code A Advising and counselling relatives?

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

Code A Oh yeah, and Code A did a lot of that.

...

Code A Yeah.

Code A ...I mean she often came in, um, in her own time to speak to relatives and come in in an evening after she had sort of, you know, finished surgery just to do that I am told, you know, I mean I didn't see that for myself but that's what the nursing staff reported to me.

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

Code A Oh the nursing staff would, you know, on a ward round.

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

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

Code A Yeah, yeah.

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

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

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

Code A Yeah go on yeah, yeah.

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

Code A Yeah.

Code A ...in a patient...

Code A Yeah.

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

Code A I'd always felt that was done yes.

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

Code A Well if there had been a, say a marked deterioration in a patient's, um, condition, um, if, you know, patients had say developed heart failure, or, um, you know, a chest infection

or whatever that, that sort of thing so, um, for example I mean if someone had a headache you wouldn't expect...

Code A No.

Code A ...that to be written in the notes.

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

Code A Yes.

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

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

Code A Yeah.

Code A ...so I'd expect that to be noted.

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

Code A Yes.

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

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

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

Code A Well I...

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

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

Code A Yeah if it was some form of antibiotics...

Code A Yeah.

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

Code A The drug chart...

Code A ...drug chart...

Code A ...and see that.

Code A And see yeah.

Code A Or the other way round look at the drug chart and...

Code A And see the entry yes.

Code A ...see the entry in the notes, you'd expect that yes.

Code A Right so they should cross refer?

Code A In general yeah.

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

Code A Usually.

Code A Usually.

Code A They're not always.

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

Code A Yes.

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

Code A Yes.

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

Code A Yes.

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

Code A Yeah.

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

Code A Yes.

Code A ...as Clinical Assistant...

Code A Yeah.

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

Code A I think that would be a matter for...

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

Code A Yeah.

Code A ...but...

Code A I mean within...

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

Code A Yes. Um we're all, we're all different, um, some of us can cope with lesser or greater workloads than others, um, and I think that what will, I mean I don't think you can generalise, I think you would have to look at what the Clinical Assistant's role actually was. I mean I think if it's say just doing two Dermatology Clinics well you can't be in the practice. But on the other hand covering a hospital, you know, where the cover is twenty-four hours, um, that does, you know, put, you know, additional sort of strains, sort of considerations on the person who is undertaking that role, particularly if they've got a very busy general practice.

Code A Okay. That's fine Code A

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

Code A No I haven't.

Code A So with regards to, um, her job summary and her duties, who was responsible for ensuring that she had completed

those then satisfactorily to that? We'll touch on it again later on I think.

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

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

Code A Yeah.

Code A Code A Now how many sessions a week was Code A Code A ontracted to there?

Code A Well I see it says there five,...

Code A Yeah.

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

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

Code A Oh yeah.

Code A Yeah. Over the hours?

Code A Um well I mean the thing we'll have to remember is that it's a nominal number of, if you multiply by five or six

times, you know, by 3½, and there's no question to me she's putting in the, you know,...

Code A The hours.

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

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

Code A Yes it was at that, yes, yes it was 3½ hours, yes.

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

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

Code A Yeah.

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

Code A I was just about to say.

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

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

Code A Yeah.

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

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

Code A Yeah that's what I meant,...

Code A Yeah.

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

Code A Well she, I mean she was in the sense that she had a contract...

Code A Yes.

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

Code A Yeah.

Code A ...that was, as I understand it, the arrangement.

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

Code A She was accountable to me for the patients on Dryad Ward.

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

Code A It is, yeah.

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

Code A Yes, yeah. It was invariable full.

Code A Yeah. And was that similar on Daedalus?

Code A Daedalus Ward had a higher turnover because it was a rehabilitation ward...

Code A Right.

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

Code A Yeah.

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

Code A Yeah.

Code A ...going out and some are coming in.

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

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

Code A Daedalus.

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

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

Code A Yes.

Code A Yeah. And Dryad...

Code A Was continuing care...

Code A Continuing care.

Code A ...at the beginning of 1999 yes.

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

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

two nurses, you know, to wash, dress etcetera, so very dependant patients and you felt there's no prospect of them getting any better, that's how it was at the start.

Code A The start of when you went there?

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

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

Code A There was an expectation you'd go...

Code A ...looking to...

Code A To go, to go...

Code A ...get that patient home?

Code A Yes, yeah.

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

Code A Yeah.

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

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

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

Code A Where the best sort of level care would be offered.

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

Code A Yes, yes, yes.

Code A What about 'palliative care' then?

Code A Yeah, um.

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

Code A Yes.

Code A ...within that respect?

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

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

Code A Right. Well palliative care to me is about sort of, um, relieving symptoms of people who are distressed in some way. Um, now that may be because of general cancer,

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

Code A — Right, so, yeah relieving...

Code A — Symptoms.

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

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

Code A — Yeah I'm with you.

Code A — Yeah.

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

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

Code A Q.A. yeah.

Code A ... at Q.A. was a palliative care ward,...

Code A Yeah.

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

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

Code A This patient is in a...

Code A Palliative care stage.

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

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

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

Code A Other...

Code A Non elderly medicine wards.

Code A Yeah.

Code A And would have, one of us would have seen them.

Code A Yeah. In...

Code A Possible if I could...

Code A Sorry.

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

Code A Yeah.

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

Code A I'm with you yeah, yeah I'm with you. So if circumstances take over a patient...

Code A Yes that's right. I mean they may be too ill to be moved to the palliative care ward.

Code A Yeah. But the palliative care ward is there for that one purpose...

Code A Yes.

Code A ...basically?

Code A Yes.

Code A Yeah. So it's fair then to say that not everybody that was on Dryad Ward was suffering from an illness or disease that would necessitate palliative care then?

Code A Absolutely, you're absolutely right.

Code A How do you feel, what do you feel the level of care and treatment was that was offered to the patients at the time on Dryad when you were there?

Code A Sorry what did I?

Code A What did you feel about the level of care and treatment that was being offered to the patients?

Code A I mean I felt the patients got very good, I felt the patients got very good nursing care,...

Code A Yeah.

Code A ...um, on, um, Dryad Ward...

Code A Yeah.

Code A ...and I mean I'd no concerns about the medical care either.

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

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

Code A Yeah.

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

Code A Yeah.

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

Code A So it wasn't...

Code A ...is behind the question...

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

Code A Oh no, no, no.

Code A No.

Code A No not for medical equipment, no.

Code A No okay.

Code A Not that I, not that I recollect.

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

Code A Yes. Well I mean essentially it was us as Consultants...

Code A Yeah, yeah.

Code A ...who decided.

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

Code A Yes.

Code A Yeah.

Code A Yes.

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

Code A Yes.

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

Code A Um.

Code A How would that have worked?

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

Code A Yeah.

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

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

Code A — Code A would usually make that decision.

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

Code A — Not that I'm aware of.

Code A — No.

Code A — So it would be her clinical judgement.

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

Code A — No.

Code A — No?

Code A — The Personnel Department would be able to tell you that sort of thing.

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

Code A — Post.

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

Code A No.

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

Code A No.

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

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

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

Code A Yes it is.

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

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

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

Code A Oh it did.

Code A Explain that then.

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

Code A Is this when it first opened?

Code A No I'm talking about when I, when I, when I, when I was there.

Code A Sorry yeah.

Code A This seemed to start around the time I was there.

Code A Yeah.

Code A Um (pause) and, oh believe it or not I mean at that time, you know, Q.A. hospital was under, was still, at that time was under huge pressure for beds, so there were always these sort of tensions: "Well you've got empty beds down in Gosport, why aren't you sort of filling them up and helping us out up in Q.A.?" Um and so what happened, I mean it wasn't a conscious decision made, it was almost: "Well let's send the least unsuitable patients there." So it might have been, so instead of it definitely being continue

patients who went down it might have been someone who looks: "Well there might be a chance that they might get back on their feet, but it doesn't really look very likely so we'll send them," and that sort of eases the bed pressures up at Q.A. I think it would be, it's difficult to understate just how much pressure there is from Q.A. to fill beds in community hospitals.

Code A

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

Code A

The least unsuitable yes,...

Code A

The least unsuitable...

Code A

...or the next most suitable.

Code A

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

Code A

They would probably have gone to Daedalus Ward.

Code A

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

Code A

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

Code A

Yeah.

Code A ...and would go home,...

Code A Yeah.

Code A ...or back to a residential home, or nursing home...

Code A Yeah.

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

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

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

Code A Yeah.

Code A ...I'd forgotten about that,...

Code A Yeah.

Code A ...we don't do it any longer.

Code A

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

Code A

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

Code A

Yeah.

Code A

...um, uh, I mean as I said I went down on a Monday afternoon but it wasn't uncommon to go down sort of other evenings in the weeks particularly if there's relatives who, you know, wanted to speak to me, so I'd go down there sort of Wednesday evening and speak to relatives. Um or I might decide I'd, you know, to pop in and see someone who I might have been a bit concerned about.

Code A

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

Code A

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

Code A

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

INTERVIEW CONCLUDES – TAPE MACHINE SWITCHED OFF

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Code A

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 1140 Time concluded: 1220

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

Interviewer(s): Code A

Other persons present: Code A

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	The time by my watch is 1140 and this is a continuation of the interview of Code A And Doctor can you just confirm that we have just stopped to change the tapes over,...
Code A	Yes, yeah.
Code A	...and the personnel in the room are still the same...
Code A	Yes.

Code A ...and we haven't spoken to you in that interim period?

Code A No.

Code A That's 1140 yeah thank you. And I'll remind you that you are still under caution. We were just talking about how the hospital treated you or saw you.

Code A Yeah.

Code A Yeah. How did you see your role exactly in charge of that ward?

Code A Well just simply as the Code A in charge of the patients.

Code A Yeah. You conducted your ward rounds on Mondays in the afternoons.

Code A Uh-huh.

Code A Yeah. Now how would you conduct them?

Code A Right I mean it's, grab what's called 'the notes' trolley' and it contains every patients' records...

Code A Yes.

Code A ...and take the Senior Nurse on duty, we've got usually the Senior Nurse on duty and we just wandered, wandered

round and so I would generally sort of start by asking the nursing staff what, you know, happened since I'd last been round, take a look at the medical notes, usually look at the prescription chart and then, if appropriate, examine the patient, um, and, you know, where appropriate, make a sort of decision about management either just to continue as we're doing, or for some change or whatever, make a note in the medical records.

Code A And it sounds a clumsy question but what was the purpose of those rounds?

Code A Well to ensure that patients have probably a good charter.

Code A And you will have the Senior Nurse,...

Code A Yes.

Code A ...yourself,...

Code A Yes.

Code A ...and when would Code A ..

Code A Code A every other week. And I think at that time we had a, we had a, um, Code A I think Code A .

Code A Oh yes.

Code A ...and he was I think in some of the ward rounds too.

Code A Yeah. What was his role then as a Code A?

Code A Well I suppose to sort of see, see, be trained, see, see what happened and, um, what I did, how the patients were managed there so that's their role so he could learn.

Code A Yeah. And what was he, just for that one ward or?

Code A Uh he just, he would come down just for that ward round.

Code A Yeah, yeah. And you, when would you make your entries did you say 'at the time'?

Code A Yes.

Code A Yeah.

Code A Yeah. After every, after every patient.

Code A So why do you write, you formulate and record your working diagnosis of a patient, what is the purpose of that, why do you do that?

Code A It is for handover to, so if someone else comes in they know what's been happening and can make, well it helps inform them and set the context and even make, hopefully make the right decisions, support the decision making.

Code A In that hospital environment how is the patient's pain recognised and addressed?

Code A Pain?

Code A Pain yeah.

Code A Well usually almost certainly the nursing staff would be there, the first people who would, um, um, be aware that patient was in pain and, um, they would, um, then, you know, depending on what type of pain it was make a judgement about what to do next. Um, and say for example it was a headache, the nurses are able to give Paracetamol, but if it's something more severe then they might want to give some Paracetamol anyway and wait and see if things have settled and after they've taken, you know, observations or, you know, in extreme cases they might want to call a doctor right away. So it could be anything from doing, you know, next to nothing to calling a doctor.

Code A What are the 'Wessex Protocols'?

Code A Well there are, there are West, there are Wessex guidelines for palliative care.

Code A Yeah.

Code A These.

Code A A copy of the Palliative Care handbook there. Yeah?

Code A Yeah. And that's been updated every so often.

Code A What do they do for you, what do they do, what....

Code A Well they give guidance on how to, on how to manage symptoms which need palliation like pain, breathlessness, distress, agitation, etcetera.

Code A This one we've got is called, we've given it a reference number of CSY/HF/3, and it's entitled The Palliative Care handbook isn't it?

Code A Uh-huh.

Code A Where did the term 'Wessex Protocols' come from? Are you aware of that?

Code A No I don't know. Well I mean all I know is that they were developed by, um, The Wessex Specialist Palliative Care Units.

Code A Yeah. And those protocols within that are they, were they actually applied in hospital settings to your knowledge?

Code A I wasn't aware of their existence back in 1999.

Code A Oh weren't you?

Code A No.

Code A No, right. When did you become aware of their existence?

Code A 2001 maybe.

Code A And what made them, what made you aware of them?

Code A I mean it may have been that they were, because they're updated every so often or re-launched and then there's some publicity.

Code A Right.

Code A I certainly wasn't aware of their existence.

Code A Because certainly today you mentioned Wessex Protocols. Am I right in thinking you understand it to be that, those books?

Code A Well I presumed that's...

Code A Is that what you understand them to be?

Code A Yes.

Code A I mean we do but some people haven't heard of them.

Code A Yeah. As I say I, I haven't.

Code A Had you heard of The Palliative Care handbook?

Code A (Pause) The first I remember hearing about anything to do with Wessex and Palliative Care was about Wessex Palliative Care Guidelines, which was in 2001 as I've just said,...

Code A Yeah.

Code A ...I wasn't aware of anything before then.

Code A Okay. So now-a-days is this advice applied and taken and applied now in hospital settings within your department for instance?

Code A I couldn't, um, we, we've certainly got, we've got guidelines at the moment for managing, now whether they're these ones or a variant of these I just couldn't say, but we've definitely got guidelines in our department at Q.A.

Code A That will answer that bit, but back in '99...

Code A Yeah.

Code A ...would there have been anything like that then?

Code A Well I mean I'm told that these existed before 1999 but I'd certainly never heard of them, but I'm not a palliative care expert...

Code A No.

Code A ...but I certainly haven't heard of them.

Code A Can you describe to us the 'analgesic ladder'?

Code A Yeah. Um, it's basically sort of saying that, um, there are three steps to pain control, you know, and that, um, ideally one should start with the lowest level of analgesia and then only move to the next level if that doesn't work and then only move on to the, if you like the top level when that didn't work. I'd have to say though I mean I hadn't heard of an analgesic ladder back in 1999.

Code A Oh yes, oh right, yeah. This is GJQ/...

Code A I mean it's what you did in, that's what you did in practice but I'd never heard it described as such.

Code A No, no, no, yeah, well...

Code A Alright you did that.

Code A Yeah.

Code A But in general terms.

Code A It wasn't necessarily given that name?

Code A Yes. But I think, I should also point out (laughs) you don't always apply the analgesic ladder. I mean if you came in with a broken hip you wouldn't thank me for giving me for giving you two Paracetamol would you?

Code A No I wouldn't.

Code A So you make a judgement about...

Code A Where to start.

Code A Where to start, yes.

Code A As I said this thing I've got in front of me is GJQ/HF/25 and it's a very basic flow chart type thing.

Code A Yes that's an analgesic, an analgesic ladder yeah.

Code A Yeah. But it's something that you, you certainly applied in those days...

Code A Yes, yes.

Code A ...but you didn't call it that?

Code A Yes. Well it wasn't, not to my knowledge that format as such.

Code A Yeah. I have heard some people describe the method, a method of applying this and I obviously didn't know

whether it was right or wrong, but taking it from the very basics and at least if I did come in with, to you with some pain that might require two Paracetamols...

Code A Yeah.

Code A ...on your judgement and you find that that doesn't work...

Code A Yeah.

Code A ...to take away the pain, you then move on to a stronger analgesic, but I've heard some people say that Paracetamol remains being used.

Code A Paracetamol being?

Code A Remains.

Code A Uh-huh.

