FFW/3085

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR Code A

Code A

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

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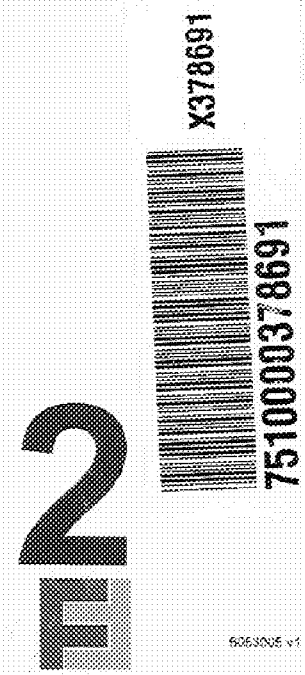
DR Code A

Code A



GENERAL MEDICAL COUNCIL

DR Code A

Index to Code A Files

File 1

1. Medical Report prepared by Professor Code A dated 12 December 2001.

2. Medical Report prepared by Professor Code A dated 10 July 2001.

3. Statement of Dr Code A

File 2

4. Witness Statements given to Hampshire Constabulary.

   (a) Code A dated 21 November 2002 at 11:21.

   (b) Code A dated 21 November 2002 at 12:13.

   (c) Code A dated 27 April 1999.

   (d) Code A dated 17 November 1999 at 11:45.

   (e) Code A dated 17 November 1999 at 12:46.

   (f) Code A dated 6 March 2000.

   (g) Code A dated 6 March 2000.

   (h) Code A dated 24 July 2000 at 11:00.

   (i) Code A dated 24 July 2000 at 12:14.

   (j) Code A dated 24 July 2000 at 14:12.

   (k) Code A dated 24 July 2000 at 14:58.

   (l) Code A dated 24 July 2000 at 15:52.

(m) Code A dated 6 June 2000.

(n) Code A dated 19 June 2000 at 11:17.

(o) Code A dated 19 June 2000 at 12:07.

(p) Code A dated 25 July 2000 at 11:10.

(q) Code A dated 25 July 2000 at 11:59.

(r) Code A dated 1 June 2000 at 15:02.

(s) Code A dated 20 June 2000 at 14:14.

(t) Code A dated 29 June 2000 at 10:26.

(u) Code A dated 29 June 2000 at 11:17.

(v) Code A dated 28 June 2000 at 10:19.

File 3

(w) Code A dated 10 July 2000 at 11:06.

(x) Code A dated 10 July 2000 at 11:54.

(y) Code A dated 20 June 2000 at 10:39.

(z) Code A dated 3 July 2000 at 10:55.

(aa) Code A dated 19 June 2000 at 14:40.

(bb) Code A dated 26 June 2000 at 18:05.

(cc) Code A dated 5 July 2000 at 11:00.

(dd) Code A dated 27 September 2000 at 14:14.

(ee) Code A dated 27 September 2000 at 15:19.

(ff) Code A dated 24 July 2005.

(gg) Code A dated 10 August 2005.

(hh) Code A dated 11 August 2004.

(ii) Code A dated 17 July 2003.

(jj) Code A dated 31 July 2000.

(kk) Code A dated July 2000.

(ll) Code A dated 7 August 2000.

(mm) Code A dated July 2000.

(nn) Code A dated 2 August 2000.

(oo) Code A dated 7 July 2000.

(pp) Code A dated 28 June 2000.

(qq) Code A dated 24 May 2000.

(rr) Code A dated 7 June 2000.

(ss) Code A dated 27 January 2000.

(tt) Code A dated 26 May 2000.

(uu) Code A dated 25 February 2000.

(vv) Code A dated 31 January 2000.

(ww) Code A dated 11 August 2004.

A

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y23

Enter type: ROTI
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: Fareham Police Station

Date of interview: 21/11/2002

Time commenced: 1121 Time concluded: 1206

Duration of interview: 45 minutes Tape reference nos. (◆)

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

Other persons present: Code A, Solicitor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(◆)	Person speaking	Text

DC Code A This interview is being tape recorded. I am DC Code A Code A of Hampshire Police serving at Hulse Road. The other Police Officer present is...

DC Code A DC Code A

DC Code A I'm interviewing, Code A could you please give your full name and date of birth.

Code A My name is Code A date of birth Code A

DC Code A And also present is...

SOLICITOR Code A Solicitor from White and Bell Co.

DC Code A Thank you. No other person is present. The date is the 21st of November in the year 2002. The time by my watch is now 11:21 hours. This interview is being conducted in the interview room at Fareham Police Station. At the

conclusion of the interview I will give you a notice explains what happens to the tapes. And I must remind you that you are still entitled to free legal advice. Code A Code A, obviously you've had a chance to talk to Code A already, that simply means two things. If you wish to consult with him further, you can do so, either in private with myself and my colleague out of the room, or you can ask him questions whilst the tapes are running.

Code A Thank you.

DC Code A Entirely a matter for you. I must remind you that you are not under arrest, you're free to leave the interview at any time that you so wish, you're here voluntarily, if you don't wish to remain here, simply inform us and we'll escort you from the Police Station. Alright?

Code A Yes, thank you.

DC Code A I do have to caution you that you do not have to say anything, but it may harm your defence if you do not mention when questioned something which you later rely on in Court. Anything you do say may be given in evidence. Do you understand the caution?

Code A I do.

DC Code A You're obviously an intelligent chap, could you just give me your understanding of that.

Code A My understanding is I don't have to say anything and, but anything I do say, um, obviously will be used in evidence against me. If I don't say anything now but say something later on in evidence, eh, then...

DC Code A That's, the case will be.

Code A ..you know (inaudible). Yeah.

DC Code A And if the matter went to Court...

Code A Yep.

DC Code A ..this can be put before a Court.

Code A Yep, sure. Right, sure, sure.

DC Code A Okay. I must also inform you that the, the interview room can be remotely monitored. This interview room is capable of being monitored when the

tape recorders in record mode only and with the tape running. So that means if you do consult privately we can't listen to any private conversations, that would be considered a legal privilege.

Code A Okay.