Code A And you're still given the Paracetamols, but you're given something else as well...

Code A We could do that as well yes.

Code A ...and then..

Code A Yes.

Code A ...on it's way back down again they'll take away the stronger analgesia...

Code A If it, if it relieves the pain yes.

Code A ...with patients coping still with Paracetamols and.

Code A Yes that's right, yeah.

Code A Right. On a similar vein, how do you assess a patient's level of pain then Doctor?

Code A Well it's sort of, um, um, I mean a variety, obviously what the patient says and you can ask them a score of 1 to 10: "How bad do you feel the pain is?" And then there's obviously, if you like the non-verbal clues, you know, is someone is sort of rolling about in agony clutching their stomach and so it's a matter of sort of, um, what you hear from the patient and, um, deduction from clinical observation.

Code A So it's quite...

Code A Subjective.

Code A Yeah, yeah.

Code A That could be quite subjective.

Code A Yeah.

Code A And I mean I think, I mean again this may help to say it, for example if someone is, um, confused particularly, um, it can be very difficult to establish, you know, what's wrong with this patient, is it pain, is it just they're very agitated, is it a combination of both? Um it can be very difficult and it's relatively easy when, you know, a patient is, you know, compos, compos mentis.

Code A This form here, copies of it, it's CSY/HF/5 and it's a copy of a policy for 'assessment and management of pain' and I'm not quite sure, it comes from the Portsmouth Health Care Trust,...

Code A Yeah.

Code A ...I'm not quite sure where that comes from exactly, but can I just ask you to have a quick look at that?

Code A Yeah.

Code A Cheers.

Code A Have you seen it before, or?

Code A Yes.

Code A Oh you have.

Code A And is that something, I mean that just sets down policies doesn't it for pain assessment and guidelines?

Code A Yeah, yeah.

Code A Is that a very old policy, or?

Code A That's been developed since.

Code A Since...

Code A I'm almost certain.

Code A Yeah.

Code A Yeah.

Code A And as I say I can't comment on the date of that but...

Code A I think it came about as a result of all of this.

Code A What this enquiry?

Code A Yeah. Well the complaints from relatives in Gosport.

Code A Yeah.

Code A It's talking about pain assessment, and it says for instance that 'patients who complain of, or appear to be in pain they must have an initial assessment to establish the type of pain

they're experiencing', which is that you've just been saying isn't it?

Code A Yeah.

Code A And then it says that 'local agreed pain assessment methods should be implemented'. Did you have anything like that going on at the Dryad at the time when you were down there?

Code A I'm quite sure there wasn't.

Code A No.

Code A Not, not, not to my knowledge.

Code A It goes on talking about, it says 'professional staff are required to obviously exercise professional judgement...

Code A Yeah.

Code A ...and knowledge and skills, be guided by verbal and non-verbal indicators from the patient, carers or relatives as well'. This is 'document sight and character of the pain'. Now if a patient was complaining of pain would you, is that something you would expect to see written and written down?

Code A Yes.

Code A Yeah.

Code A I mean, well I mean you know if someone's got arthritis in the knee and they're complaining of pain every, you know half an hour or complaining of pain two or three times a day and it's well recorded before you wouldn't necessarily to expect to record that, headache you wouldn't but if a patient develops sufficient new pain then yes you would expect that to be recorded.

Code A Actually really this flow chart sums it up a little bit ...

Code A Yeah.

Code A ... better doesn't it because it's got the assessment.

Code A Assessment.

Code A It goes through the body language etc.

Code A Yeah.

Code A An action plan.

Code A Yeah.

Code A Yeah, document plan goals of the care and reassessments ...

Code A Yes.

Code A ... to see if that is effective and then again a further reassessment, then a medical review and reassessment and it goes round in a circle doesn't it?

Code A Yeah.

Code A Yeah and what, that is something that you wouldn't necessarily expect a doctor to have to follow would it because you would think that a doctor would follow that sort of ...

Code A I mean it's your sort of natural, sort of ...

Code A ... yes.

Code A ... it's the way you work.

Code A Absolutely, yeah it's quite a ...

Code A But it graphically illustrates ...

Code A ... yes.

Code A ... you know what thinking processes and decision making you go through.

Code A Yeah and I think we touched on it before the importance of writing, documenting down ...

Code A Yes.

Code A ... you told us before it's for other people when you hand the patient over ...

Code A Yes.

Code A ... or when you're not there and another doctor ...

Code A Yes.

Code A ... comes to see them.

Code A Yes.

Code A Yeah. Were there any policies in place at Dryad Ward regarding prescribing strong opiate analgesics?

Code A Not that I'm aware.

Code A No.

Code A I should say I don't we, we didn't have the same at QA either at the time.

Code A Yeah.

Code A So I don't think that was, that wasn't unusual.

Code A And similar in regards to diamorphine?

Code A Well yes it's ...

Code A Same thing.

Code A ... it's the same.

Code A Same thing, yeah. If a patient was commencing a treatment of prescribed diamorphine ...

Code A Yeah.

Code A ... yeah, who had the responsibility of that patient, the prescribing doctor?

Code A Well initially the prescribing doctor but I mean ultimately it's the consultant in charge of the patient.

Code A Yeah. How would you receive and review patient notes? Presumably when you went on the ward round?

Code A Yes.

Code A Yeah.

Code A Yeah.

Code A Would you have ever, if a patient was admitted say on a Tuesday ...

Code A Yes.

Code A ... day after your ward round ...

Code A Yes.

Code A ... and you don't get back to the hospital until Monday ...

Code A Yes.

Code A ... would that be your first contact with the patient?

Code A Yes. Yes.

Code A Would you have ever received any communications regarding that patient?

Code A Very, extremely unlikely it would only have been if Code A Code A had been, you know particularly concerned about something or maybe a member of the nursing staff was particularly concerned.

Code A Yeah. When, when a patient was transferred to the ward it could be from somewhere else within Gosport Hospital couldn't it, I suppose?

Code A That would've been unusual.

Code A Unusual or ...

Code A More than likely …

Code A … more than likely from another hospital?

Code A … it's more like QA and St Mary's usually.

Code A Yeah.

(MOBILE PHONE RINGS)

Code A Oh sorry that's my phone.

Code A That's alright.

Code A I'll switch it off, sorry.

Code A That's not a problem.

Code A Sorry.

Code A Would you normally get the notes accompanying the patients on transfer?

Code A No I mean it's, not infrequently the notes would not accompany the patient or there'd be bits of the notes missing or whatever and I mean last month whenever, I've got a staff grade doctor down in Gosport who did an audit. Again a third of the patients transferred came with defective notes or really too ill to have been transferred I mean it's just a huge problem. It's, always going on, still

getting patients transferred, it was certainly happening back in 1999.

Code A

Yeah. If you got a patient in a hospital ward in QA, I mean we've all been to hospitals and seen our relatives and friends and in hospitals and you've got a set of notes at the end of the bed, yeah and they're normally the charts aren't they that the doctors write it?

Code A

Yes, yes.

Code A

And there's presumably another set of notes somewhere else is there or ...

Code A

Yes usually the main notes are kept in a notes trolley, usually in the Ward Sister's office or the doctors office.

Code A

... and say for arguments sake you get asked to go and see a patient in, in QA ...

Code A

Yes.

Code A

... to assess ...

Code A

Yes.

Code A

... for going down to Dryad Ward ...

Code A

Yes.

Code A ... and you say "Yes let's take this patient down to Dryad Ward". How do the notes, how should the notes get married up to the patient then when the patient goes down to Dryad Ward?

Code A Well it's usually the nursing staff who do that.

Code A Yeah.

Code A They should get together with the, you know their records, all the observations charts, the prescription sheets x-rays and they should all be bundled up and go with the patient.

Code A That's what, so they should go with the patient?

Code A Yes.

Code A Okay but it doesn't always happen and has that been a problem since time immemorial?

Code A Time immemorial.

Code A Yeah.

Code A And I doubt whether we're the only place.

Code A And how often would it be before the notes will turn up (inaudible) then, if they (inaudible).

Code A Well sometimes never, sometimes the following day.

Code A Yeah.

Code A It's anywhere between the following day and never.

Code A Yeah. Did you ever admit any patients into Dryad Ward? I mean actually physically see them come in?

Code A I couldn't, I might've done, I can't, I can't remember doing any but it's possible.

Code A The only reason I ask that is if you were admitting a patient and I know it might be rare because it isn't one of your rolls is it?

Code A No.

Code A If you're ...

Code A Well I might've seen someone at home and decided well this patient, no I don't think that would've happened at that time. The occasion, what I was going to say was I see people at home and I may have admitted them to Gosport but in that situation I might've you know have clerked them in myself.

Code A ... but if you, if you started to clerk in a patient ...

Code A Yes.

Code A ... and there were no notes with the patient ...

Code A Yeah.

Code A ... how would you know what was wrong with the patient, what would you do?

Code A Well I mean what would, always make contact with, I mean the nursing staff would usually phone up to the ward that had sent them and say "What's going on? Can we have some information?" and Code A might well have tried, say to get hold of a junior doctor the following day but often when patients were transferred over, you know the staff, cos often they arrive late in the day, you know after five o'clock (1700). The junior doctor who had been looking after them at QA, had already gone home so you know it's ...

Code A Yeah.

Code A ... difficult.

Code A Regarding nurses what level of care could the nurses provide to patients within Dryad Ward?

Code A Well obviously all nursing care and obviously they were responsible for the administration of medicines which have been prescribed.

Code A Were there any cases where a patient needed care beyond that which trained staff, trained nurses could give? Were there any?

Code A I mean I can't, I mean I can't think of what you're meaning but I can't think of ...

Code A Well for instance palliative care ...

Code A ... yeah.

Code A ... was, is a particular skill isn't it?

Code A Yes.

Code A Yeah, both from a doctor's point, medical point of view and nursing ...

Code A Yeah.

Code A ... point of view?

Code A Yes.

Code A Yeah and if, if a patient is receiving palliative care ...

Code A Yes.

Code A ... which could happen on Dryad or Daedalus Ward couldn't it?

Code A Yeah.

Code A Yeah how would ...

Code A Well every nurse has basic knowledge of palliative care you know and I'd have thought even in 1999 all nurses would, you know be aware that if it's pain we're talking about, if paracetamol wasn't relieving something then someone needs something stronger to be prescribed for them and if that didn't help them, something stronger again. I mean some nurses might've worked in a palliative care environment and had more knowledge than others but I mean I would expect all nursing staff to have a knowledge of basic palliative care.

Code A ... if a patient needed to have bloods taken.

Code A Yes.

Code A Yeah, how would that happen, who would take it?

Code A I'm honestly, I'm honestly not sure who did that whether some of the nursing staff did it or whether there was, what we call a phlebotomist, you know it's someone who goes round the wards to take blood, or whether even Code A Code A did some, I, I just, I don't know. I can't ...

Code A What about intravenous infusions, who was trained to do that?

Code A ... oh I don't think any of the nurses at that time would've had skills in doing that, so that would've been medical staff would've done that. So either Code A or myself but I don't ever recollect doing it in Gosport.

Code A Okay.

Code A In fact I mean I think at that time we wouldn't have admitted, well no I can't, I just can't remember.

Code A What about simple things like saline bags or stuff like that?

Code A Oh you can give subcutaneous fluids ...

Code A Yeah.

Code A ... and that's just putting a needle under the skin, the nurses are allowed to do that.

Code A Yeah and was that something that was used quite often down there or not or ...

Code A I can't remember.

Code A ... no. Oxygen, was oxygen available down there?

Code A Yeah.

Code A Yeah and was that used?

Code A I presume it would've been used at times (inaudible).

Code A And presumably again that will be medical staff prescribing that or not?

Code A No, no, no nursing staff can administer oxygen if they're concerned about a patients condition.

Code A Okay. We've mentioned an ECG didn't we and you said there was one of those down there (inaudible)?

Code A Yes.

Code A Did you ever use ECG's down there for patients?

Code A Oh ECG's would be done, probably by the nursing staff.

Code A Okay.

Code A Probably at my request or Code A request.

Code A Yeah.

Code A And Code A I mean there might've been an occasional time when I did one myself.

Code A Blood transfusions?

Code A I, we did do blood transfusions in the War Memorial. I, to the best of my recollection we did. I can't remember whether we did them in Dryad Ward though, we might not have done.

Code A Yeah.

Code A But I certainly think they did in Daedalus but in the day hospital we did and I possibly did in Dryad Ward. I just couldn't be sure about that at that time.

Code A So you can't remember if ever a patient needed blood for instance ...

Code A (Inaudible) Dryad Ward.

Code A ... wouldn't?

Code A No.

Code A What would they done, had to go somewhere else to do that?

Code A Yes.

Code A Yeah.

Code A I don't remember anyone ever being transfused on Dryad Ward.

Code A What about intravenous antibiotics, would they have been given at all?

Code A That would've been, no.

Code A No.

Code A I think that's very unlikely because I don't think any of the nurses were, had a certificate of ...

Code A To administer that, yeah. So presumably ...

Code A ... if you felt someone was that sick and ill and you wanted to actively treat them you'd have sent them to QA.

Code A To another hospital, to QA, yeah. So, so the War Memorial wasn't set up to deal with common medical emergencies or was it?

Code A No.

Code A No, again that was QA?

Code A Not, no, no.

Code A And emergency transfer was that available to QA?

Code A Oh yeah, yeah that's always available.

Code A Yeah.

Code A It would be, obviously.

Code A Was there a policy in respect of that at all?

Code A No.

Code A No.

Code A No it was up to the judgement of the doctor who saw the patient about whether they felt it was appropriate.

Code A Yeah and were there any guidelines for getting that patient back again to the War Memorial after, if a patient was say in Dryad Ward ...

Code A Yeah, I think it would, there were no, I don't, well I don't know whether there were guidelines or not but there might've been but in general terms and I'm talking generally not specifically about ...

Code A ... yeah.

Code A ... Dryad Ward, if it was felt that the first place that patient was not appropriate to have gone, you know out of compassion or whatever, people say well let's not send them back let's just try and manage the problem here. I think they would then think very seriously before taking the patient again if they didn't feel that it had been appropriate first time round.

Code A That ends that section does it?

Code A Yeah.

Code A Any questions on that Code A?

Code A No fine. Just do the next bit.

Code A Yeah will do. This next piece Doctor is only about the documentation we would've used, that you would've used sorry, at Dryad at the time.

Code A Yeah.

Code A Just get you to talk through the various forms if we can if that's alright and this is, it's labelled CSY/HF/6.

Code A Yeah.

Code A That's just our exhibit reference.

Code A Yeah.

Code A There was ...

Code A Do you want me explain, that's a bundle of ...

Code A Yes.

Code A ... the majority of documents that ...

Code A Yeah.

Code A ... we think you would have used.

Code A Well I, I mean that's certainly what we use at the moment. I honestly can't remember whether we were using that in 1999.

Code A Before we just go onto that, I just, there was an admissions policy wasn't there for Dryad Ward?

Code A Was there?

Code A This document, GJQ/HF/7, yeah and it is, it says 'Operation Policy, Dryad Ward Continuing Care'.

Code A Right.

Code A And it was dated, right it was dated in February of 95.

Code A Right, okay then.

Code A So whether that was ...

Code A But I don't remember ever seeing it. Do you want me to glance through it?

Code A (Inaudible).

Code A … yes please, have a read through please yeah, yeah.

(Silence – 1 min, 30 seconds).

Code A Talk me through, you've already explained the difference between Dryad and Daedalus …

Code A Yes.

Code A … in that one was rehab and the other one was continuing care.

Code A It says 'Continuing Care' right up at the top doesn't it?

Code A That's right …

Code A Yeah.

Code A … yeah, yeah.

Code A Yeah and I mean it says the emphasis will be on the social aspects of patients lives, emotional welfare etc.

Code A And is there anything within that that you've just, I know you've only had a few moments look at that.

Code A Yeah.

Code A Is there anything you fundamentally think was different to when you were working there?

Code A No.

Code A No.

Code A No.

Code A No.

Code A Except as I said they're all changed.

Code A They've all changed?

Code A Well yeah I mean it changed in the time that I was there. I mean that was the role when I, around the time when I started there.

Code A And it's the first bit, I mean the, most of this is stuff that probably wouldn't necessarily concern you overly ...

Code A No that's right.

Code A ... reception procedures isn't it?

Code A Yes, yeah.