DC Code A A warning light will indicate when monitoring is taking place. As you can see that red light is lit which means that there are colleagues listening to this interview. It's a tape recorded interview, I know you've never been interviewed before hand, you're very, very close to the microphone, you're clearly spoken, that makes our job very much easy, and as you continue in that vein I'll be very grateful.

Code A Okay, I'll try.

DC Code A Thanks very much. Can I confirm Code A that you've had disclosure? You've had a copy of an exhibit Code A which is a twenty eight page document which you have signed for.

SOLICITOR I have.

DC Code A Excellent. You've had time to consider that document with your client.

SOLICITOR I have.

DC Code A And you don't need any further time, and you're happy for the interview to proceed?

SOLICITOR At this stage, yes.

DC Code A Thank you Code A. What I'd like to ask you, Code A is to give me a little bit of background about yourself, but firstly do you understand why you're at the Police Station and why you're giving this interview today?

Code A I un, my understanding is it's in relation to the eh, the events at Gosport War Memorial, over, over a number of years. And, eh, I'm the Chief Executive of Fareham and Gosport Primary Care Trust and obviously want to help with the investigation.

DC Code A Thanks very much indeed. I've never met you before and I think it would be helpful if we just go back over some of your personal history and

your...

Code A Right.

DC Code A ...experiences to date within the National Health Service.

Code A Okay.

DC Code A So really over to you Code A, can you tell me a bit about your involvement in the National Health Service from when you started and...

Code A Yes.

DC Code A ...the roles that you've undertaken?

Code A Okay. I joined the National Health Service in 1981 , eh, twenty one years ago as a, eh, a graduate Finance Trainee working for what was then the Wessex Regional Health Authority, eh, which is a, and, and the training scheme is a four year training scheme, um, which basically enables me to obtain an accounting qualification but also gain experience of working within the NHS. During the majority of that time I was, eh, based in Portsmouth at, um, Portsmouth and South East Hampshire Health Authority working in the Finance Department, and I had a variety of roles within that. Um, I was in Portsmouth undertaking that role until 19, the end of 1980, I've got to get my dates right now, 1984, eh, when I moved to West Glamorgan Health Authority in Swansea, started there in 1985 as a, again as an Accountant within, eh, within West Glamorgan Health Authority. I moved back to Portsmouth Health Authority in the November of 1985 to undertake a finance role within the Health Authority, and I stayed at the Health Authority undertaking a variety of financial roles, u, until 1989, and in 1989 I moved to work at St Mary's Hospital in Portsmouth as, what was called then, a Unit Accountant. Eh, so my main responsibility there was ensuring that the finances of the Hospital were, eh, run, eh, in the correct way, and we, that we achieved all our financial targets, obviously within that remit I would have worked closely with, um, clinical colleagues, Doctors, Nurses, etc. but it was ma, it, it was exclusively a, a finance role. Eh, in 1990, um, I moved to what was known as Portsmouth Community Unit, it was a directly managed unit, part of the Health Authority, again as the role of, eh, of Finance Director for the Community Unit . And the Community Unit was responsible for providing, um, a variety of services for the

local population, um, elderly services, mental health services for ad, adults and elderly, learning disability services, eh, community services including Community Hospitals of which Gosport was, eh, was, was one. Um, and remained with, eh, the Community Unit as part of the Health Authority until, eh, 1994, and in 1994 that organisation became an NHS Trust. Eh, because in the early '90's, you know, Conservatives were, were introducing this Internal Market concept into the NHS of Purchasers and Providers, and, eh, what was Portsmouth Community Unit became Portsmouth Health, Portsmouth Health Care NHS Trust in 1994, eh, April, and I was appointed Finance Director, eh, in 1994. That was a free standing organisation, eh, I was a Board member and still a, a very, sort of a, a finance (inaudible), I was the Finance Director responsible for insuring we had financial planning, financial systems, we paid our bills on time, we had budgetary control systems, we dealt with external, internal audits, um, probity function, etc. So I started that role in 1994 and I remained with Portsmouth Healthcare Trust until February 2002, um, in a, in, I think it was March 2001 I became the Operational Director when the previous Operational Director move on, moved on to a new job, eh, I became the Operational Director in March 2001, eh, but left that organisation in February 2002 when I was appointed as the Chief Executive of Fareham and Gosport Primary Care Trust which was a, again another, a new organis, there's a lot of changes happening in the NHS over this period. Eh, and that organisation came formally into being in April 2002, but I was appointed ahead, ahead of that. And, and I've been Chief Executive of that organisation from then. Primarily responsible for setting that organisation up, working with the Chair of that organisation. Um, and I've been in that position, eh, since, since then.

DC Code A Okay. Thank you very much for that. That's very complete. From what, from what you're saying, clearly, you're very much a finance...

Code A Yep.

DC Code A ...an accountancy background.

Code A Yep.

DC Code A Are you Chartered or Certified Accountant?

Code A Um, I'm a member of CIFA, it's the eh, the Chartered Institute of

Public Finance and Accountancy.

DC Code A Right.

Code A So it's a, it's a public finance...

DC Code A It's a public finance...

Code A ...Council qualification.

DC Code A ..as apposed to a..

Code A Yep.

DC Code A Yep. Okay. You've obviously risen up through the Health Service, through that particular...

Code A Yep.

DC Code A ..line.

Code A Yeah.

DC Code A To the position that you hold a the moment.

Code A Yeah.

DC Code A And the majority of what you've said has, has all been finance based really, hasn't it?

Code A It has been finance based, there have been other el, elements that I, I began to get into. Um, when I was a Portsmouth Health Care Trust the, the Chief Exec wanted us to all have a, a broad range of experience.

DC Code A Yes.

Code A Yes, we all had our specific, you know, key um, key role including mine was, was finance. But over a number of years I, I did develop interests in, eh, in other areas. Um, a large one was in 1998, excuse me. I was asked to take on the lead role for Learning Disability Services and eh, spent a lot of time working with the Learning Disability Service Teams, working with Social Services in Hampshire and the City, developing a, a strategy for Learning Disability Services, helping the Trust to develop it's Social Care arm, and I ha, and again I held that sort of, um, sort of personal role port, portfolio supporting that service, from about 1998 'til about 2001. Eh, that was the one, eh, I was, acted as a Children's Services Manager in about, fairly early on in that period, about 1991, '92, I held, I helped out on information, eh, IT

management. Eh, I also was very interested in risk management and helped develop some of the clinical governance and risk management processes within, within the, eh, within Portsmouth Healthcare Trust, and from about, I can't remember the exact date, but it would have been about 1997, or 1998, um, chaired the Risk Management Group of the Trust, which is primarily looking at non-clinical risks, health and safety, it was something called control assurance which was a national initiative, that was um, issued in about 1998, and the aim of that, um, and we were one of the first NHS Trusts in the country to, to be proactive around risk management, and, um, so it, it would look at, um, and some of the issues that we looked at were how we dealt with manual handling, eh, to try and prevent the, the whole aim of it was to try and identify the risk the organisation was facing, um, and then identify ways in which those risks could be minimised and, as a Finance Director I had an interest in that because they usually want required extra resourcing as well, and I would be the one who would try and make that money available, so I could remember we did things around manual handling to prevent back injuries to Nurses, we did something about, eh, CPR, Coronary, eh, Pulmonary Resuscitation, so again, eh, training for, for Staff around that. Um, were two of the things that we did, so, I chaired that group from about 1998 although it had been in, in existence since about 1994. Um, I also, because of, I also, I'm obviously in audit as well, eh, and because of my knowledge of that, I was asked in the early days of clinical governance which I wasn't responsible for leading, that the Chief Executive and our Medical Director, to help give some thought about how, from a, an audit systems perspective, clinical governance could be established within the, eh, within the Trust. But again I wasn't de, involved in, sort of, delivering it, I was just, you know, sort of instrumental in some of the early thinking around that.

DC Code A Just that saying you've touched on there is clinical governance.

Code A Yeah.

DC Code A when did that, when were the early days of, that got established.

Code A The c, the er, the, as a, as a, as a concept, as a title...

DC Code A Yeah.

Code A ...clinical governance emerged in about nine, the end of 1997, '98, 1998. It was all in the new, eh, the many new initiatives of the new incoming Labour Government in, in 1997. and the aim of the concept was to focus on improving, um, the quality of the service that the patient experiences, eh, and again the, the way we dealt with that as a Trust was to see that as a, as a cultural issue that we wanted to engage as many Staff as we possibly could with this, with this idea. So we had a number of workshops, um, and we set up, or the organisation set up, a Clinical Governance Group which I wasn't on and that was accountable to the Board for how clinical governance was delivered, but that Board consisted of the Chief Executive, the Medical Director, the Nursing Director and our, and the Quality Manager, and I think one or two other people were on that group, but I, I wasn't. um, but there was also a Clinical Governance Reference Group, eh, which was a, a much broader, eh, range of individuals within the organisation. Eh, and again that was to try and gain broader ownership, broader understanding of the, eh, of the concept. Eh, but it was, clinical governance is all around, you know, en, ensuring the, eh, the highest quality of, eh, um, care is provided to individuals, and that's undertaken by having standards, um, making auditing compliant with those standards and then taking any corrective action, eh, nec, if necessary to improve the quality.

DC Code A Was, you said clinical governance, (pre???) '97, I think, was when the Labour Government came in.

Code A That was the, yep.

DC Code A Was that....a title that was given to that particular...

Code A Yeah. The...

DC Code A Was it something that was happening before hand, or....?

Code A I would argue, it was, but not in the, not in the systematic way.

DC Code A Not in a structured way.

Code A Yeah, that...

DC Code A Yeah.

Code A ...that, if, if you like, clinical governance gave a, cor, the, the concept

of it gave it, you know, gave it credibility, gave it credence...

DC Code A Sure.

Code A ...and gave it a framework within, audit was happening already, standards were being set already, um, you know, quality was, was an issue, um, but clinical governance, the concept, pulled all that together. Um, but, I suppose as well, I think it would be fair to say, in the early '90's, certainly when the creation of the, the previous government before that, the internal NHS market, the focus really was about competition, um, and trying to create, you know, au, this p, push the Providers, split, Providers competing with each other for, for business, this concept of a market, um, and clearly what was important then, well, probably wasn't the, the quality dimension as much, the focus was very much on the money side of it, and the patient activity, the patient throughput, the number of patients that were being treated, and I know in the early '90's and mid '90's that the real, the real anxiety amongst Clinicians, around this whole, what was known as The Contracting Process, was that the emphasis was on the money and on the activity, and the quality side, um, you know, what, there wasn't as much emphasis being put to that.

DC Code A It's poor cousin.

Code A Yeah.

DC Code A Yeah.

Code A So when the concept of Clinical Governance was introduced, I think the, the Clinicians, you know, really breathed a sigh of relief and were very positive and welcoming of that, because it, you know, it was seen as a counter balance to, you know, to the money and the, eh, and the patient activity side. But...(inaudible)

DC Code A Sorry, if you continue.

Code A Well, I, I was saying I think there were elements of Clinical Governance already happening, well, within, within, within the NHS, but it certainly wasn't as well developed...

DC Code A Yeah.

Code A Eh, and it certainly wasn't the sort of, um, the framework that was, that, that was introduced, eh, and the accountability for Clinical Governance, and that was

probably one of the keys as well, because up until, because with, with Clinical Governance came the, the concept that the Chief Executive being accountable for the qu, the, the clinical quality of what went on in, in an organisation. Prior to that, Clinical Governance had, had been, eh, a personal, professional issue, so if you were a Doctor, you know, you had your oath and you had your own standards, and that in, in effect defined what your Clinical Governance arrangements were, if you were a Nurse, similarly, but what Clinical Governance introduced was this concept that the Chief Executive of an organisation, as well as being accountable for the money...

DC Code A Sure.

Code A ...he was accountable for everything that went on, and that included the patient quality.

DC Code A The clinical care.

Code A Yeah, the clinical care.

DC Code A So, very much a more top to bottom...

Code A Yep.

DC Code A ..involvement of all staff...

Code A Yep.

DC Code A ..in clinical care.

Code A Yeah. Yeah. And that's what we want. We'd already generated within Portsmouth Healthcare Trust, the, the organisation already had this very bottom up approach.

DC Code A Yeah.