Code A And it's talking about the medical staff providing ...

Code A Yeah.

Code A ... by yourself Code A

Code A Me, yeah.

Code A And visiting on a weekly basis.

Code A Yes.

Code A Cover provided by Clinical Assistants and, but fundamental, that was basically as it was when you were there yeah?

Code A Yes.

Code A Yeah.

Code A Well when I started there.

Code A And when a, when a bed became available ...

Code A Yeah a patient would be identified and they'd go.

Code A ... yeah.

Code A I wouldn't be consulted about it, they'd just, they'd be taken off the waiting list and go.

Code A Yeah. Yeah. The, you didn't have any input into that at all, well it was already made before you ...

Code A Yeah.

Code A ... got there wasn't it?

Code A It was made long before I got there.

Code A Yeah. Yeah. Did, when they come out with these things Doctor do they come as a surprise to you then that you haven't seen them before or, I mean some of them, it's a bit unfair because a lot of them you can't date can you so ...

Code A Yeah.

Code A ... you know they're ...

Code A I mean not really, um, um, (inaudible) I mean I don't think even now you would present, when you appoint a consultant, a list of all the operational ...

Code A ... no.

Code A ... policies for the wards they're going to work on.

Code A Okay but if we just go through this.

Code A Yes.

Code A This is CSY/HF/6 and this is just ...

Code A Yes.

Code A ... covering the patients records.

Code A Yes, yes.

Code A Yeah. Correspondence presumably that would be letters and that sort of thing ...

Code A Yes.

Code A .. in that part of the folder yeah. The next one would be the clinical record?

Code A Yeah in behind the pink sheet would be all the sort of medical records.

Code A What would you expect to see within that ...

Code A Well admission notes, you know regular sort of updates and ...

Code A ... and that would be in the bit that you would input particularly as well as ...

Code A ... that would've been at the time ...

Code A .. Code A

Code A ... yes.

Code A Or any other ...

Code A Yes.

Code A ... doctor that's seeing the patient?

Code A Yeah.

Code A This one probably self explanatory ...

Code A Yeah.

Code A ... therapy and nursing notes.

Code A Yes.

Code A That's a similar section for the nurses.

Code A Yes.

Code A Yeah and prescription sheets and observation charts. Now presumably observation charts that's a, that's done by the nurses?

Code A Yes.

Code A Yeah and prescription sheet ...

Code A Yeah.

Code A ... they would be another part of your input?

Code A Yes, yes they would be.

Code A And Code A ?

Code A Yes.

Code A Yeah. Was there was something else I wanted to ask you?

Code A The current prescription sheet though would be, the one that was in current use ...

Code A Yes.

Code A ... was kept in a separate folder on the bedside.

Code A Right so it's like ...

Code A So it was only the old ones that would actually be in the notes ...

Code A ... yeah.

Code A ... at the time you were looking after a patient.

Code A Sure, yeah. Yeah within, sorry in this yellow part ...

Code A Yeah.

Code A ... as well we had, as well as prescriptions ...

Code A Yes.

Code A ... and fluid prescriptions, you had the obs charts ...

Code A Yes.

Code A ... the fluid charts and the weight charts.

Code A Yes.

Code A Yeah, is that something that, how would they be composed? Who would compose those?

Code A One of them would be done by, well the last three would all be done by the nursing staff. Fluid prescriptions would be written up by a doctor if this is intravenous fluid ...

Code A Yeah.

Code A ... that would be written up by a doctor.

Code A Yeah and ...

Code A And probably subcutaneous too.

Code A ... okay. Would all patients have an observation chart for instance?

Code A Certainly whey they first come in.

Code A Yeah.

Code A Yeah.

Code A What about fluid and weight?

Code A They probably would have a fluid chart if there's concerns about either their fluid intake or let's say if you were starting them on treatment for heart failure where they're passing gallons of water to find out whether it's being effective or not.

Code A Okay, investigations?

Code A Yeah.

Code A Yeah, this is stuff that's coming back from the lab and ...

Code A Yes.

Code A ... yeah, yeah. That's it Code A isn't it are they the same are they?

Code A Yeah they're (inaudible) yeah.

Code A I think we've covered, you, did you have any involvement in instigating any policies or protocols regarding assessment and management of pain in patients?

Code A Not, not in Gosport at that time.

Code A You've since ...

Code A Yes.

Code A ... yeah.

Code A Well I was, as I said earlier I was Code A of the Code A and after the first few complaints came through, became sort of very conscious that we certainly lacked documentation around pain and I was Code A what we call the Code A and so one of the things that we decided to do was that we needed a Pain Management Policy which would, would also include appropriate documentation so it would be easy for nursing staff to record, you know what, if patients were in pain, if the pain had been relieved, etc because in sort of, looking back at things become apparent that what had let us down was a lot of the documentation in relation to pain.

Code A Did you have any concerns ...

Code A And that Pain Management Policy that you saw ...

Code A ... yes.

Code A ... came about as a result of ...

Code A Ah.

Code A ... of that.

Code A Yeah. Did you have any concerns about the management of pain at all at the time?

Code A In the statement I made about, I can't, I think it was the Code A I said that I remember speaking on one occasion to Code A cos I observed this sort of large dose range and you know she gave me an explanation as to why she'd done that. She was, (inaudible) partners were unhelpful at coming out when she wasn't there and I mean as I remember the dosage range I think was 20 to 80 milligrams and I accepted that explanation at the time.

BUZZER SOUNDS INDICATING THE END OF THE TAPE.

Code A Yeah.

Code A But I honestly didn't have any concerns about Code A Code A management of pain other than having that one discussion.

Code A Code A anything from you?

Code A No.

Code A Right what we'll do, we'll take a break there because the tapes are coming to an end now anyway and I think we'll stop, this is a good time to stop for lunch I think.

Code A Yeah what's the time?

Code A And the time now is 1220, turning the machine off.

Code A

WITH REGARDS TO THE ATTACHED E-MAIL REGARDING THE DOCUMENTS FOR Code A (ON BEHALF OF G M C)

THE RELEVANT RECORD OF INTERVIEW WITH Code A IS NOW ENCLOSED

THERE IS NO RECORD OF AN INTERVIEW BETWEEN 1220 HRS AND 1320 HRS. (PROBABLY A REST BREAK)

PAGE 5 OF THE KEY POINTS DOCUMENT IN RELATION TO Code A IS ENCLOSED

Code A

5

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Code A

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 1319 Time concluded: 1359

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

Interviewer(s): Code A

Other persons present: Code A

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This interview is being tape recorded. I'm Code A Code A and my colleague is …
Code A	Code A
Code A	… and we're interviewing Code A . Doctor could you give us your full name and your date of birth please?
Code A	Yes it's Code A , my date of birth is Code A

Code A — Thank you very much. Also present is Code A who is Code A Can you please introduce yourself?

Code A — Yes Code A in Code A

Code A — Thank you very much. This interview is being conducted in an interview room at Fareham Police Station, Hampshire. The time is now 1319. The date is the 4th of July 2006. At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes. I must remind you Code A that you're still entitled to free legal advice. Code A is here as your Code A Have you had enough time to consult with Code A in private or would you like further time?

Code A — Yes I have thank you.

Code A — Thank you. If at any time you wish to stop the interview and take further legal advice from Code A you're quite free to do that just let us know and we'll stop it in order for that to happen.

Code A — Thank you.

Code A — I'd also point out that you have attended voluntarily, you're not under arrest and you've come here of your own free will.

Code A — Yes.

Code A So if at any time you wish to leave the police station you can do that. We can't stop you, we won't stop you, okay. 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 Code A ?

Code A Yes.

Code A I've explained it to you, I broke it down didn't I?

Code A Yes.

Code A Do you want me to do that again?

Code A No thank you.

Code A The room that we're using can be remotely monitored. If the red light is on it means that somebody is remotely monitoring it and as I said to you this morning that will Code A who is doing that. That enables us to carry out any enquiries that may come out as a result of anything said in here today.

Code A Yes.

Code A No person can hear anything that happens in this room via this equipment when the tape machine is not running, okay.

Again we're talking to you about Operation Rochester, you know that , we explained to you this morning and as before when we read to you this morning we're going to go over some questions and topic areas and we'll explain that as we go along, okay?

Code A Yes.

Code A The next topic area is supervision. As a Code A you would have supervised the Code A is that correct?

Code A Yes, yes.

Code A And these questions now are an opportunity for you to explain how that line management operated ...

Code A Yes.

Code A ... at the hospitals in general and whether the supervision that you provided and were provided with were sufficient. What was the role of the Code A ?

Code A The first thing I should say is I'm not a hundred per cent sure that there was a Code A at that time. I think there was but what I'm not clear about is was he just the Code A of the hospital or did that person, did he have other responsibilities as well as being the Code A

Code A Right. Does the name Code A, does that ring a bell?

Code A Right so, so right she was the Code A was she, okay.

Code A We think she was.

Code A We think she was.

Code A She may have been.

Code A Yes cos the chap I'd been thinking of was, his name will perhaps come back to me but I think he may have been Code A senior. Okay but yes Code A Code A, yeah.

Code A And would that, would the Code A have any supervisory ...

Code A Role over me?

Code A ... role over, on you?

Code A No.

Code A No, no. How was your work supervised?

Code A It wasn't in the sense that, I mean, I don't think any consultants work was supervised at that time. I mean, yeah

I didn't have an annual (inaudible), I did actually on my, when I came to Portsmouth in fact I set up a system of appraising consultants cos it wasn't national, a national requirement at that time. So it was one of the things I did and some time during 99 I would have had an appraisal I think from Code A but I mean I would, that wasn't really, I'd hesitate to call that supervision. In other words I mean a consultant is regarded as being an independent medical practitioner and therefore someone who, as I understand it, doesn't need supervision.

Code A So from ...

Code A Certainly that was the understanding at that time.

Code A ... so if I understand that right, earlier on when we talked about the junior doctors, the house officers, senior house officers, the registrars, consultants they go up the pecking order ...

Code A Yeah.

Code A ... and they're supervised by the next person above them?

Code A Not really all junior doctors in training are supervised by the consultants.

Code A So but then when you get to that consultant level ...

Code A That's where it stops.

Code A ... that's where it stops.

Code A Yes.

Code A Oh right.

Code A I mean, I mean I don't, I don't think it would've been sort of formally defined but I mean I would've seen myself as being responsible to Code A as, cos he was the head of the department for my clinical practise.

Code A Right.

Code A The Code A is, they're always different and I was accountable to the Code A for that but I mean I would, I certainly wasn't formally supervised or even informally supervised.

Code A If you were a or if a consultant, not just you, but if a consultant was under performing ...

Code A Yes.

Code A ... what or who would be able to identify that and take issue with it?

Code A Right it would, well it might be, it might be a fellow consultant but I think it would, at that time it certainly wasn't clear who you would go to. I mean if it had been

another consultant in my department he might've gone to Code A On the other hand some might find they couldn't go to Code A and might actually have gone to the Chief Executive. I suppose someone might've, I mean if a nurse say had been unhappy about the way I was working she might've gone to Code A Code A and said "I don't feel happy" but I mean I don't think Code A would have felt that it was, she was supervising me and I think she would've probably pushed it up to, to the Code A or something like that but there weren't sort of formal lines of supervision.

Code A Okay.

Code A Okay and you mention the appraisal, is that appraisal that you said you had in 99 with Code A ...

Code A Yes.

Code A ... you get that every year now?

Code A You get them every year now, yes.

Code A Yeah but that was you ...

Code A I introduced that.

Code A ... you introduced that. Did you instigate that or ...

Code A Yes.

Code A ... oh you did?

Code A Yeah.

Code A Yeah.

Code A Before it became compulsory. It was one of the first things I did when I came as Code A to ...

Code A Oh it was in that role.

Code A ... Portsmouth Health Care Trust.

Code A Yeah.

Code A I decided that we were going to have Consultant appraisal, annual Consultant appraisals even though it wasn't, as I say, compulsory to have them at that time.

Code A And how, how does that take, what form does that take then?

Code A Well the way we did it locally was, although it's not done this way everywhere, was, well how it's done in most places is that you have an interview with your, sort of, superior and nowadays it would be, it would be me with Code A or another consultant. I decide that, because I was Code A , I if you like supervised,

well appraised what we called the Lead Consultants, so people like Code A and we'd twelve Lead Consultants. Ten or twelve. I appraised all of them but because they were in services like Adult Mental Health, Community Paediatrics, things I knew absolutely nothing about I involved the Senior Manager of the service. They were sort of present at the appraisal so that I could turn to them and say, well doctor so and so says this, you know what about it? So that was, we did it in a sort of slightly different way from everywhere else.

Code A So as well, so you appraised Code A and he appraised you?

Code A No, well I, yes he did in the first couple of years we did it but now the situation is that Consultants can almost sort of choose whoever they want to, within reason, to appraise them.

Code A Okay fine and what about Code A then did she have an appraisal system?

Code A No.

Code A No?

Code A No. I mean at that time I mean as I said appraisals weren't compulsory even for Consultants and I mean I would, I doubt there was anywhere in 1999 was actually appraising

their, having a regular line of appraisal of Clinical Assistants.

Code A If the Clinical Assistant had any problems either with the patients or with the organisation of the hospital ...

Code A Yes.

Code A ... then how could Code A refer those?

Code A Well she could've spoken to me if it was about my patients, spoken to Code A about her patients. I mean she could've spoken to, I mean let's say she had maybe concerns about either myself or Code A she could've spoken to Code A cos he was the Lead Consultant. She, were you just referring to medical issues, if Code A had a problem with medical issues?

Code A Well we'll stay with that for a minute, yeah.

Code A Okay, yeah. So and I suppose, I mean if she was very concerned and felt that she'd have gone to the Chief Executive. I mean that wasn't a formal route but that would be something that was open to her or she could've gone to Code A as Code A

Code A And so what if it's non medical issues (inaudible).

Code A Oh yeah I think probably Code A

Code A Obviously you, you supervised Code A work. Was there anything laid down, anything structured as to how you do that?

Code A No.

Code A No?

Code A No. It was just, I was normally responsible for, not normally responsible, I was responsible for her work with patients.

Code A Yeah.

Code A But you know what that, I mean what that meant in practise for me was you know looking at, reviewing the patients as, on a ward round.

Code A So, so it's ...

Code A That was my supervision of her.

Code A ... the reason you're supervising her is because she is treating your patients?

Code A Yes.

Code A That's how it ...

Code A Yes.

Code A ... effectively was?

Code A Yes.

Code A Right. What about the nursing staff, did you have any supervisory role over those?

Code A No, none at all.

Code A No who supervised those?

Code A Well I mean for the nursing staff on the ward it would be the Ward Manager and then I think it was, I think probably Code A was the Code A of the Ward Managers ...

Code A Yeah.

Code A ... but I, I mean I can't, there may have been some, I'm not sure whether there was someone in between, I think it was probably Code A they reported to.

Code A And the Ward Managers what they're the Ward Sisters are they?

Code A Well the Ward Sisters, yes sorry it's the same term.

Code A Syringe drivers.

Code A Yes.

Code A Do you know when they were introduced into the War Memorial Hospital?

Code A Before I came.

Code A Before you came, you don't know who started that off or ...

Code A No, no idea.

Code A ... and were the nurses capable of setting up and monitoring the ...

Code A Yes.

Code A ... drivers? Yeah.

Code A Yes.

Code A Were you happy with the work they were doing, in that respect?

Code A Yes. I mean I wouldn't, I mean I wasn't supervising them but I've no reason to think that they were doing it, anything other than appropriately.

Code A Performance reviews we know, we've just done that haven't we. There was a nurse, a Code A I believe wasn't she, Code A ?

Code A Yes.

Code A Where did she fit into the system?

Code A Well she was the Ward, she was the Code A , the Code A Code A .

Code A For Code A ?

Code A For Code A

Code A What about named nurse, what was the role of the named nurse?

Code A The role of the, every patient and I think this was something, I think the Government sort of insisted on, I think it was a Government, that every patient should have a named nurse who was, if you like, the key, seemed to be the key person involved in the care of that patient. So that for example when the relatives came in we used to have the name up, you know key nurse Angela or whatever it was and then the relatives would know that if they'd questions about care that was the person to approach. So that was the sort of role.

Code A Would nurses, we've already had it explained by yourself that if you went off on holiday ...