Code A The organisation was structured in six, six operating divisions, eh, three of those were geographically located, eh, one for Fareham and Gosport, one in the North of the district, up in Havant and Petersfield, and one in, um, in the City, and then there was service based, um, divisions as well, but the emphasis all the time was to get decision making ownership of issues devolved as low within the organisation as we possibly could, along with accountability. Eh, so again, so again, when, when clinical governance came, this concept of, you know, we, we already had a lot of the, the processes in place for, for engaging front line staff, and this was just a, you know,

a really helpful way of reinforcing some of that.

DC Code A Sometimes we do things and someone else comes along with a label for them, and...

Code A Yeah.

DC Code A Yeah.

Code A And (inaudible) that's new.

DC Code A We've all seen that.

Code A Yep, yeah.

DC Code A But going back to that, when, when do you feel that that was really coming in, those, that bottom up approach that was taken by the Health Authority?

Code A Well, I wouldn't, I wouldn't say it was set in by the Health Authority, I think it's impor, it is important to distinguish there are, sort of, almost three phases to this. There's the, the phase up until, up until 1994, um, the c, the Community Unit as, as it was known then, was part of the Health Authority, and was not a separate organisation...

DC Code A No.

Code A ...and didn't have it's own Board meetings in public, etc. etc. The, that, that was the remit of the Health Authority, they were the accountable legal Health, Local Health Organisation, and the Community Unit was a, a directly managed part of that. We had certain freedoms, um, but u, ultimately we were accountable and part of the, the Health Authority. But in that time, we, I think we tried, very early on to, to sort of try and get some of that. I suppose the, the real devolution down to the bottom really began when Portsmouth Healthcare Trust was created and we had these, you know, we set up our, our values the way, the way we wanted to do business, you know, the people matter, pounds matter, partnerships matter and performance matters, and our aim again was, was to try and embrace that and we, we got everybody signed up to those values. Um, and we, we genuinely wanted to be a bottom up organisation and have Staff opinion surveys to check that out, we would devolve resources, budgets were budgets were devolved down to Ward level, um, with, with training

given, my Finance Team, each division had their own Finance Team, their own Personnel Team, so, you know, we, we tried to, to run, this is what is called a Holding Company concept, that the, in actual Headquarters bit, um, you know, someone, in effect, came up with some, you know, some standards I suppose, but the actual Divisions themselves, eh, were the, were the, were the key driving force of the organisation. And clearly, you know, sort of NHS is always difficult because you've always got top down requirements as well.

DC Code A Right.

Code A Uh, but what we tried to, tried to do was to try and make sure those, those top down elements were, you know, keyed into the bottom up. Eh, it certainly wasn't a, a rigid hierarchical organisation, it was something (inaudible), I think technically it was a matrix organisation where you try and get all different parts of the NHS working with each other, eh, both within Portsmouth Healthcare and outside, because we, we realised we couldn't do our job without working with the GP's who were outside, without working with Social Services, without working with the Police, (inaudible), Mental Health issues, you normally had to work closely with the um, with the, with the Police, so w, we always tried to have, you know...

DC Code A A multi agency approach.

Code A ...a multi agency approach...

DC Code A Yeah.

Code A ...to, to what we did, and to engage as many people as we possibly could. And I think that came across in the, eh, in the CHI??? Report that was, that was published. Eh, some of the comments that are made in there, around the leadership style and around the, eh, the, the inclusiveness of that, I think, were, were quite positive.

DC Code A Okay, thank you for that. Were the other roles that you have described, you had, including Clinical Governance...

Code A Yep.

DC Code A .and the Learning Disability (inaudible).

Code A Yes.

DC Code A These were all done in conjunction with your, dare I say, you main...

Code A Oh, yeah, yeah, yeah.

DC Code A ..area of professionalism, which is accountancy.

Code A Yeah. I carried on, I carried on being the, being the Finance Director until I became the Operational Director and I was very fortunate to have a good and able Deputy.

DC Code A Right.

Code A And, and the financial situation was stable, eh, so that enabled me and the organisation to, to, to do different things but, but it was also part of the culture of the Code A that he wanted people to, to develop, I'd always wanted to be a Code A Code A of an organisation as well, and realised that, you know, it would be a, a difficult step to make from a pure Finance Director into that, so, for my own career development I sought some of these opportunities, as well, eh, so I could, when I, you know, when, when, when the time came to apply for Code A I wasn't just a Finance....

DC Code A Finance.

Code A ...person, I had, you know, a, a portfolio of other non-finance experience, alongside that.

DC Code A So you, I mean you're going back to 1981 I think it was you started.

Code A Yep, '81, September, '81, yeah.

DC Code A You've, was that your first job?

Code A Yep, I left Uni, I was, I daren't say this, I'm in Fareham not Portsmouth, I went to University in Southampton.

DC Code A Right.

Code A Eh, and lived there for three or four years, eh, yeah, and it was my first, first, I'd had summer jobs when I was a student, but, eh, this was my first...

DC Code A So you've always been involved in the Health...

Code A Always, I've always worked in the NHS, I've never worked for

anybody else.

DC Code A In the NHS. Okay. Just to really sort of build on everything you've said already, um, do you have any, what medical knowledge do you have or understanding?

Code A I, I'm not a Doctor.

DC Code A No.

Code A mean I don't have any detailed medical, eh, medical knowledge, eh, I was married to a Nurse for a while, so I, I, I gleaned a little bit from that but, no, I, eh, and within our organisation, although we were, we're all encouraged to have a broad awareness of issues, um, certainly for medical and nursing advice, uh, there was a medical, a Medical Director and a Nursing Director on, on the Board and, and they were the people to whom, um, if there were, there were details and iss, issues around that, that we would turn to.

DC Code A Would, would it be fair to say then, that the, the key roles that you undertook were finance...

Code A Yep.

DC Code A ...administration, management...

Code A Yep.

DC Code A ..you put those under two.

Code A Yep, yep.

DC Code A And, and some development.

Code A Yeah, and other, I, I will classify them as sort of general management opportunities, I, I, I worked, you know, supporting, um, in a strategic way working with Learning Disability Services, facilitating, you know, I suppose my role was a bit of a, sort of, Internal Management Consultant, was the role I adopted.

DC Code A Right.

Code A And if it would just be, you know, different areas that I would then get involved with.

DC Code A But anything clinical...

Code A No.

DC Code A ..obviously you'd, you'd take advice.

Code A Yep, yep.

DC Code A Or, there'd, it'd, (inaudible) as someone else's responsibility

Code A Yes, yes.

DC Code A Okay? Code A is there anything that you wanted to ask Mr Code A

DC Code A No, covered everything.

DC Code A No. thank you very much for that. You're obviously here today, you've seen the documentation that has been...

Code A Yeah.

DC Code A ...passed to Mr Code A

Code A Yep.

DC Code A And if you look at the very first page, there is a letter from yourself...

Code A Yep.

DC Code A ..dated the 17th of September 2002.

Code A Yes.

DC Code A And that relates to these papers that are contained within this bundle.

Code A Yep, yep.

DC Code A Going back to 1991.

Code A One. Yep.

DC Code A Can I ask you when you first saw these papers?

Code A I first saw these papers the day before. It would have been the afternoon, it would have been the afternoon of the 16th of September, sometime after between 3.30 and 4 o'clock. I just, you know, I remember it well because I just, eh, finished, eh, an interview with Meridian TV of, at the Fareham and Gosport Offices, and, eh, walked back up to my office and was handed the file then by Code A who was the Director of Personnel at the Primary Care Trust and she'd received them

that afternoon, eh, we'd been having a, a regular, sort of, series of Staff meetings at Gosport Hospital, and obviously to support the Staff through what has been a very, very difficult, eh, time. Eh, and my understanding was that that file was, was handed over, (and???) whether it was directly to Code A but Code A ended up with the file, eh, and she passed it on to me round about 3.30, 4 o'clock on the previous Monday the 16th of September.

DC Code A Did you retain a copy of that for yourself?

Code A I have got a copy of it, sure. Yes.

DC Code A (inaudible) obviously Code A .

Code A Yep.

DC Code A ..was very brief with it, so I, I, thought you'd probably...

Code A Yeah, yeah I do have a copy of that, yeah.

DC Code A ..have read it through. First impressions, really, when you read it through?

Code A When I read it, um, as I said, it, it, um, I'd never, ever seen this information before. Eh, so I read it through, um, sort of quickly just to, eh, ascertain the facts. Eh, I was surprised, eh, because again I, this was a, I'd never ever, um, was aware that this, these were raised in, back in 1991, I had never ever seen any, any of the, eh, any of the papers. I ne, never ever had a conversation with anybody, um, in relation to the contents of this, eh, of this, of this report. So I was shocked, eh, surprised, um, when I first read it. Eh, my reaction then was to, because obviously there are individuals who are named in here, some of the names I recognised. Eh, so, I, I, I qu, I quite naturally, I think, made contact with two or three of those people to say, look, you know, I've just received this information, eh, you know, does it, does it ring any bells with you, it rang no bells with me at all, I'd never ever seen this before. I immediately contacted (inaudible) Code A at the Health Authority, eh, to inform him of its existence. Um, the Chair, Code A , was, was already at the PCT officers, so she was already aware of it. Ah, and then we had a, sort of a, a bit of a meeting around before, um, try and decide what we actually did. Obviously contacted the Health Authority...

DC Code A Sure.

Code A ...and I've got, again there was a, I've got a note somewhere of a, of a meeting that we had that, that, that afternoon. Eh, and then I made sure that, eh, a copy of this was with Code A , eh, 9 o'clock the next morning my Director of Public Health, Code A hand delivered it to the Health Authority offices, eh, and before it went I had spoken with Code A and, eh, that's were Code A and I put the letter together, eh, and I was very, I was concerned to make sure that the information got to the people who needed to have it, and I think the letter...

DC Code A Yes. I think that's...

Code A ...tried to demonstrate, you know, that clearly, I think what we were saying was this now needs to, to get out. It's clearly a, another piece in a, in a big jigsaw, and eh, I wanted to make sure that it got to the appropriate people as soon as possible.

DC Code A Okay. You were aware of the previous Police investigation.

Code A I was aware that there had been previous Police investigations. I wasn't involved...

DC Code A No.

Code A ...in any of them. I wasn't interviewed, yes, I was aware that, eh, previous Police investigations, eh, well two had been undertaken within, in relation to Code A um, Code A

DC Code A That's right.

Code A And obviously the, the four preliminary inquiries, if I remember the terminology, in relation to the, the other four families.

DC Code A That's right. You were never contacted, it's a matter of record that you were never spoken to...

Code A Nope, no.

DC Code A ..by the Police.

Code A No.

DC Code A And from what you have said, you would not have been aware

of this documentation.

Code A I was, this, this was, I, I'd never ever seen this documentation before until I saw it on the 16th of September.

DC Code A Okay. Now, when you, you spoke that you recognised the names that were contained...

Code A Yep.

DC Code A ..in the documentation, you contacted them...

Code A Yep.

DC Code A ..to ascertain if they had any knowledge...

Code A If it rang any bells with them.

DC Code A And who were the people that you spoke with?

Code A I spoke with three people. Um, I spoke with Code A , um, Chief Executive of East Hampshire Primary Care Trust. I spoke with Code A who was the, um, the previous Chief Executive of, um, Portsmouth Health Care Trust, and I spoke to Code A , who was the, back in 1991 and until 1999, was the Divisional General Manager for Fareham and Gosport Services whose, within whose remit Gosport War Memorial Hospital was. I spoke to all those three, um, well, I think I spoke to certainly, certainly the first two, I spoke to that afternoon, and I contacted Code A in that evening and he came in to see the file the next day on the Tuesday morning, he came into work because he's, he's re, he's retired. He came in just to see if by reading, 'cause ob, if by reading it, because when I spoke to him about it on the Monday evening, he could remember anything about it, and, but he said he would come in and read it, just to see if it jogged his memory, and, from what I can remember, it was a while ago now, I don't think it could, and again Code A and Code A initial reactions were, eh, they couldn't remember anything either. But eh...

DC Code A Code A is your opposite number in East Hampshire isn't he?

Code A Yes, yes, yes.

DC Code A It makes mention of numerous Clin, Clinicians, I think is the expression you use.

Code A Yes.

DC Code A And that's Medical Staff...

Code A Yes.