Code A Yes.

Code A ... or short extended periods away, no one would effectively takes over your role ...

Code A That's right.

Code A ... the Code A would do her own ward rounds on her own.

Code A Yes.

Code A Were nurses doing ward rounds on their own at all?

Code A I wouldn't have thought so.

Code A No.

Code A Cos nurses they tended to work, because of the key worker, a nurse would say have half a dozen patients who were her patients. Which might have been one single six bedded bay so she would attend to the patients within that bay but I mean she wouldn't be taking, she wouldn't be taking the medical notes trolley and doing a ward round in the way that we would be doing it.

Code A What about a senior nurse like one of the sisters?

Code A I would, I'd be, I'd be very surprised if ...

Code A Is that anything you've ever seen before?

Code A ... I've never seen nurse ward rounds before.

Code A What was the role of the nurse in prescribing and administering controlled drugs?

Code A Well nurses can't prescribe controlled drugs, they can only administer controlled drugs and my understanding of the regulations around administering controlled drugs is that two nurses have to you know go to the controlled drugs cupboard. Open the keys, count up the number of, you know Morphine tablets or ampoules of Diamorphine. Look at the prescription chart, check it off, so that, if you like, they are safely administered. So that there is less chance of errors being made between what was being prescribed and what's being administered to the patient.

Code A And that was something that you didn't concern yourself with that would be ...

Code A No that was entirely nursing.

Code A ... yeah.

Code A And the two nurse check that's laid down by, well I presume it's, it's statute of some sort.

Code A Yeah. With treatment plans ...

Code A Yes.

Code A ... a member of staff whether they be nursing or medical, how could they question treatment plans if they didn't agree with treatment plans?

Code A Could they question?

Code A Yeah could they?

Code A Yes. I mean it would, with nurses, well we use the medical notes to which, in which we sort of laid out what we felt the treatment should be.

Code A Yeah.

Code A So if I was concerned what Code A doing or she was concerned about what I was doing then we could question each other. Nurses as you're probably aware have their own treatment plans and I would imagine that if a nurse was unhappy about what was written in a treatment plan she would speak either to the nurse involved or to the Ward Sister.

Code A And same with prescriptions if ...

Code A If a nurse was unhappy about a prescription. Oh if a nurse was unhappy about a prescription then she could either speak to Code A if it was Code A who'd prescribed it. She could speak to me if it was I who had prescribed and if she didn't have the confidence to do that, I mean I would have hoped that they'd the confidence to speak to the Ward Manager, the Ward Sister and if the Ward Sister agreed then the Ward Sister to you know ask Code A or myself why a drug had been prescribed or why that dose or whatever.

Code A Were there ever any circumstances in that respect like that?

Code A I've no recollection at all of any nurse sort of questioning a prescription.

Code A And what about yourself, if you came onto the ward and looked at the treatment plans and prescriptions ...

Code A Yeah. If I saw something I wasn't happy about?

Code A ... yeah.

Code A Well I would speak to Code A about it and as I've said earlier on one occasion I did speak to Code A Code A about a prescription. I think it was diamorphine where she'd prescribed you know a sort of wide dosage range. She told me that this was because her partners weren't good at coming out. She herself wasn't immediately available and she didn't want patients to suffer

by having to wait and so she prescribed a, that's why she prescribed that sort of dosage range. To allow sort of nurses to use their discretion.

Code A How would, you set a treatment plan in motion, how would you instruct staff to ensure that that was followed?

Code A If it was nursing staff ...

Code A Yeah.

Code A ... I would, I mean it, it would emerge during the course of the ward rounds and if it's something important I'd almost certainly write it in the medical notes to, so tell the nurses and write it in the medical notes.

Code A So we've just talked about questioning the treatment plans and prescriptions. Presumably, I was going to ask you a question about who the nurses would go to for advice.

Code A In relation to prescribing?

Code A In relation to general advice about patients.

Code A I think it would depend what the problem was. If it's a medical problem come to us, if a nursing problem I would expect to go up through the nursing hierarchy. If it was something a physiotherapist or occupational therapist had said or written then I'd expect them to approach that member of staff.

Code A Without being specific to patients but being generic. Was that something that happened very often or not?

Code A People being challenged?

Code A Well people coming to you and asking, you know saying?

Code A No I can't, I mean I can't remember, they may have asked the odd question about why I was doing something but I would have thought that was more by way of explanation rather than a challenge to what I was doing.

Code A Yeah.

Code A I certainly don't remember being challenged about any prescribing practise.

Code A Code A

Code A No, nothing mate.

Code A Thanks for that doctor we'll go onto another topic area now which is syringe drivers.

Code A Right.

Code A Syringe drivers, the use of, is normally dictated by a doctor obviously isn't it?

Code A Yes.

Code A Yeah and there are different reasons for employing the syringe driver?

Code A Yes.

Code A We're just going to ask for some explanations as to why syringe drivers would be utilised and the way which you envisage they would be utilised ...

Code A Yes.

Code A ... or used. Do you recall what kind of syringe driver was being used on the wards at that time?

Code A No, no I don't.

Code A We've got a copy of a, here. Now we took this down, this is a copy of something that was on the, I think it was on the nurses wall in the nurses office.

Code A Right.

Code A This was in 2002, so this is four years ago.

Code A It's CSY/HF/8.

Code A And there's two bits to that.

Code A Right.

Code A Sorry, I thought you were still looking at it. Does that look familiar?

Code A Yeah.

Code A It's the same sort of thing is it?

Code A Yes.

Code A Is that the same sort of syringe driver they're still using now?

Code A Pass. I haven't seen a syringe driver since, I can't remember the last time I saw a syringe driver in use.

Code A Oh right. Are they not being used widely now then or is it just (inaudible)?

Code A Just I haven't seen anyone recently who's, who's needed one. What, what I, it's slightly peripheral to all this but what I can tell you about, or what I remember about syringe drivers is that we, there were two types of syringe drivers this is across the whole organisation ...

Code A Feel free ...

Code A ... there were two types of syringe drivers in use and one was administered in something like ml's per hour and

others in milligrams per minute. Now that is totally confusing so one of the things we did sort of fairly soon after this became apparent, is we actually standardised on one type of syringe driver throughout, throughout the PCT so that sort of, these errors couldn't occur because it's potentially ...

Code A Yeah.

Code A ... really dangerous.

Code A Yeah.

Code A To have more than one type of syringe driver. So we standardised one type, which I think was actually the MS26. I couldn't put my hand on my heart and say that.

Code A I think we have a similar problem with diesel and petrol engines.

Code A Oh we do, yeah.

Code A Yeah.

Code A Yeah.

Code A Right so but that certainly is ...

Code A Oh that's the type of thing that's used, yes.

Code A ... yeah. What is a syringe driver, what's it's purpose?

Code A It's to administer medication continuously. So that one can achieve stable levels, well stable levels of a drug within the blood stream or within the body and I mean there are two main reasons for its deployment. First is that, well where a patient is not able to take things orally any longer, by mouth any longer and the other is where you're having to give sort of say repeated injections to relieve someone's pain or distress. So to avoid that set up, syringe driver.

Code A So it's one needle ...

Code A Yeah so it's just, you've got one thing and it stays in place for however long it happens to, I mean it usually lasts several, you know three or four days.

Code A ... and who would make the decision to use a syringe driver? Who could make that decision?

Code A Well it would only be Code A or myself who could make that decision.

Code A Yeah and ...

Code A I mean other, the nurses might suggest that we're having to give Mrs so and so injections every, you know three hours to keep her pain under control, you know what do you think about a syringe driver but it would have to be Code A Code A who prescribed it or myself.

Code A ... and if a nurse came up to you and said something like that what, you'd expect some sort of justification for using that?

Code A Absolutely.

Code A Because they're saying that we're having to inject her every ...

Code A Yes, yes, yes.

Code A ... five, you know and it's causing her distress?

Code A Yes.

Code A What, did, had you had any training in the use of syringe drivers at all?

Code A No.

Code A No?

Code A No. I mean I wouldn't normally set them up, well I've never set up a syringe driver it's always been nursing staff who've done it.

Code A Yeah. Yeah.

Code A And the nurses were trained to do that.

Code A

Yeah. We've just shown you that. Were there any policies on the ward as to how syringe drivers should be set up and monitored?

Code A

I think there probably were but I mean it would be the nursing staff who'd know that because it was, it was a process that you know nursing staff undertook. I'm almost certain there would be a, a protocol for how to set them up.

Code A

Relating to diamorphine, if a patient was on diamorphine and that dose, that current dose wasn't controlling the patient's pain ...

Code A

Yes.

Code A

... how much would you then increase the dose?

Code A

Right, well what people would say now, cos I think there's guidance's that are much clearer, is that you would look at the total dose that someone had received in the previous 24 hours and probably increase that by fifty per cent and write up a sixth of that dose to be given as required so that if that increased dose didn't meet it there's still, nurses would still have the option of giving a bit more. So if someone's let's say had had 40 milligrams one day in total which hadn't controlled pain what one would usually do is increase it to 60 milligrams, in other words fifty per cent more and then say 10 milligrams could also be given every three to four hours if there's a break through pain.

Code A And how would that be administered, that ...

Code A That, that would be administered as a jab, a single, a single injection.

Code A ... intra ...

Code A Well it can be underneath the skin or into muscle, yeah and, yeah and then what you'd do the next day is if you'd, if it was 60 milligrams and you'd had to give three lots of ten then you would make it, but that still hadn't controlled the pain, then you'd make is 60 plus 90 plus, what's that, 60 plus 30 that's 90, plus another half of 90 so you'd go up to 135.

Code A ... yeah.

Code A That's the (inaudible).

Code A And was it different then then?

Code A There wasn't the same knowledge at that time. I think that, well for all sorts of reasons, knowledge about the correct way of administering drugs by any opiates it's now much clearer than it was back in 1999.

Code A How new were syringe drivers then, then?

Code A I don't, I mean, I'd be guessing maybe ten years.

Code A So they'd been around a while?

Code A A while yeah, I don't know whether they'd been in Gosport that time.

Code A No, no. Had you experienced them before?

Code A Yes I'd experienced them previously when I'd been in Southampton before then.

Code A Yeah. How would you convert from, oral morphine to ...

Code A Diamorphine?

Code A ... subcutaneous Diamorphine?

Code A Yeah well there's, what I'd usually do is I'd look at, there's a book called 'The British National Formulary' ...

Code A Yeah.

Code A ... which is on every ward.

Code A Yeah.

Code A And what I usually like to do if I'm doing that is actually go to the book and make sure that I'm making the appropriate conversion but if ...

Code A So if I show you this, which is CSY/HF/9, you'll probably recognise where that's come from?

Code A ... yeah that's probably come from the BNF.

Code A Yeah it's a blown up page from there.

Code A Yeah.

Code A Yeah. Is that the chart you , the area of the BNF that you're talking about?

Code A Yes that's right, yeah and there's also some written stuff ...

Code A Yes.

Code A ... alongside that which obviously compares, well things like Fentinol and, I mean there's other opioid, other opiates besides ...

Code A Yes.

Code A ... morphine and diamorphine.

Code A S Yeah. So as an example can you explain how you would convert say, 10 milligrams of Oramorph to ...

Code A Ten, if he was having it every four hours ...

Code A Yeah.

Code A ... that's 60 milligrams in a day, given by infusion it would be a third of that, which is 20 milligrams.

Code A Twenty milligrams.

Code A I mean I'd have to also say, I mean I've certainly see guidance in the past that, that's a third of the dose ...

Code A Yeah.

Code A ... I've certainly seen guidance in the past which has said a half, a third to a half of the dose and I mean that's presumably taken from a recent ...

Code A I'm not sure which one it was taken from.

Code A ... BNF because it might be interesting to look at what BNF said back in 19 ...

Code A 99, yeah.

Code A ... 99.

Code A Yeah get a copy of it.

Code A Cos that's like a working book really isn't it, BNF?

Code A Yes it is and it's continuously sort of developed.

Code A Yeah.

Code A So what's in it now may not have been what was in it in 1999.

Code A Is it annually or twice annually? Is it an annual book or ...

Code A Twice.

Code A ... so it's bi-annual, yeah.

Code A So when prescribing these opiates do you take other factors into account regarding the patient?

Code A Yes I mean clearly, well I mean how much pain the patient is actually having. I mean it's a bit like a sort of discussions that we had earlier about the, if you'd a broken hip you know I wouldn't give you paracetamol. So there maybe situations in which you feel, well that's the guidance but I feel I'd like to, you to give a bit more because this patient just seems to be in so much pain, I have my doubts about whether that dose is actually going to relieve the pain. So I think it's important to say this is guidance, it's not, but it has to be based on what you see in front of you and it's what you see in front of you which is, is, you know is clearly an influence in your prescribing decision.

Code A So if we're talking about pain relief, yeah, obviously the type of pain is a factor isn't it?

Code A Yes.

Code A Yeah and as well as the source of the pain?

Code A Um, the intensity of the pain, (inaudible) not sure whether the size of the pain makes, I'm just trying to think of, not sure about that, I can't think of a association where that would make a, I can't off the top of my head think of a situation where the size of the pain would make a difference to what I prescribed.

Code A What about the actual physique and the person, the patient themselves?

Code A You mean if they're small, large?

Code A Yeah. Yeah.

Code A Patients are sort of variable in their response and clearly if, yeah if it's a sort of huge, very large, obese individual then that might influence you in given more than you would say a sort of frail little, 90 year old lady.

Code A Uh huh, is age a factor?

Code A That's, that is specifically just prescribing for the elderly.

Code A Elderly, yeah.

Code A And so there are different, I mean I'd have to go and look at the, I wouldn't like to quote the BNF says today myself, I'd have to go and look again to see what it says actually in relation to prescribing opiates for adults ...

Code A Yeah.

Code A ... and clearly they're, you know there may be 85 year olds who are more like us, you know in terms of being fit and well etc compared to you know that frail 90 year old lady. Equally there may be a frail 65 year old who you certainly want to use this rather than say the prescribing for adults.

Code A The BNF, that is obviously quite an important ...

Code A Yes.

Code A ... document to you isn't it?

Code A It is.

Code A From what you've just been saying.

Code A Yes.

Code A Yeah and is it, do I take it you refer to it constantly?

Code A I, in relation, I mean I don't, I do very little prescribing of opiates ...

Code A Yeah.

Code A ... just because it's usually other people that do it but if I am and certainly if I'm converting, I mean it's the conversion between opiates that I think is the, where the potential for error arises and which is where I'm most careful.

Code A Who, you say that the nurses were, their levels of operating the syringe drivers were okay, you know they were doing that ...

Code A Well ...

Code A ... who was responsible for ensuring that they were able to do that? Again that was the nursing management?

Code A ... oh that would be nursing management, yes.

Code A We talked about how a patient would lead up to getting a syringe driver, getting to the condition that they'd ...

Code A Yes.

Code A ... need that. So you have to justify it presumably, implementing the syringe driver.

Code A Mm, mm.

Code A Yeah would that be recorded?

Code A I mean I would say it should be recorded but you know let's say there's someone who's been getting some oral diamorphine regularly and maybe starting to become a bit drowsy and then starting to get the occasional injection, then someone might not record that they'd switched them over because they didn't feel that it was such a significant change. I think it would depend how much of a, the degree of change but in general terms I would think that you should record and you should (inaudible) syringe driver.

Code A And that would presumably be the ...

Code A Prescriber.

Code A ... prescriber?

Code A Yes, yes.

Code A Prescription charts. How do they work doctor, these are a bit of a mystery to me sometimes?

Code A Right.

Code A Think we've got one here, got a blank one and I think this is CSY/HF/10 and I think this is pretty common isn't it?

Code A Yes I think that was the, think that was the, I think that's the same as the chart that was in use at that ...

Code A Yeah.

Code A ... time.

Code A Yeah.

Code A So, it's just a general ...

Code A There's a front page and some, some ...

Code A ... cover sheet with some, really sort of guidance as to how to sort of ...

Code A ... yeah.

Code A ... complete it.

Code A Guidance to the doctor and to the nurse, yeah.

Code A And to identify that there may be additional charts.

Code A Right, yeah.

Code A Now page two if you like to call it.

Code A Yeah.

Code A Patients details. That is used for once only drugs. So if someone's got a headache or they're going for an operation, pre-medication that's the section you'd use.

Code A Okay, yeah.

Code A And where you don't anticipate that there's going to be a repeated need for it, it's likely just to be a one off. This section is for as required. So for example say someone who gets headaches frequently. You'd write up Paracetamol, two tablets every, four times a day and the nurses can therefore give it according to ...

BUZZER SOUNDS INDICATING THE END OF THE TAPE

Code A ... patient need.

Code A So that, in that, the as required you've got, you put the drugs name down, there's a box for that isn't there?

Code A Yeah.

Code A The route, so that's how it's going to be administered?

Code A Yes, yes, yes.

Code A Yeah, the dose ...

Code A Dose.

Code A ... the date.

Code A Date.

Code A I don't know the pharmacy ...

Code A Oh the pharmacy I think just, don't know what they do.

Code A ... and signature presumably ...

Code A Yes.

Code A ... from yourself or whoever prescribes. Special directions what ...

Code A Well that might be the frequency with which it could be given that would be the most usual thing so ...

Code A ... yeah.

Code A ... say three to four hourly, as required or it might be up to four times daily or ...

Code A Yeah. Yeah and then the next section is for the nurses to ...

Code A ... put in ...

Code A ... put in as they give it.

Code A ... as they give it ...

Code A Date, time, dosage.

Code A ... yeah when they give it and the dose ...

Code A Yeah.

Code A ... and who gave it.

Code A Yeah, sure and that's another tape coming to an end. So we'll just, we'll come back onto that if that's okay.

Code A The time?

Code A The time is 1359, turning the machine off.

6

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Code A

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 1402 Time concluded: 1440

Duration of interview: 38 MINUTES Tape reference nos. (→)

Interviewer(s): Code A

Other persons present: Code A

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	The time by my watch is 1402. This is a continuation of the interview of Code A . Doctor can you just confirm again that we've just had a quick pause to change the tapes over?
Code A	Yes.
Code A	And we haven't spoken to you about the matters that you're being interviewed about?

Code A No.

Code A Thank you. Before the tape ended we were just going through this prescription ...

Code A Oh yes, yeah.

Code A ... sheet, yeah?

Code A Yeah.

Code A And we've just done the as required ...

Code A Yes.

Code A ... what, they call that something else don't they, is that ...

Code A P, PRN.

Code A ... PRN isn't it?

Code A Yes.

Code A Yeah, thank you and the next page is ...

Code A Is for the, the next two pages ...

Code A ... yeah, thank you two pages, yeah.

Code A ... are for the drugs that are to be given regularly.

Code A What sort of drugs would we see there?

Code A Oh well you would see, for example if you had heart failure ...

Code A Yeah.

Code A ... and needed to be given diuretics, water pills, that would be there, if you were on blood pressure pills, cholesterol lowering pills. If you'd got an infection, you know and needed antibiotics, that would be written up on this section ...

Code A Yeah.

Code A ... so basically all, almost everything, everything that has to be given regularly.

Code A Yeah, okay and same, the same set up as before isn't it you have the box for the drug ...

Code A Yes.

Code A ... the route, the dose ...

Code A Yes, start date.

Code A ... start, yeah.

Code A And the purpose of the review date is for things like antibiotics, you know whether you want to give them for three days, five days, seven days whatever.

Code A I see.

Code A To try and make sure that they are discontinued at the right time they're not given too long.

Code A And this one has a box in doesn't it for the time of day they ...

Code A Yes so you can ...

Code A ... it can be given.

Code A ... up to six times a day.

Code A Yeah, okay.

Code A And then the next is for prescriptions which require a reviewing on a daily basis so drugs like, well sometimes they're not locally, Warfarin which is a blood thinning treatment where you sometimes have to titrate the first few doses of treatment or alter the dose from day to day. You would write Warfarin in here, they'd write their signature and then each day you would write up the dose.

Code A Is that because it's sometimes difficult to establish the proper ...

Code A Yes, yeah.

Code A ... yeah, and the right effect?

Code A Yeah and obviously you could, you could write up a syringe driver on this where you are, if someone seems to have escalating amounts of pain, you're finding it difficult to control ...

Code A Yeah.

Code A ... so you could put it, you could put it in this section.

Code A That would be acceptable?

Code A Yeah so you could write, 60 milligrams today, 80 milligrams tomorrow and then the last page, I can't remember what that is.

Code A Reasons why not given

Code A Sorry yeah the reasons why a drug wasn't given.

Code A Right. Thank you very much, we rattled through that.

Code A I mean you can write, let's just, you can write syringe drivers sort of it, you could have written on the regular prescription section to, so it only just be written on the, on the ...

Code A Yeah, yeah thank you very much. So why would, so syringe drivers could be written up in two parts of that form?

Code A ... yes.

Code A And both would be right or ...

Code A Yes.

Code A ... yeah.

Code A I mean if someone has a fairly sort of constant dose then you'd write it up in the regular.

Code A Yeah.

Code A If a patient is sort of very unstable you might choose to write it up on the, on the other ...

Code A Yeah.

Code A ... on the reverse side.

Code A Okay.

Code A What about PRN, would that ever be written up on that?

Code A That would be written up in the, in the PRN bit. But you wouldn't be giving a syringe driver as required.

Code A No.

Code A Cos you're altering the ...

Code A But, yeah so you're saying ...

Code A ... but you ...

Code A ... it shouldn't be in the PRN you saying?

Code A ... oh no it wouldn't be in there, I've never ever seen it in the PRN bit.

Code A Yeah.

Code A It would just be the additional doses for breakthrough pain that you'd put in the PRN bit.

Code A Yeah that's the extra jab?

Code A As you were explaining that ...

Code A Yes extra jabs, yes.

Code A ... as you were explaining earlier on?

Code A Yes, yeah.

Code A When did Code A start a proactive prescribing policy?

Code A Well I don't recollect seeing her, I mean until I saw the drug chart, I don't recollect her, seeing her prescribing drugs proactively. The discussion I had with her was 20 to 80 milligram in relation to a patient who was in pain but I certainly don't remember until you know some of the cases were presented of seeing her writing up drugs proactively.

Code A What until we came to you on this enquiry?

Code A Yes.

Code A Is that what you're saying?

Code A Yes I've no recollection ...

Code A When we gave you patient notes ...

Code A ... of it being written up proactively until you came to me.

Code A ... so you don't recall her prescribing variable doses and, instead of fixed rate doses or do you?

Code A Well I recall her writing, you know as I say variable doses in terms of like 20 to, well certainly on one occasion writing 20 to 80 milligrams ...

Code A Yeah.

Code A ... I recall her doing that.

Code A You spoke about that earlier on didn't you

Code A Yes.

Code A Yeah.

Code A Yeah but I don't remember her writing up, you know morphine or diamorphine for patients who weren't in pain at all.

Code A Yeah. Do you, do you recall when you first saw her doing, writing a variable dose?

Code A You mean the 20 to 80?

Code A Yeah that sort of thing.

Code A I, I'm really not, I'm not sure when it was and I, I think it was early on in my time there but I'm just not, I'm just not sure.

Code A Yeah.

Code A What is the difference between a variable dose and proactive prescribing?

Code A Well to me proactive prescribing is giving, prescribing something, well in this situation it would be prescribing in the absence of any pain.

Code A Yeah in case ...

Code A Yes, yeah in case.

Code A Anticipating?

Code A Yes.

Code A ... and variable would be ...

Code A Where someone was in pain but you are giving discretion as to what the nurses ...

Code A ... discretion of the nurses to ...

Code A ... yes.

Code A ... is there any sort of policy or guidance on to how large that, that variance can be?

Code A No I've never seen any policy or guidance as to how large that variance should be. No not at that time.

Code A Right.

Code A So if we're talking about proactive prescribing do you know where she got the authority from to do that? Did she need an authority to do that?

Code A No she didn't need an authority to do it that was, that was, in the absence of any pain that was her decision. She didn't come and speak to me about it. So she was free to do that, although that's, that's not good practise. Well for things like to proactively prescribe opiates, I mean proactively prescribing paracetamol in case someone has a headache is a different matter.

Code A Yeah.

Code A Or perhaps a sleeping tablet you know for someone whose got difficulty sleeping but proactively in other words in the absence of any pain prescribing opiates is not, it's just not acceptable practice.

Code A It's not?

Code A No.

Code A I mean I was going to liken it to, well prescribing an antibiotic in case you got an infection. Is this ...

Code A Yeah.

Code A ... I'm not talking about after an operation ...

Code A Right.

Code A ... I was just, almost .....

Code A Well I mean, I mean there might be situations which you proactively prescribe antibiotics. For example there's someone who's known to get, say repeated urinary tract infections.

Code A Yeah.

Code A And becomes you know symptomatic and gets distressed very quickly. You might give a proactive prescription, I mean that happens out in general practice with that sort of thing. I don't think, I mean, but again say you might do the same again in a situation say someone has got chronic bronchitis subject to repeated chest infections but you wouldn't do it for someone, where there's no history of that sort of happening.

Code A So with the, the, even the variable prescribing when they're given a start, a starter dose shall we say and a finish dose and is it left to the nurses then to judge where within that ...

Code A Yes.

Code A ... that to start

Code A Yeah that's what happens.

Code A Is that good practise?

Code A Um I, I mean I think that depends on the range of variable dose that's prescribed, so if it's you know 20 to, 20 to 40 milligrams then I think that's, you know at that time that wasn't an unreasonable thing to do but say to give, you know 20 to 200 you know I don't think is acceptable practice.

Code A And having prescribed in that manner is there any way of, I mean if you happened to prescribe in that manner between 20 and 80 but you're thinking I'd rather we started at a lower end, we're talking about diamorphine for pain relief, I'd rather start at a low end but at least it gives the nurses the option to move up

Code A Yeah.

Code A How could you ensure that it was started at the lower end and not straight away at 80?

Code A I couldn't, I couldn't.

Code A You can't?

Code A No. One would be relying on the, one's relying on the discretion and if you like the common sense if you like of the nursing staff to do that and as I said before there are two nurses to check every prescription that's administered

to patients. So it would have to take two nurses to think, if you like, to say, to agree that they would give 80 milligrams rather than the prescribed starting dose. So I'd expect the nursing staff to follow that.

Code A While we are on this, can I just ask one more thing from a little while back

Code A Yeah go on, course you can.

Code A Code A asked you about other factors that should be taken into account when prescribing morphine and opiates and he asked about age and build and things like that. Well what about certain types of illnesses or conditions, would that have any bearing on the prescribing of opiates?

Code A Yes. If you've got a chronic bronchitis we know that opiates can cause what's called respiratory depression, in other words your breathing becomes more shallow. So as far as possible you'd like to avoid giving patients with chronic bronchitis opiates but I mean there may be situations in which you can't avoid that.

Code A avoid it, no

Code A Yeah in the interests of relieving you know patients distress but you would certainly be more cautious with the dose you employed.

Code A What about people that have kidney or liver, some sort of kidney or liver failure, would that make a difference?

Code A Yes I mean I'd have, I'd want to check the BNF again to see exactly what it said about that. So people with significant renal and kidney impairment, I would want to look at the BNF.

Code A No that's all.

Code A What, going back to the proactive prescribing policy that Code A ..

Code A What the wide ...

Code A ... the actual proactive bit first where she's proactive prescribing ...

Code A ... diamorphine for people who are not in pain?

Code A ... yeah, yeah ...

Code A Or not documented in pain?

Code A ... yeah.

Code A Yeah.

Code A Yeah that wasn't in consultation with you?

Code A No.

Code A No and there was no other authority as far as you're concerned that …

Code A Absolutely.

Code A … that she would've obtained …

Code A Yeah.

Code A … there was no policy in place at the time?

Code A There was no policy in place.

Code A No and the variable dose …

Code A Yes.

Code A … is that similar or was there a policy for that?

Code A There wasn't a policy, no as I say she, when I saw that prescription and discussed it with her and she gave me the reason why she'd done it and I accepted these reasons.

Code A So the time you challenged Code A that was for a variable dose?

Code A Yes.

Code A As opposed to proactive?

Code A Yes.

Code A So you are not and you were, let me get it straight you are not aware of her proactively prescribing?

Code A Not until I, no ...

Code A Until this enquiry?

Code A ...until this, yeah.

Code A And out of interest is this a term that's, known in medicine proactively prescribing or is it just ...

Code A Well the first time I've really heard it ...

Code A ... something that's been called ...

Code A ... well it's, I don't know when I first heard it. I mean I think the first, I mean I heard the term anticipatory prescribing. The first time I heard it was really in relation to this enquiry. I hadn't heard that term before. But proactive I couldn't, I couldn't say when I first heard that term.

Code A Well be it proactive or anticipatory prescribing, same thing and yes it has, it does happen but it might be for people that have constant headaches and (inaudible).

Code A Yes, yes, yeah.

Code A Paracetamol and sleeping tablets, those sort of things.

Code A Yes, yeah, not normally for diamorphine, no.

Code A okay.

Code A Yeah. Just trying to find ...

Code A Which one you looking for?

Code A ... twenty seven.

Code A Are we on ...

Code A Got it somewhere here. This, right what's this one, this is CSY/HF/27. Now that's a, that's a copy, faxed copy actually 'Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion'.

Code A Yeah.

Code A Now do you recognise that, that policy or protocol?

Code A Certainly, yeah I remember seeing, I remember seeing this yes. Yeah I think, yeah I mean, see it says, I remember seeing these recording charts but I don't, I'm not sure I

recollect seeing, seeing the rest of it. I mean, no, no I mean I honestly can't say that I can recollect seeing that.

Code A You've seen what it's about.

Code A Yeah well I mean I've seen that it says up to double the dose of, I mean I said the fifty per cent, this says double.

Code A Yeah.

Code A And I think it's just an illustration of, which I think this is quite old.

Code A Yeah again there's no date on this.

Code A And you know things have moved on a bit since that was written.

Code A Yeah.

Code A So I don't know when that dates from.

Code A And what it's talking about, it's, it's talking, it's saying 'To overcome this in order to give guidance to nurses who maybe unsure as to how much analgesia to administer (diamorphine) to administer within a variable dose prescription'.

Code A Sorry I hadn't picked that up.

DOCUMENT RECORD PRINT

Code A READS FROM CSY/HF/27.

Code A I certainly don't recollect seeing that.

Code A No. Who, who was Code A ?

Code A She is an Code A and she's based at Queen Alexandra Hospital. Code A is, it's another, it's what we call a career post it's like a Clinical Assistant but it's at a much higher level. It's someone who has got a specialist qualification but for one reason and another has chosen not to work at full consultant level but it's not far short of consultant level.

Code A Well our understanding is that this was kicked off around the Trust at the time to establish a policy on this ...

Code A Which time was this?

Code A ... around about ...

Code A Around about 1999?

Code A ... about that ...

Code A About that time I think somewhere between 98 and 2000.

Code A Right okay.

Code A ... and, because there was some confusion about, about the variable dosage, yeah and as I say it was kicked out and it was sent around with an idea to creating a policy, yes and you can see that this copy we've got here has got some handwritten, I mean it's very difficult to understand because it's a poor copy ...

Code A Yeah.

Code A ... but it's got some handwritten amendments on there. Do you recognise that handwriting at all?

Code A No.

Code A No? and I think the idea being that if you disagreed with it you wrote in what you wanted to say and you sent it back to Code A and ...

Code A So was it her who prepared this?

Code A Well I must admit my understanding is, is Code A has possibly made the amendments.

Code A The amendments I mean I don't know her handwriting well enough to ...

Code A No and it's a poor copy for, for the handwriting.

Code A But it doesn't appear that that was ever written or written up or signed up properly as a policy.

Code A ... right.

Code A It was a protocol that was ...

Code A Developed.

Code A ... developed ...

Code A But never got translated into policy?

Code A Yes.

Code A ... yes.

Code A I don't know as I say I certainly don't recollect seeing it.

Code A But our understanding is that that was how ...

Code A What, why the nurses were able to use a variable dose prescription.

Code A ... well this, we understand that although that it was never ratified but that ...

Code A But that's what they were working too?

Code A ... that's what they were doing at Gosport.

Code A Working too.

Code A Yeah.

Code A Right.

Code A Does that make sense to you or does it ...

Code A Well yes.

Code A ... and do you recall it at all now?

Code A No.

Code A It's not a policy or a document that you've drawn up then?

Code A No.

Code A And you don't recall seeing it?

Code A I don't recall seeing it.