DC Code A ...across the board.

Code A Medical Nursing Staff, yeah.

DC Code A Yeah. Did you know many of the people that were mentioned within in that?

Code A Um, I'm, trying to think. Obviously Doctor Code A, eh, who I'm, I'm, I've, eh, I'm aware of, eh, eh, Doctor Code A who's name is mentioned in there, who I, who I, who I know, but I don't think I've actually, I, I haven't met. Um, and I think that was about it. I think I, I might need to refresh my memory.

DC Code A Of course.

Code A Um, some of the nursing names ring a bell, but I, I don't know, I have, I've never, I've never met them. Um, but certainly Doctor Code A, Doctor Code A Code A who's mentioned.

DC Code A Yeah.

Code A When he, Code A was working on (inaudible), I, I, I worked with Code A um, because in the late 90's we appointed Code A to be, um, a Governance Ma, Cli, or a Governance Cli, or a Governance Manager, um, and my work with Code A in that, in that area, in my role of eh, you know, with my interest in risk...

DC Code A Yes, in risk assessment management. Yeah.

Code A Yeah, yeah. So it was Code A used to undertake clinical risk assessment, he's a Nurse by background again...

DC Code A Yep.

Code A ...so he, he was somebody who I knew, um, lets go back I never, Code A Code A I never knew, Code A I think his names in here, I, he wasn't, not a, who's, but he was the, he was the General Manager. Um, Code A I, I never knew, Doctor Code A I knew, eh, Dr Code A yeah, Code A mentioned in that letter. And obviously Code A who, he was the Divisional General Manager, District General Manager for the Health Authority, um, 'till he died, eh,

(and obviously??) Code A , and RCN Officer Code A who's RCN Officer (inaudible). Um, but in terms of the, of, of, of the Clinicians, yes, certainly Doctor Code A and Doctor Code A Eh, the names are familiar.

DC Code A Putting aside that particular documentation, it raises some issues, I think everyone would agree with that. And very, very in a nutshell, what do you see those issues as, that have been raised?

Code A I think the issues that were raised, clearly, back in 1991, um, some, some of the staff, um, at a Ward which was to, was to transfer into Gosport War Memorial, were raising um, concerns around, not the, not, not the totality of the prescribing of eh, of diamorphine, and they weren't, from, again, from, from what I can remember about the documentation they weren't, sort of, eh, challenging some of the, eh, the clinical, eh, judgements, eh, nec, necessarily, uh but there were clearly some concerns around the, um, the prescription and administration of diamorphine, um, and those concerns were raised, um, and a series of meetings were held, I think it, two of which are minuted. Eh, additional training was provided, I believe, to some of the, eh, some of them are qualified Nursing Staff, I mean, that's were Code A came in. meetings were held with Doctor Code A um, the person in charge of the Hospital, and, um, it appears, although the final letter does leave it a bit up in the air, it appears that, um, you know, some sort of resolution was, was reached, training was provided, Doctor Code A went through, in general terms, because no specific names, apparently, were provided at any of, at the meeting, um, that the, the issues had been addressed and Doctor Code A sort of, tried, I think tried to explain how, um, how the prescribing of Diamorphine maybe in cases were people are not in obvious pain, might be, eh, might be necessary. And if there were any issues, um, that they would, eh, you know, contact Doctor Code A or contact, um, I can't remember, is it Sister Code A eh, and if they had concerns, to contact him.

DC Code A Yeah, I mean, that's, that's it really.

Code A And, and...

DC Code A You summed it up quite well. It's, it's concerns about the use of Diamorphine, and although it's not contained within that, use of syringe drivers.

Code A Right. Yep.

DC Code A And other devices, and...

Code A Yeah, and clearly when I saw that, that they were the, you know, obviously I've got enough knowledge of what was happening there.

DC Code A Sure.

Code A In terms of the Police enquiry and the Commission of Health Improvement investigation, that clearly those were the, eh, the issues that, eh, led to the, the Police investigation, the, eh, preliminary enquiries, and the Commission for Health Improvement reveal, I think that's for me why, although it rang, it rang bells to make sure this got to the right people...

DC Code A Yeah.

Code A ...I'd never, you know, I was unaware of that documentation, I was unaware of, of any of these concerns, um, p, obviously prior to, prior to 1998.

DC Code A Okay.

Unknown (inaudible)

DC Code A The documentation sets out a series of concerns. When were you first involved with the Gosport War Memorial Hospital?

Code A In terms of?

DC Code A Management or finance.

Code A Well, as I said the Gosport War Memorial Hospital was part of the, um, Community Unit that was created in 1991...

DC Code A Yes.

Code A ..into part of the remit...

DC Code A Yes.

Code A ...of that organisation. I suppose I first got involved, um, back in, in the early 1990's when the new Hospital was being developed, um, new Hospital finally commissioned and built and it opened in 1994, eh, and I was heavily involved in the financial consequences, eh, of that, of, of the, of that development. There were services transferring from Knowle Hospital, eh, my Finance Manager for Gosport was involved in all the detail, but I was involved in making sure the Health Authority gave

us all the additional resources that we would need to, to run the Hospital, but, so that, I, I got involved with, (inaudible) the first time I'd sort of visited Gosport War Memorial would have, would have been around that time.

DC Code A So, it's clear you went through a very detailed CV, so it's clear in my mind, you, you were purely involved in the finance...

Code A Yeah.

DC Code A ...side of the Gosport War Memorial...

Code A Yeah.

DC Code A ....Hospital.

Code A Yes.

DC Code A Up to about 1994.

Code A Yeah, '94, and ev, even beyond that. I, I was the Finance Director of the Community...

DC Code A So...

Code A ...Trust, and, and again...

DC Code A I'm assuming that there would be no, it wouldn't, it wouldn't be normal for you to be told about any clinical concerns.