Code A Death certificates that's the next one. Well it's a legal requirement obviously that, the completion of a death certificate and that can only be undertaken by a medical practitioner and there are specific guidelines to be followed. So we're just going to try and see if we can get an understanding of what was required, from your point of view in regard to the completion of this process. Did you get involved in death certificates much?

Code A No.

Code A What is the difference, do you know, can you explain between verification of death and certification of death?

Code A Well my understanding would be ...

Code A Yeah.

Code A ... is that verification is someone stating that someone has died, like, I suppose you could say a nurse might verify that someone has died.

Code A Yeah.

Code A But a certification is a process, is the actual issue, issuing of the certificate which can only be done by a doctor and that would be ...

Code A Yeah.

Code A ... not not seeing that, I mean a doctor could I suppose verify someone's died as well as nurses. That would be my understanding but ...

Code A Can you, what circumstance would, in what circumstances could a nurse, would a nurse verify death then?

Code A ... if a death was expected.

Code A Yeah.

Code A I mean I think I'm sort of guessing, I mean I, I think probably the thinking behind this was in hospitals if there is someone who's clearly dying, they died during the night, so that they didn't have to waken the doctor up during the night nurses were allowed to verify death, where it, this is where it was expected.

Code A Yeah.

Code A Yeah.

Code A That's my ...

Code A And a doctor would certify it in the morning.

Code A ... and a doctor would certify it in the morning.

Code A Yeah actually that's, I think there's more on this but there's this, CSY/HF/11.

Code A Yeah.

Code A It explains there that it's not the duty or responsibility of the nurse to confirm the death if a doctor can reasonably attend to do so.

Code A So I would say certainly verification as being the same as ...

Code A Yeah.

Code A ... confirmation of death.

Code A Yeah.

Code A Yeah.

Code A This goes on to say about qualified nurses, it says may verify death and then it gives exclusions to that. For once on this one we have got a policy date which is 1998 so that was presumably in place at around about the time that you were there wasn't it? What was the process that the doctor undertakes to certify the death in ...

Code A Well if it's, obviously has to be that the patient is known to you and as far as concerned the hospital that someone's been under, whose been seen by a medical practitioner involved before death who's had an opportunity to, I suppose, to make diagnosis and after death has occurred then feels comfortable that what, that his findings could've been responsible for the patient's death.

Code A ... yeah and presumably at the War Memorial these, you weren't involved at that stage of the patient were you?

Code A No.

Code A And presumably that was all down to Code A was it?

Code A And her partners, yeah.

Code A And her partners, yeah and did you supervise that at all, did you have a responsibility to supervise that at all?

Code A I wouldn't have seen that as being part of my responsibilities.

Code A No. Did you, would you see the death certificates at all or …

Code A No.

Code A … no, so if you saw, say for arguments sake you came in on a Monday, saw a patient and you weren't in to see the patient again for another week, no maybe say you're on holiday two weeks and in that three week period when you come back the patient has died. You wouldn't expect to see …

Code A No.

Code A … no?

Code A No.

Code A You never had cause to query a death certificate?

Code A Well I never saw any.

Code A Or query cause of death?

Code A No.

Code A No did you was there, would you be notified that a patient had died ...

Code A No.

Code A ... no?

Code A No.

Code A So if you did see a patient on Monday and the patient died on Tuesday you wouldn't ...

Code A No.

Code A ... no and the, there are some forms around death certificates, are they forms that you'd be familiar with at all or not?

Code A (Inaudible).

Code A No I'll get them out in a minute.

Code A We'll get them out in a moment but I'm just wondering whether it's worth going down that line.

Code A Well it will be later, yeah, yeah. The question I was going to ask, certain deaths are reportable deaths is that correct?

Code A Yes.

Code A What deaths need to be reported to the coroner?

Code A Well if you're uncertain of the cause of death.

Code A Well that's unfair because it sounds like an exam and it's not an exam but there are as we said, you said there are ...

Code A Yeah.

Code A ... certain deaths ...

Code A Deaths within a year of an operation and ...

Code A ... I've just had a quick look at another document we've got which has got the ID reference of CSY/HF/4, which is a copy of the 'Department of Medicine for Elderly People, Essential Info for Medical Staff' and one of the pages in there has got 'Referring deaths to the Coroner' it's got sixteen, well certainly sixteen reasons, alright if you just have a quick look at that, I mean does that, would that be about right? As you said it's deaths as a result of an accident.

Code A — On ...

Code A — Violent Deaths, abortions, sudden infant deaths, natural diseases, suicides those sorts of things but accidental death, road traffic, in the home, at work etc, is there a time limit on the accidents if you understand what I mean?

Code A — ... yeah.

Code A — Do you understand what I mean?

Code A — Yes, yes, I do.

Code A — Yeah.

Code A — Not at that I know of, no.

Code A — So if, if a patient falls at home and fractures a hip, that's quite a common one in the elderly isn't it?

Code A — Yeah that's different cos there was an operation.

Code A — Right so, in fact there's actually two then is it, two reasons possibly then why ...

Code A — Well, yes I mean to me the reason for that is cos she had an operation.

Code A — ... so if somebody's had an operation ...

Code A Yeah.

Code A ... and doesn't leave the hospital, might leave that hospital and go to another hospital ...

Code A Yeah and they die.

Code A ... and they die.

Code A Die within a year.

Code A Within a year?

Code A Yeah that should be reported to the coroner.

Code A Right ...

Code A That's my understanding.

Code A ... yeah, no that's fine. In fact it says here 'Where surgery has been performed within the past 12 months ...' sorry I didn't read this '... and where an accident has occurred within the past twelve months'. So if they've fallen over and bruised themselves badly shall we say ...

Code A Yeah.

Code A ... and died as a ...

Code A Right ...

Code A ... (inaudible).

Code A ... well yeah I'd ...

Code A It's alright collecting all these documents but understanding them is a different matter isn't it?

Code A ... I mean I don't think, I mean in terms of interpreting what's an accident ...

Code A Yeah.

Code A ... if somebody falls over and bruises themselves but doesn't break anything, doesn't have an operation I wouldn't regard that as an accident. If it had been a sort of road traffic accident or they'd you know fallen off a roof at work or then ...

Code A Well no I was just thinking if they'd fallen down the stairs at home and injured themselves, seriously, because they're old or elderly, they require some sort of hospital treatment but it might not require an operation. So it's probably they normally break a hip or something like that do they?

Code A ... yes usually

Code A So that's that one and you want to move onto the other one's don't you?

Code A Yeah I put them in here actually.

Code A It's in the other bag.

Code A (Inaudible) now Code A

Code A (Inaudible).

Code A Well we, you didn't fill out the death certificates ...

Code A No.

Code A ... or the medical certificates ...

Code A Medical cause of death.

Code A ... cause of death?

Code A No.

Code A No?

Code A No the only thing I would've done was maybe two or three part two of the cremation forms.

Code A It requires two doctors to sign.

Code A So I would've done. I mean I can't, I can't absolutely put my hand on my heart and say there wasn't one, there

might've been one death I certified if Code A was away.

Code A Yeah.

Code A I didn't sign any.

Code A No we haven't?

Code A No that's, that's what I say I think we'll leave that for a minute. Apart from the fact that who was supervising Code A work around that area then, death certificates, medical report of death certificates?

Code A (Silent).

Code A Can you picture the certificate, the medical certificate of cause of death?

Code A Yes there's ...

Code A There's a box labelled 'Approximate interval between onset and death'.

Code A ... yes.

Code A The onset of the condition.

Code A Yes, yeah.

Code A Is that normally filled in?

Code A Yes.

Code A Is it a requirement to be filled in?

Code A I don't ...

Code A You don't know?

Code A ... don't know.

Code A Okay and what is, did we ask this, what was the difference between a death certificate and a medical certificate of cause of death?

Code A It's, I thought that was the same isn't it?

Code A I'm not sure cos they're two different forms, it's ...

Code A Ah, right I think, right, okay. I think ...

Code A ... and if you're not sure it doesn't matter cos as I've said it's not an exam, it's unfair isn't it?

Code A ... I mean this is ...

Code A We'll come back to that.

Code A We'll come back to that.

Code A ... the business of the, the business of ...

Code A I think it would be fair if we came back to it.

Code A ... I mean the death certificate I've always taken to be that.

Code A And that's, that's what we've been calling a medical certificate of cause of death.

Code A Oh right, okay.

Code A And that is, no it's not that one.

Code A Yeah that was a death certificate.

Code A Yeah, well that's the one that the doctor signs up isn't it ...

Code A Yes.

Code A ... the medical certificate of cause of death?

Code A Yeah.

Code A Yeah.

Code A On, we were discussing just now weren't we about the causes of death etc? What is a resuscitation policy?

Code A That's a policy which instructs ...

... well gives guidance, gives guidance to staff around, about the issues surrounding resuscitation ...

Code A Yeah.

Code A ... you know when and ...

Code A Because not all patients will be regarded as suitable for resuscitation will they?

Code A ... that's right.

Code A I think at QA, did they call it treble 5

Code A Yeah they've got a 'Do not attempt resuscitation' policy.

Code A Yeah that's the sort of thing you're talking about there?

Code A Yes.

Code A Can you recall any patients at the War Memorial having that written on their, 'Not for Resuscitation'?

Code A Er, I mean I can't recall any specific patients.

Code A No.

Code A But it certainly wouldn't surprise me if it had been written that some patients were not for resuscitation.

Code A If, you know because of the nature of the patients that were in there and ...

Code A Cos they were ...

Code A ... yeah.

Code A ... yeah.

Code A Yeah. Would, if a patient isn't for resuscitation would it normally have been written up 'Not for Resuscitation' specifically or ...

Code A Well it would now, I think it's difficult you know thinking back to 1999. I mean well my view would be if a patient had certainly very clearly expressed a wish not to be resuscitated and relatives had been very clearly ...

Code A ... yeah.

Code A ... expressing a wish not to resuscitate one would hope that that would be recorded in both their medical and in the nursing records so that ...

Code A Yeah.

Code A ... you know attempts weren't made to resuscitate the patient.

Code A Is there any other way of writing 'Not for Resuscitation' up?

Code A Yeah, just well probably just write 'DNAR' which is 'Do not attempt resuscitation'.

Code A Okay, yeah.

Code A Or write 'Not for Resuscitation'.

Code A I think I've seen 'Not for 555' on ...

Code A Yes that, yeah that sort of thing yeah, which is the emergency response number.

Code A ... so is that a doctors decision or is it a decision made in conjunction with the patient and/or the relatives?

Code A Back in 1999 it would not surprise me if that was very frequently a decision that was made by the doctor and possibly with consultation with the nursing staff. Possibly with consultation with the relatives.

Code A Would you expect to see an instruction that the doctor was, would be satisfied for nurses to certify death?

Code A I mean if a patient was clearly dying, I mean cos what we're talking about is verifying, not death, not ...

Code A Yes.

Code A Yeah confirm I think it was.

Code A ... confirming death. So I'd, if a patient, if it was very clear that you know they were dying I'd be quite happy for that to be written in the notes.

Code A Would that be written, if, that's the next topic, if a patient had entered, in the medical opinion, the terminal stage in their life ...

Code A Well it might, yes I mean, yeah it's generally for people that are terminally ill or who are very, very frail, (inaudible).

Code A ... well I think Code A it would be written if it was expected a patient would die?

Code A Yes.

Code A Would it be written if a patient wasn't necessarily expected to die?

Code A No, well I wouldn't expect it to be written.

Code A You wouldn't expect it to be written.

Code A I think what we'll do Code A, it's thirty eight, we'll take a break ...

Code A Yeah they can stretch their legs can't they?

Code A ... get a cup of tea (inaudible). Right the time by my watch is 1440 I'm turning the tapes off.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y25F

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/06/2006

Time commenced: 1500 Time concluded: 1540

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

Interviewer(s): Code A

Other persons present: Code A

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the interview of Code A and the time by my watch is 1500. Doctor can you just confirm that we've stopped to change the tapes over?
Code A	Yes.
Code A	And we've just been outside and had a bit of fresh air?
Code A	Yes.

Code A And a comfort break and we haven't talked to you about ...

Code A No.

Code A ... the matters that you're being interviewed? The same personnel in the room?

Code A Yes.

Code A Thank you. When we finished off ...

Code A Time?

Code A ... yeah I just, sorry 1500 thank you. When we finished off that last part of the interview we'd been talking about resuscitation policies, nursing verifying death etc and one, one other thing we talked about during it, we introduced ...

Code A Can I just clarify, just clarify something which you said what supervision would Code A have in completing death certificates?

Code A Okay.

Code A Yeah.

Code A Yeah.

Code A I mean just to really to, I mean I wouldn't supervise my junior doctors in QA review their death certification unless

they particularly asked me, you know what should I put on this, so, no it wasn't sort of usual practise to ...

Code A Yeah.

Code A ... supervise death certificates.

Code A Right, okay. Where was that, CS, 27 is it here?

Code A It's back in there, is it what I think it is?

Code A Yes.

Code A Do it later, do it again.

Code A Do it in here?

Code A Yeah.

Code A We spoke about palliative care doctor. Who would make the decision as to what kind of care a patient would receive on, on admission of the patient?

Code A Well I mean Code A would form a view and I'd form a view myself.

Code A And would you have formed your view first because presumably for a patient to be admitted into Dryad ...

Code A No it would certainly be the other way round, it would be Code A because she would see the patient, she'd more than likely have seen the patient before I saw them.

Code A ... but how, but what I'm saying is wouldn't someone from your department, a consultant from your department have seen the patient before ...

Code A Oh yeah and they'd have said 'Transfer to Gosport for rehabilitation' or 'For further assessment' or whatever, yeah.

Code A ... yeah and then Code A would see the patient?

Code A Yeah.

Code A And was she able to change the type of care that a patient was going in for then?

Code A If she felt the circumstances had to change.

Code A Yeah.

Code A I mean if someone was, at that stage was clearly, clearly dying I mean occasionally you do get surprises you know patients are sent down for, well, we had a waiting list for patients to be transferred for rehabilitation.

Code A Yeah.

Code A So from being seen, to be sent down their condition could have changed very significantly from how they were when we assessed them. So that someone who was sent for rehabilitation and could literally and there has been occasion, at deaths door when they came through the door.

Code A Yeah.

Code A Because there'd been a, you know maybe two weeks, four weeks since they'd been and had actually come down but that didn't happen very ...

Code A No.

Code A ... didn't happen very often.

Code A But if a type of care change it was the reviewing doctor who, who would ...

Code A Yes.

Code A ... record that?

Code A Yeah.

Code A Yeah. Palliative care would obviously differ from rehabilitation and continuing care wouldn't it?

Code A Yes I mean one, palliative is looking to, the principal aim is to relive symptoms that that patients got. I mean it might

be that someone, well for example you know might develop severe heart failure while they were undergoing rehabilitation. You might think oh gosh things don't look very good, possibly going to die, given them some morphine, some, treat for heart failure and then if they got better you know you're back to the rehab plan.

Code A

Yeah, okay. Recording interactions with, oh no one other question on palliative care that we wanted to know. Does that equate to the term 'Terminally ill'?

Code A

No. I mean, um, we're often, talk about going down the palliative care route when patients are terminally ill but I mean as I've said, I mean it's usually people who, they've got what you think is a potentially life threatening illness and, but occasionally you know people do recover from life threatening illnesses so they may not be, although we might think they're terminall they may not be terminal so palliative care is and I think I've said before patients say have got cancer, they may not be dying but we know they're going to die at some stage but it might be you know two, three years down the line but they've say got terrible bone pain. So they come in and get some treatment for that and then go home again. So they've received palliative care but they've not been terminally ill.

Code A

I'm with you, yeah.

Code A

Okay.

Code A Okay thanks for that.

Code A I mean usually they are but not invariably.

Code A Yeah. Recording of interactions with patients is a fundamental requirement of health care professionals. So this section we're going to move on to now will seek to obtain more explanations as to how notes should be completed, when, by whom and why.

Code A Yeah.

Code A What should be recorded in patients medical notes and by whom?

Code A Well the ...

Code A Thinking about GMC best practise that sort of thing.

Code A ... right. Are you talking about now or then?

Code A Well then, yeah.