Code A Not, not in, not in great detail, no. Eh, no, it, it wouldn't be. I mean we had the, we had a process, we had a review process, one of the ways we sort of managed the organisation was to have a quarterly divisional review process. Um, and that basically meant, I think, myself, a Personnel Director, Operational Director and somebody from the Nursing or, or, or Quality from the Trust Headquarters, having a review of, of the issues, um, the financial issues, the patient ser, service issues etc. with each of the division on a, on a month, on a quarterly basis. Um, and obviously one of those would have been with a Fareham and Gosport Division, and, eh, I, and we would, towards the end of that process, we would sort of look at, um, certainly towards the back end of the 1990's when this c, concept of Clinical Governance came in we reviewed the way we did that and we did look at complaints and we did look at, um, well, we, we looked at complaints and people would put reports around, um, I don't know, issues that they thought were, were relevant so I would come into contact

with, with clinical issues that people had raised from, from within the division, um, but I wouldn't get involved in, you know, I wasn't the trouble shooter if there was a, you know, a medical issue...

DC Code A Sure.

Code A ...you know, it wasn't me who would, who would be, who would be wheeled into that.

DC Code A Were those complaints, were they internal or external or both?

Code A Um, no the complaints would be any formal complaints that have come through the NHS complaints procedure. And again, as far as I can remember, and we used to have six, six divisions that, that we would review, Fareham and Gosport division, um, was always, eh, you know, managed very well, um, the levels of complaints were, were low, um, they were never that, you know, it wasn't as if they were, you know, a significant blip and large numbers of complaints about, about Gosport War Memorial or St Christophers. Um, those issues, you know, sort of never really, never really registered, and I'm saying the, over the last few days I've been thinking, you know, when did I first become aware of, of Gosport, and it would have been in the context of the op, opening of the new Hospital, and the divisional reviews never really threw, um, I can, you know, I c, I, I, it was a, it was a well run, it was a well managed, um, well managed division, eh, and I think (CHAMIN) again the (CHARMIN???) report from 1998 almost confirmed that, uh, with strong local, local, local management. Obviously, you know, once the 1998, '99 sort of, the three complaints...

DC Code A Yeah.

Code A ...you know, the one that led to the Police investigation, the one that went to the Health Service Ombudsman and the one that went through the NHS complaints process, to independent review. Um, you know, we, they were being monitored, um, and the action plans developed as a consequence of those, we're, we're monitored through the review process. Um, but at that time no connection, connection, sort of, wasn't, wasn't made, in hindsight, um, it should have been, I think

we were all, we were all new to all of this. eh, I think again was submitted in the, eh, in the, in the, in the (CHINA?????) report, but they were going down separate routes, the, you know, the Police, that, the actual Police report as a result of the, eh, of the Code A enquiry wasn't handed over to the Trust until February 2002. um, the Health Service Ombudsman review of, um, the, the case did not uphold the complaint and the independent review, you know, process that was, that was going through. Eh, I've learnt this in, you know, with hindsight....

DC Code A Sure.

Code A ...I wasn't involved in the time...

DC Code A Sure, sure.

Code A ..but obviously with my dealings with the media since April of 2001 in my role as Code A I've sort of got up to speed with some of this stuff. But I know that's what the, some of the thoughts that were, that were going on, and with the Police investigation I think we've all learnt, um, that, you know, a Police investigation shouldn't stop an internal investigation...

DC Code A No.

Code A ..and I think in that instance that's, that's what happened, and that wouldn't happen now if, if they there was a, a Police investigation now, the, eh, the, an internal investigation, we'd, we'd, we'd clearly carry on, there's been a lot of learning through, through this.

DC Code A They, they can run side by side.

Code A Yeah, yeah.

DC Code A Okay.

Code A Yeah.

DC Code A Now you became Code A in 1999?

Code A No, I became Code A of Fareham and Gosport Primary Care Trust in 2002.

DC Code A 2002, sorry.

Code A February 2002 I was appointed the Code A of Fareham and Gosport PCT.

DC Code A And is that when you started to inherit the issues from the Gosport War Memorial?

Code A I, I suppose I, I really got involved in, eh, April 2001. Um, I, I was appointed the Operational Director in March 2002 because Code A left to go to East Hampshire, and he had been previous Operational Director. And I commenced Operational Director role for the Health Care Trust in March 2001. Uh, in April 2001, that's when, um, the first media, eh, noises were being made, a lot of publicity in the Evening News in April 2001, through the, through the Code A eh, case. So I was, the Code A was away, so I dealt with the media stuff around that, and that's where I, sort of, first got involved and, you know, I discovered, started to talk to, to people just to, to get the background to all of this. Um, so I dealt with that, obviously in July 2001 and that's were I began to talk to the, eh, to the Police as well. Eh, in July 2001, I think that's when the Crown Prosecution Service decided not to, not to take that case further, eh, and I can't remember the gentleman who I was in, involved with at the time from the, from the Police, but, um, that's when, I know, he said that they were going to be taking four, because obviously there was a lot of public interest and more, more families had come forward. Eh, and in the July, um, that's when I, we dealt, worked, worked with the Police on that one in terms of the media, eh, and then got the request for the, the other four sets of notes, again I didn't deal with that, that was dealt with by Code A who's the Quality Manager for Portsmouth Healthcare Trust and Code A the Chief Executive. But again I dealt with the initial contact because I was the, I was the one who was around. Um, and again I, so that's where, my involvement was really around, sort of, the media handling side of it, and eh, and then in July wor, yeah, working, working with the Police, eh, on that, and then I, and then the CHI contact, I was again always, I just happened to be in the wrong place at that wrong time, you know, on that day Code A was out so I got their first telephone call saying that the Commission for Health Improvement were involved in that, so again I, I, I spoke with CHI on that. Um, but in terms of the preparation for CHI and had prepare, you know, all the media again, that was something that Code A, um, and Code A sort of led on,

so I was, you know, sort of dealing with the media stuff, but, eh...

DC Code A From, from that stage on.

Code A Yeah, from, from that stage on, so, and obviously, um, then got to the, um, the Chief Exec's job within, within Fareham and Gosport and was, was aware clearly that this issue was, was happening. I was interviewed by CHI in January 2002, uh, twice, uh, so I was aware the CHI report was, was, was coming out, was aware that the Police still haven't made up their mind on the four, the four cases that were outstanding at that point. Um, so was dealing with that. As soon as I became Code A one of the first things I did was to write to all the f, I, I was aware there were nine families involved at that stage, the four who had gone to the Police, the three, the, Code A , Code A , um, Code A and um, Code A Code A , Code A And there were two other cases which had bubbled up in, in, in February, so, yeah, I think in April, May time I wrote to all the families offering to meet with them and talk to them and discuss their issues and, and concerns as, as a new organisation, because...