Code A I mean I think, I think it's a bit difficult to say without you know actually seeing what the GMC guidance said at that time. I would doubt that it said anything terrible specific except that it was probably, you should keep, you know good notes. So I think it's going to be, probably very general but to answer your question I mean I would expect there to be a sort of brief résumé of this, what the problem

the patient was transferred or admitted to the hospital with and a sort of a management plan. As an absolute minimum. So if we're talking about the War Memorial Hospital again ...

Code A Yeah.

Code A ... I think as I said earlier I wouldn't expect, unless they had a reason to do it, a huge sort of detailed history, examination as one would do for a patient coming in sort of fresh off the street to QA. Cos these are patients being transferred from one hospital to another who most of whom would be stable, so all, as I say would be looking for would be a résumé of the major problems and a management plan.

Code A Is the management plan the same as a care plan?

Code A Yes. A plan.

Code A Yeah a plan of how best to go forward for the care of that patient?

Code A Yes, yeah.

Code A And there is a bit of, and there are two, you've got medical plans haven't you and ...

Code A Yes and nursing and care plans yes, yes.

Code A ... and they're, (inaudible) medicals are done by the doctors ...

Code A Doctors, yes and would generally tend to focus on medical and general issues like you know in heart failure you'd need such and such a treatment or needs for rehabilitation or whatever, something.

Code A ... how are nursing plans, how do the nurses formulate their plans then?

Code A Well ...

Code A Is that something you'd know about or ...

Code A ... not, not certainly not any detailed knowledge.

Code A ... no.

Code A I think the care plans that were in use at that time had about of eight different components. So you looked at, you know food and hydration ...

Code A Yeah.

Code A ... pressure area care, looked at continence you now bowels and bladder and there was also communication with the relatives, a section for that and there are other sections but I can't you know immediately bring them to mind but I

wouldn't have been involved with that. Although I mean sometimes I did make, would make reference to them.

Code A Yeah. Where did the nurses, I mean they just didn't come along and sort of make a plan off the top of their head on a patient did they? Where would they get ...

Code A Oh some of that would come from, well certainly some of that would come from the medical staff.

Code A ... yeah.

Code A You know either what they'd said or what they'd written or a combination of both.

Code A Yeah. Okay, thank you and when you, when the patient was seen and the medical care plan is recorded.

Code A Yes.

Code A Yeah what is, again what is the purpose of that?

Code A It's so that anyone else coming along can know what their plan is to guide future treatment.

Code A For instance if you saw a patient today and recommended a form of treatment for that patient, you'd record it presumably?

Code A Yes.

Code A Yeah?

Code A Yeah.

Code A Because presumably if you go home and you had an accident on the way home and you couldn't come in the next day ...

Code A Yeah and you know if someone came in with advanced cancer and was in pain, you know you would write, say 'Advanced cancer, in pain, (inaudible) for symptom control only ...' ...

Code A Yeah.

Code A ... (inaudible) GP who doesn't know the patient is called out during the night cos they've got a chest infection, he can then make a more informed judgment about how appropriate it is to, you know whether to treat them, not to treat.

Code A Yeah and who accepted the patients onto the ward? Was that Code A ?

Code A Well, um the patients were transferred from a list ...

Code A Yeah.

Code A ... held by the secretaries at Queen Alexandra Hospital. So they would send the patient down so Code A is like, well she didn't have any, I'm sure she didn't, well I mean unless the patient was, was sick and she felt wasn't fit to be in the War Memorial and thought it was more appropriate to go back to QA. I mean that was the discretion she would have but not to say well I don't want to look after this patient or whatever. So she wasn't given the option, do you want to take this patient or not?

Code A Right, yeah.

Code A She got the patients presented to her and unless she felt, as I say they were ill or not to go back to QA she would, you know do what she thought was necessary.

Code A And who was responsible for the initial clerking?

Code A Code A

Code A Code A

Code A Or her partners.

Code A Yeah, okay. When would, and you wouldn't see the patient, I think you've already answered ...

Code A Until the Monday.

Code A ... until the Monday?

Code A Yes.

Code A Yeah, so irrelevant of what time they came in, if it was after Monday you wouldn't see them till the following Monday?

Code A Yes.

Code A When a patient arrived on Dryad Ward, you were the person solely in charge of those, well not solely in charge ...

Code A Yeah.

Code A ... because you had Code A working with you but you had responsibility for each patient?

Code A Yes.

Code A Yeah and then Code A had a responsibility as well, yeah. Were there any policies in place for completion of notes?

Code A No.

Code A No?

Code A Not that I'm aware of.

Code A — No. We've seen, I know we've already had a look at Code A job description and that clearly states in there what she should ...

Code A — Do you mean in terms of note keeping?

Code A — ... yeah, yeah. What were your standards like at the time? Note keeping ...

Code A — My standards?

Code A — ... yeah, record keeping?

Code A — Well I would generally sort of write what I thought was important information. So I wouldn't, you know I wouldn't examine, well my note keeping would reflect what I'd actually done with the patient. So if it had been a discussion about say a patient who has had a stroke and you know how they're getting on in physiotherapy and occupational therapy I'd be asking the nurses, well what's this patient doing in terms of being able to wash and dress and themselves, are they continent and trying to, in my own mind well we'd like to get this patient home. So I would write something like, you know 'Now able ...', you know '... walking with a zimmer frame and one person, continent, aim for getting back home' or something like that.

Code A — So ...

Code A If they'd had a (inaudible) or chest infection I would usually write down you know what I'd found, when I'd examined them and what I'd done about it in terms of prescribing antibiotics.

Code A ... would you expect other people to follow ...

Code A To do the same?

Code A ... yeah.

Code A Yes.

Code A Yes, yeah. Were you satisfied with the standard of record keeping then?

Code A At the time I felt that Code A although her notes were brief, did actually record significant changes in either patients condition or the significant in the management plan at the time.

Code A Yeah. You were conducting a ward round, a.m. at QA ...

Code A Mm, mm.

Code A ... on a Monday and a ward round p.m. at Gosport. Did that stop you, the fact that you had such a busy day, on a Monday, did that interfere with your ability to record keep?

Code A No.

Code A No.

Code A Just on the note keeping, the 'Good Medical Practise Guide' ...

Code A Yeah.

Code A ... and we've got a photocopy there ...

Code A Oh right, okay.

Code A ... (inaudible) GMC, it's got an ID Reference of CSY/HF/2. Just being shown that, on the, page 13, it's got the date which is October 1995.

Code A Okay.

Code A And the bit that, I think Code A wanted to refer to, is on page 2, which is about good clinical care and in providing care you must, the last paragraph is, 'Keep clear, accurate and contemporaneous patient records which will report the relevant clinical findings, decisions made, information given to the patients and any drugs or other treatment prescribed'.

Code A Yeah.

Code A Which is just there.

Code A Fine. Fine, okay.

Code A And I don't believe that's changed much since ...

Code A No if anything it's likely to have been ...

Code A ... yeah.

Code A ... maybe even more explicit.

Code A Yeah.

Code A But as far as you're concerned you were, did, was that a guide that you followed?

Code A I mean I would, I mean I would have to say, it's a guide that I personally followed.

Code A Yeah. Yeah.

Code A You know reviewing and at the time as I said I felt that Code A recorded most of the important changes that had been made. I mean I was very conscious that she was very busy and that you know she may not have recorded when she, you know when a patient had, say a urine infection or something that's ...

Code A Yeah.

Code A ... relatively minor, yes she should record it but you know if you're busy you may sort of get distracted and go onto something else.

Code A Sure.

Code A As I said I thought she recorded most of the important decisions that she'd made.

Code A Were they any occasions when you raised the subject of record keeping with any individuals or groups of people?

Code A No.

Code A No?

Code A Not to my recollection.

Code A There were never any occasions when due to a lack of accurate or clear recording on patients records that it was difficult for you to follow the plans, the treatments etc that were in place?

Code A Well what I did, if, if that situation had arisen then what I would do, I mean the nursing staff are always there on the ward rounds so I would say "Tell me what's been happening". So I'd be able to learn from them what had happened. If there hadn't been a, yeah as I say if Code A Code A if there was someone written up for an antibiotic and I wasn't, there'd been, there hadn't been a

record as why that hadn't been written then I'd speak to the nursing staff.

Code A Did that happen regularly or ...

Code A No I don't remember that happening regularly.

Code A ... no. So you were always able to follow the, having not seen a patient for a week, you know or maybe more than that you were able to understand how the patient was ...

Code A Yes.

Code A ... being treated and cared for?

Code A Yes.

Code A Yeah. What would you expect Code A , if Code A was admitting a new patient, yeah to see a new patient on the ward, what would you expect her to, to actually, what would you expect to see her having written down?

Code A Well I'd expect her to write the main diagnosis like, you know stroke, or heart failure and what the sort of management plan was you know like for rehabilitation, for, for continuing care, for whatever you knew she thought was appropriate at that, as a result of her initial assessment. So I'd have expected to have a looked at the medical records. Looked at the patient, made sure from

observations, probably the observations of the nursing staff, that the patient was stable, pulse, blood pressure, temperature were all okay. If the patient were unwell in anyway then I would have expected her to have examined the patient and recorded her findings and what she was doing about it.

Code A Was it proper for Code A to be doing all that then?

Code A Yes.

Code A And was, could a nurse do that?

Code A Nurses could do some of it. I mean nurses can take a history, they can read the medical records and find out what's going on. They will obviously not be as competent as a doctor in perhaps knowing what to make of diagnosis that were written. You know if heart failure was written I think it would be quite difficult for nurses to assess say the severity of the heart failure and I think only a doctor could do that and nurses are, I mean can't examine in terms of listening to chests and hearts and nurses can't make, they can make simple diagnosis but I mean that's not a role that's required often. I mean intelligent nurses will often suggest to you what, what might be wrong with a patient.

Code A Yeah, okay. When Code A was on holiday, what you're saying earlier was that her practise covered for her, is that right?

Code A Yes.

Code A Yes. Were there any problems presented through that or ...

Code A Well I mean what was, I mean I can't remember any specific problem. The problem that the only issue as reported from the nursing staff was that some of Code A Code A partners were reluctant to attend when, or give, well reluctant to attend patients when the nursing staff felt it would be appropriate but I was never given any specific example of that, that would just seem to be a general belief rather than, I mean I don't remember any specific incident being reported to me.

Code A ... how, I think you'd said this as well, they were paid, it was like she was, Code A was subcontracted.

Code A Well I mean I don't know what the arrangement was but that effect, I think that's what the arrangement was.

Code A Yeah. Now can you remember how many beds there were? You said was it ...

Code A There's 20 in Dryad ...

Code A ... 20, yeah.

Code A ... 24 on ...

24.

Code A ... on Daedalus and she might also have some patients on Sultan Ward as well, the GP Ward.

Code A But certainly 20 and 24?

Code A Yeah the minimum sort of.

Code A Yeah. Did Code A ever raise any concerns with you or any other members of the management regarding the pressures of her job?

Code A I don't, I don't clearly remember, I remember having one conversation with her and I can't remember when that would be but my guess would be probably early in 2000 that she was finding things, she was finding things difficult and what had become sort of clear to me at that time was that cover, the level of medical cover that she was able to offer wasn't adequate and I've already described, and the reason I thought that was because as I said we'd started having empty beds. We then started transferring patients who probably needed sort of slower term rehabilitation rather than being for continuing care. Now that happened over a period of a few months and what one's not clear about, cos you do get sort of get you know cycles sometimes where there aren't large numbers of patients on the waiting list and then it builds up again, was just whether this was a sort of natural sort of variation or whether this was a permanent change. Well I think it, to me

it became clear by you know early 2000 that this was a permanent change and that we were going to be seeing more demand from QA to take patients at an earlier stage and I felt that the medical cover we had really, through Code A and through no fault of Code A Code A really wasn't enough and that what we'd really needed was a sort of staff grade doctor, a Clinical Assistant who was there, you know Monday to Friday, 9 to 5.

Code A Full time job basically?

Code A Yes.

Code A Yeah.

Code A So what I said, so I said to Code A that I think you know these pressures are going to continue, we are going to have these number of patients, hoping that she would say, well this is getting, if this is the case this is getting beyond me and perhaps I ought to consider, you know my position. Yeah and I mean it was shortly after that that she put in her resignation.

Code A You say you're hoping that she would say that.

Code A Yes.

Code A Why do you say that?

Code A

Well because to try and, we needed the resource, well the money that was used to like, Code A I felt would go towards employing staff grade, sorry employing sort of a full time doctor, Monday to Friday 9 to 5.

Code A

Yeah.

Code A

I mean, I, Code A had given you know years of very valuable service to the War Memorial Hospital and I felt that in the first instance it would be better to suggest to her that you know the world had moved on and that she should be thinking about her position rather than sort of turn round and say well look we're going to get rid of you sort of next week. So that's what, that's what happened.

Code A

Wouldn't you have considered that she could have given up her GP role and taken that role on?

Code A

I didn't discuss that, I didn't discuss that with her. I mean as I say it was only a sort of, sort of fairly general conversation about the role of the hospital was changing and likely to change further. I mean if she had wanted to become a full time staff grade I mean we would have certainly considered her doing that. If she'd expressed that view but I mean I would suspect you know from a financial point of view it would be far more lucrative working as a General Practitioner than as a Clinical Assistant, cos they're not paid particularly well.

Code A And has that actually happened now, have they taken on that ...

Code A Yeah in, I think it was June 2000 we appointed a staff grade doctor at the War Memorial Hospital, round about then.

Code A ... were you aware of her raising any other concerns to anybody else about this?

Code A No. Well I think she'd possibly spoken to Code A about it but I wasn't aware of anything else.

Code A No, okay. How would you expect her ward rounds to be completed? We've talked about your ward rounds, so how would you expect hers to be completed, conducted?

Code A Well what I understand she did was come into the wards every morning. Ask if there were any problems, see any patients who had problems. Come in again in the afternoon, see any new patients and then review any patients she'd seen in the morning or if there were any other patients the nursing staff wanted her to see she would do that. What I'm not clear about, cos I haven't asked her is, you know when I was away did she do a ward round in the same way that I did. I just, you know I don't know. What I'm very clear about though is that she did visit the wards sort of everyday. Twice a day.

Code A But you don't know if she actually conducted a ward round in the way that you did?

Code A I just don't know.

Code A Our understanding is that she'd be in the hospital about seven thirty (0730).

Code A Yes.

Code A And she'd be in her own surgery by about nine (0900).

Code A Yes.

Code A This is her daily routine.

Code A Yes.

Code A She return midday ish (1200) to take in the new patients.

Code A I mean my understanding, I mean I could be wrong, is that she came sort of much, she came mid afternoon, presumably before she did an evening surgery. As I said she sometimes came after evening surgery as well.

Code A And then we, yeah we understood that she went to the hospital at about 7pm (1900) and we think that, well our understanding of the amount of time she spent at the hospital she was doing more than the five sessions that we knew she was contracted for. She, apart from what you've

just spoken about, did she ever raise issues regarding the time she was spending at the hospital with you or anyone else before, what you've just explained about?

Code A

I don't remember her raising it with me or with anyone else for that matter.

Code A

What is telephone prescribing doctor?

Code A

It's, nursing staff phone up, describe a problem to you, doctor makes a diagnosis and suggests a treatment and usually suggests a drug treatment of something that's not been written up on the prescription chart but asks the nurses to take a verbal message that that's the drug that they would like to be given.

Code A

And what's the process of recording that problem?

Code A

Well the, I mean it's a nursing issue, I think the nurses would record it in their care plan and I'm not sure what happened about the prescription sheet, what, I mean there was a policy I'm pretty certain for what, it's more correct called verbal orders, so I'm pretty certain there was a verbal orders policy but I couldn't speak to the detail of it in terms of what should be written on the prescription chart.

Code A

As I understand it, if, well certainly what you're saying is a nurse has the ability, out of hours, to call a doctor.

Code A

Yes.

Code A Yeah say look Code A has got blah, blah, blah ...

Code A Yeah.

Code A ... this isn't working ...

Code A Yeah.

Code A ... and the doctor can prescribe, say for arguments sake, another drug?

Code A Yes.

Code A Or increase the dose of a drug that she's already on?

Code A Yes.

Code A The nurse can then administer that drug?

Code A Yes.

Code A Yeah, then ...

Code A The doctor will come in and write up the drug at a later stage.

Code A ... yeah on the prescription chart as you've shown us earlier on?

Code A Yes.

Code A Yeah. That's still a practise that goes on isn't it ...

Code A Yes.

Code A ... quite rightly and properly yeah?

Code A Yes.

Code A So why, why do, why would a doctor need to prescribe a range of drugs then when you've got that facility in place, for verbal orders, why is a range of drugs sometimes prescribed?

Code A Well a verbal order would be for something new that had happened probably, whereas a variable dose is to manage an existing problem. So for someone who's in pain, writing the 20 to 40 or whatever it was, the variable dose, if someone develops sickness or started vomiting, you know whatever or let's say, I mean what sometimes happened a report would come back from the laboratory indicating that someone had a urine infection so call up a doctor and the doctor say, you know what does it say, what drugs is it sensitive to, just start them on some Tremethopriminol and other antibiotics and I'll come in and write it up in the morning. So it would be, so a verbal order would be usually be for a new problem.

Code A Okay.

Code A Of where an existing prescription didn't take, I mean let's say someone was in pain and there was no as required dose of pain written up ...

Code A Yeah.

Code A ... so someone's on diamorphine say 40 milligrams and the nurse would phone up and say oh she's in a lot of pain and say well give another 2.5 or 5 milligrams and I'll write it up in the morning.

Code A If nurses administer drugs within that range of drugs, yeah ...

Code A Within the dosage range?

Code A ... within the dosage range and say for arguments sake go from 20 to 40 then would you expect to see a corresponding entry somewhere?

Code A Sorry if the nurses had, if it was written 20 to 40 and a nurse had?

Code A Gone from 20 to 40 ...

Code A I'd expect there to be a note in the nursing record, yes.

Code A ... yeah as to why that was done?

Code A Yes.

Code A Yeah.

Code A Yes.

Code A And was there any interaction between doctors and nurses over prescribing a range, the dosage range?

Code A Well ...

Code A Specific instructions or ...

Code A ... I mean it was Code A who you know did most of the prescribing and she would, I would imagine that would also have spoken to the nursing staff about what she'd written up on the drug chart and not just, if you like sign a drug chart then disappear, she'd actually point out what she'd done.

Code A ... well what would you expect, as well as the clerking, what would you expect the Code A to record in the medical notes of a patient?

Code A If, are we talking about this specific situation in Gosport?

Code A Yes sorry, yeah, yeah.

Code A Well it's mainly just diagnosis and diagnosis problems, treatment plan. I can't ...

Code A So there's no set sort of, you'd expect to see your doctor write something everyday or every ...

Code A ... ah, oh right I see what you mean, right I'll, sorry I thought you meant at the time they came in?

Code A ... no, no, no apart from, no after that.

Code A In the situation of Code A I mean good practise would dictate that when you, there's a change in someone's condition or you prescribe that you make a record of that. So I'd have expected that to be done.

Code A How comprehensive would you expect the notes to be then?

Code A Of, I think it depended what the problem is, you know in other words if you'd switched over to a syringe driver say from, you know regular doses of morphine just to put and in sort of you know constant pain, start syringe driver or something like that, a brief note. On the other hand if someone had developed, you know heart failure for example then I'd expect a bit more around you know, patient complaining he'd been short of breath, no chest pain, pulse rate this, blood pressure that, heart sounds, listened to the chest, record all of that, etc.

Code A And again the purpose of making those notes and records, you've already told us, would you agree ...

Code A Yes.

Code A ... it's for other people to ...

Code A Yes.

Code A ... pick on when they come to see the patient later?

Code A Yes.

Code A And so medical notes, who would actually read the medical notes then, medical pages?

Code A Well Code A and I oh some, I mean the nurses might look at them too, yes.

Code A Yeah. When we did proactive prescribing, she never discussed that with you?

Code A No.

Code A No. But you did say you spoke to her about, for instance, I think it might, diamorphine, oramorph, hyoscine and midazolam were typically proactively prescribed.

Code A I've only seen that once.

Code A One patient?

Code A Yes and it was during the course of this investigation and where it was written the prescription sheets, I'm as certain as I can be, I didn't ever see that.

Code A Okay and you spoke to Code A about that did you say or not?

Code A No I didn't see it.

Code A No.

BUZZER SOUNDS INDICATING THE END OF THE TAPE.

Code A That means the tape is just coming to an end and the time is 1540 and I'm turning the machine off.

8

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Code A

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 1542 Time concluded: 1600

Duration of interview: 18 MINUTES Tape reference nos.
(→)

Interviewer(s): Code A

Other persons present: Code A

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	The time by my watch is 1542 and this is a continuation of the interview of Code A Code A sorry, Code A Doctor can you just confirm that the personnel in the room have not changed and we just stopped to change the tapes to change over?
Code A	Yeah I can.
Code A	Do you feel that Code A kept her notes in line with the GMC Guidelines?

Code A Can I look at the GMC Guidelines again?

Code A Course you can.

Code A Benefit of the tape it's CSY/HF/2, it's got the tape, probably on about page three I think.

Code A Thank you. No, not to the letter, no.

Code A No. Was it, did you try to ensure that she did keep notes ...

Code A I didn't discuss her note keeping with her. For two reasons, the first reason was that I felt that she's a senior responsible GP, she should know the importance of good note keeping and secondly it was also my impression that when there'd been a significant change in the patients condition she did actually record that and the third reason is that, forgot what I was going to say, it'll perhaps come back to me in a moment.

Code A ... you spoke about her experience, the fact that she was so experienced and ...

Code A Oh I mean I knew she was under pressure for time and I didn't want to add to the sort of the burden by insisting that every sort of encounter with a patient was documented.

Code A ... but what, how did you follow the treatments etc, you're saying that you were able to through her ...

Code A Well looking at what she had recorded, through looking at what was, had been prescribed and then through, if I wasn't clear about things talking to the nursing staff but I don't recollect, I don't recollect there being a problem.

Code A ... okay. In 1998 allegedly Code A raised some issues with the management ...

Code A In when sorry?

Code A ... 1998 so that was the year before you went down there, were you aware of that or what that was?

Code A No, no idea first time I've heard about it.

Code A Would it be an accepted practise to prescribe a range of drugs for out of hours use? I think we've partially covered that.

Code A Yes I think it would be.

Code A Yeah. Code A apparently was available out of hours and was called by the nurses on occasions, was there anybody else on call? Anybody else on call?

Code A Well there'd be, there's always a consultant on call for the whole elderly ...

Code A For the Elderly Medicine Department?

Code A ... unit, yes.

Code A Yeah. Yeah.

Code A And that included the beds at Gosport.

Code A So that included that range of hospitals and the wards, yeah.

Code A Yes included Petersfield Hospital, Christopher's, the War Memorial.

Code A Were you ever part of that ...

Code A Yes, yes, yes.

Code A ... yeah, yeah and that's one of your roles now presumably is it that you still do?

Code A Yes, yes.

Code A Yeah. Did you ever get called out to the War Memorial hospital?

Code A Don't recollect ever being, I mean I couldn't, couldn't, I don't, I don't recollect getting called out, no.

Code A No, okay. Do you feel that Code A note keeping met the standards that you were setting?

Code A Having seen the sort of, four sets of notes that you've given me, there are deficiencies in the note keeping.

Code A (Inaudible) 27 that one.

Code A Yes thank you very much.

Code A (Inaudible).

Code A Yeah, true. Doctor earlier on …

Code A Yeah.

Code A … when we showed you this CSY/HF/27 …

Code A Yes, yeah.

Code A … do you remember that that's the protocol?

Code A Yes mm, mm.

Code A Yeah and we asked you some questions about it …

Code A Yes.

Code A … and you said to your knowledge you haven't seen that before.

Code A I don't remember seeing it.

Code A You don't remember seeing it before. What, if I show you another document, this comes from the paperwork that we hold and what I'll do I'll introduce this as ...

Code A GJQ/HF/39.

Code A ... GJQ/HF/39 and we'll call this ...

Code A Memorandum for the Protocol ...

Code A ... yeah.

Code A ... for Prescription.

Code A Yeah calling it Memorandum for the Protocol for Prescription. It's quite a bit of documentation but if I show you that ...

Code A Yeah.

Code A ... it's from you isn't it?

Code A Yeah.

Code A Yeah.

Code A Yeah.

Code A It's pp'd I don't know who that is.

Code A Yeah.

Code A But that is a letter from you isn't it?

Code A Yeah.

Code A Yeah and it's ...

Code A Is it this is it?

Code A ... well yeah, shall I read it, it says 'Re Memorandum for the Protocol of Prescription and the administration of diamorphine by subcutaneous infusion ...

Code A Yeah.

Code A ... I enclose a draft protocol and a blank infusion pain control chart and a completed diamorphine infusion pain control chart. I should be grateful for your comments' and it's signed in your absence and it's distributed to Code A Code A

Code A Yeah.

Code A ... and Code A

Code A Yeah.

Code A Yes and I'll turn it over you'll see that it's ...

Code A It's that isn't it, yeah.

Code A ... yeah.

Code A Okay.

Code A Yeah.

Code A Right, okay.

Code A And that's, this one is, you can see that it's a ...

Code A (Inaudible) letter.

Code A ... date at the bottom 3/12/99.

Code A Yeah.

Code A Yeah. Do you remember it now?

Code A Yeah, well I remember it now cos it's now, I recognise the sort of, I can recognise the sort of the font, the font at the top, it's just the photocopies.

Code A Yeah I mean all this one is just a ...

Code A Yeah. Yeah.

Code A ... it's a smaller version isn't it?

Code A Okay.

Code A I see what you're saying, the font is slight different but is the wording the same?

Code A It's ...

Code A It looks it to me.

Code A ... yeah and it's, well it's, but yeah, no I, I recognise that, well I mean, if the letter's from me attached to it I can see.

Code A Yeah. Can you remember what that's all about now then? If I show you the rest of the documents that are in it.

Code A Yeah.

Code A (Inaudible) prescribing committee.

Code A Yeah.

Code A Yeah?

Code A Yeah.

Code A And it's got on there Code A reported that the protocol was produced as a resort of a complaint and it's currently being ...

Code A Yeah.

Code A ... piloted.

Code A Yeah.

Code A The feedback so far has been positive (inaudible) ...' and then talk about other protocols and operation.

Code A Yeah.

Code A 'It was agreed that Code A would make contact with the Rowans and Charles Ward and (inaudible) document to the nursing advisory committee to ascertain the view of district nurses ...

Code A Yeah.

Code A To report back at a future meeting'. So it's come about as a result of a complaint?

Code A Yeah.

Code A It possibly might even have been the police investigation mighten it?

Code A No I don't think it was.

Code A No.

Code A Oh you mean the original police invest..., you mean the Code A

Code A Yeah. Yeah.

Code A Code A

Code A And there's another lot of Code A Code A is this one that you sit on or ...

Code A ...I Code A it.

Code A ... you Code A yeah and then item four (inaudible) reported that she was engaged in developing nursing policy on pain recognition and pain control and developed a policy on syringe driver control. Code A agreed to write to Code A and Code A indicating that Code A would be contacting her at some stage about this.

Code A Yeah.

Code A Yeah.

Code A Yeah.

Code A And then another letter here dated February to Code A Code A?

Code A Yeah mm, mm.

Code A And that's asking him about their views on it and whether they're using the protocols or reshaping the one that you've sent them so that a Trust wide protocol could be developed.

Code A Yeah.

Code A (Inaudible) copies of it and I believe that there's a letter there from Code A concerning it, so that's obviously her reply ...

Code A Right.

Code A ... and I believe that, is that a copy that we've originally showed you there, the one which she sent back with some writing on.

Code A I honestly don't know because I wouldn't recognise her writing from that.

Code A Okay. So can you talk us through this now, how this is ...

Code A Yeah I mean ..

Code A Actually is that your fax number on the top with a phone number Code A ?

Code A ... sorry?

Code A Is that a fax or a phone number gone onto it?

Code A No that's the departmental fax number.

Code A Right, yeah.

Code A As in Elderly Medicine not as at QA.

Code A It's obviously come out when you faxed it to us (inaudible) 25th of October 2004 I think.

Code A ... and so, can you talk us through how, what this is all about in fact?

Code A I remember there being concern about the sort of documentation of pain in relation to the use of, of a syringe driver and I, well I, and I can't remember whether that was, cos we did have a problem with a patient and controlled pain who was in the Q.A and it was becoming apparent to me that, and I think this was just after the Code A stuff started coming to attention and so I thought as Code A Code A it was appropriate that we actually develop a policy for the management, well you know diamorphine given by subcutaneous infusion and that we had appropriate documentation to sustain that. So I think it was in the light of the Code A case and then what happened sort of nationally with Code A That's my recollection now.

Code A Was there anything in particular, local that, well you're saying it was Code A ..

Code A Well as I say this is the Code A

Code A ... but was it something that, you're a Code A as in your role as Code A ?

Code A Yes.

Code A Yes, so it was obviously, that fell within one of your responsibilities did it?

Code A Yeah.

Code A Yeah and when you came down here you said one of the first things you did was instigate the appraisal system.

Code A Yes.

Code A Yeah because there wasn't one?

Code A Yes.

Code A Yeah and is this the same thing you've seen something else that could do with tidying up, if you like, or introducing?

Code A Yeah definitely I mean ...

Code A Yeah.

Code A ... I mean I just, nationally there was increasing concern about it and as I said there's the Code A case

which had sort of, I mean I didn't ever see the Code A Code A records because there'd been a complaint which I didn't, I mean I didn't handle the complaint and then the relatives involved, you know the police and the records with you, after that time were with you but obviously I had picked up the sort of the gist of some of this that there was concern around the prescribing of diamorphine and therefore I felt that it was important that we develop policies and protocols for, so and, as a, I mean I don't recollect it being in relation to any specific incident in the War Memorial. The first time that I became aware of, was in relation to the Code A .

Code A Yeah.

Code A ... which I think she died in late Code A and then in the early part of 2000 I was asked to sort of deal with the that complaint and that was the sort of, that was the first time when I met Code A which would be I think March time 2000, that I saw the prescription that you know I had a bit of concern about.

Code A Your concerns concentrated on?

Code A It was the switch from Fentanyl to Diamorphine where I felt that, I mean I said in my earlier statement that, I felt that the dose, I, I'm a more cautious, I'm a cautious person, that it would've been more prudent to have given, I think it was 20 to 30 milligrams rather than the 40 milligrams which Code A had prescribed.

Code A So it was following, so this protocol was ...

Code A That protocol I started to develop before I had concerns about the prescribing of Diamorphine. I mean the first inkling, as I said, I got of that was with the Code A and Code A complaint which I dealt with and I think it was in March 2000.

Code A Yeah. Were there, because we're talking generic, you worked at QA.

Code A Yes.

Code A As well as Gosport?

Code A Yes.

Code A And you were Code A so it was one of your roles, were there any other occasions within the Trust brought to your attention causing you concerns about the prescribing of Diamorphine?

Code A No.

Code A No.

Code A I mean there was an incident in QA which had, but that was more about the documentation of pain.

Code A Okay. So, so this protocol that was being developed …

Code A Yes.

Code A … was it in it's embryonic state?

Code A Yes.

Code A Was, as a result of events at Gosport War Memorial Hospital?

Code A Only in part.

Code A Yeah.

Code A Code A case and …

Code A Yeah.

Code A … the fact that you know nationally, you know the prescribing of Diamorphine was becoming you know, was having a profile …

Code A Yeah.

Code A … and so I felt it was important for the Trust to have policies, you know for its use and for the recording of its use.

Code A But as the Code A ..

Code A Yes.

Code A ... you weren't aware of any other problems within the Trust?

Code A No, no, no as I say other than the one in, the incident in QA.

Code A Which was a different type of incident?

Code A Different, yes.

Code A Documentation rather than ...

Code A Yeah documentation rather than ...

Code A ... yeah. Got anything you want to say Code A ?

Code A No thanks.

Code A No.

Code A Call it a day?

Code A Yeah. Doctor thank you very much for your time.

Code A ... okay.

Code A Have you got anything you want to add to what we've discussed?

Code A No I don't think so.

Code A Anything to sort of clarify or ...

Code A I mean I can't immediately think of anything.

Code A ... what about yourself Code A ?

Code A No that's fine thank you.

Code A Right well the time by my watch is, bang on again look, 1600 and we're turning the machine off. We're going to just do a notice explaining what will happen to the tapes and hand that over to you okay?