DC Code A Sure.

Code A ...obviously nobody really knew, new organisation had, had new responsibilities, so I wanted to establish with our new Chair, Code A a sort of a, a relationship and rapport with, with the families because obviously there'd be no, know it had been a very, very distressing time for them, so we offered to meet all the families face to face, um, most of which we did. Eh, obviously we then had the CHI report in, in, eh, in July, and, was li, liasing with the Police around, actually, around the, the media briefings for that and obviously took, or took part in the media briefings and in the hyphen BBC Studios and all of that. So I've been invol, intimately involved with, eh, with it really since, eh, since then and obviously in August, um, liasing with the Police about the, eh, the decision to take, to send all the papers up to the CPS, then in early September getting a phone call from Sir Code A Code A , informing me about the, eh, in his, his request to get Professor Code A involved. Eh, dealing with the media associated with that, dealing with the Sunday Times article, eh. But all that was being managed, and um, I know I was

actually complemented by the Health Authority Chief Exec, Code A, eh, on the day we were actually temporarily transferred to, to other duties and that, I asked him, you know, is, is this because of the way the other things have been happening, and he said, no, you've handled the, eh, all the media and all the relationships very professionally and very competently, so, eh. The (wrong??) rambling story but, that, I've, I've had a lot of involvement, um, recently but my, my, my first real involvement would have been probably around the April 2001.

DC Code A April of last year.

Code A Yeah.

DC Code A Yes. So. You were obviously fully briefed with regard to the problems?

Code A When, sorry?

DC Code A That, that's what I want, want to know.

Code A Um, to be honest it was when, April 2001 was a bit of a baptism of fire. I was aware that, um, well, I, I was aware that there was a, there were, there was a, there was a Police investigation going on.

DC Code A Yeah.

Code A I wasn't aware that there'd been one previously, and this was, and this was the second. Um, so I, I had to do a bit of hunting, I, I cannot, I cannot remember, and this is a genuine honest answer, I cannot remember whether as a Board we had, I, I was there when this was discussed or I wasn't there and it had been discussed and I, I wasn't there, but I was aware through our Divisional Review Process and through, um, Code A who's the Quality person dealing with this and I live on opposite sides of, of a corridor, so...

DC Code A The buzzer just means the tapes can be changed. Just finish what you're saying and we'll stick some fresh tapes...

Code A Yeah. So, um, so I, I, I had a general awareness, but no detailed awareness and no detailed in, involvement really until April.

DC Code A Okay. I'll just turn the tapes off there, there's just a, a few more things we'd like to go through.

Code A Yep, okay.

DC Code A The time by my watch is now at 12:06 hours and I'm turning the tape recorder off.

[redacted]

B

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y23A

Enter type:
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: Fareham Police Station

Date of interview: 21/11/2002

Time commenced: 12:13 Time concluded: 12:22

Duration of interview: 9 minutes Tape reference nos. (→)

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

Other persons present: Code A Solicitor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(↵)	Person speaking	Text

DC Code A This is a recommencement of an interview with Code A Present are the same persons as before. The date is the 21st of November in the year 2002 and the time by my watch is now 13 minutes past 12. Code A can I ask you to confirm a couple of things. Firstly that you understand that you are still under caution, that is you do not have to say anything but it may harm you defence if you do not mention when questioned something which you later rely on in Court. Anything you do say may be given in evidence. Do you understand that?

Code A I do.

DC Code A Good. Can I also ask you to confirm that you've not been asked any questions in the break about the matters that have been discussed in the previous interview tape.

Code A I have not.

DC Code A You've been provided with a tea and a...

Code A I have.

DC Code A ...glass of water, and you're quite happy to continue?

Code A I am.

DC Code A Thank you. Code A anything you'd like to say?

SOLICITOR No, nothing thank you.

DC Code A Okay, Code A

DC Code A Yeah, fine.

DC Code A Great, thank's very much. We, we covered quite a lot in the, in the first interview, a fairly detailed curriculum vitae of yourself, your roles and responsibilities, not just of finance but the other areas that you'd covered...

Code A Yep, yes.

DC Code A ..whilst you'd been with the NHS.

Code A Yes.

DC Code A And, and we were talking about when you first became aware of the issues at the Gosport War Memorial Hospital.

Code A Yes.

DC Code A I should add one of the key things that we spoke about was a documentation...

Code A Yep.

DC Code A ..which was served on you, this pre-interview disclosure, you first became aware of that on the 16th of September.

Code A Yes.

DC Code A Both in it's documentary form...

Code A Yes.

DC Code A ..and also the issues...

Code A Yes.

DC Code A .. that it raised.

Code A Yes.

DC Code A Because you, you were unaware of those...

Code A Yes, I was unaware them until...

DC Code A (inaudible)

Code A .until the 16th, yeah.

DC Code A Okay, that's fine. Now we were, we were, we touched on when, when you became fully aware of what the problems at the Gosport War Memorial Hospital were, and I would just like you to expand on that. When, when you fully understood the issues.

Code A I think I fully, I fully began to understand the issues, um, I think when I started the, the process started in April of 2001 when I was involved in the, in the media stuff and Code A wasn't around and, eh, he had been, well obviously le, dealing with the complaints and dealing with the independent review process and with the, and with the Health Service Ombudsman and so, and, and I had to get up to speed, you know, sort of fairly quickly so I got some briefing then, eh, from, um, from the (inaudible) Governance Manager who also happened to be on leave. And so it was very much, you know, trying to um, in terms of the real, the real detail of all of this, eh, go up a very, very steep learning curve.

DC Code A And what, what did you understand those problems to be in April 2001? What were the concerns?

Code A Well, April 2001 I think the, the focus was very much around (inaudible). There was a, there was a Police enquiry that had, that had happened. Eh, I was aware that the, um, the charge, there was an allegation of unlawful killing that, that had, that had been made and the Police had conducted an in, an investigation and had forwarded their file, there report onto the Crown Prosecution Service and we were waiting for the out come of that, the Trust and Staff within the, had co operated fully with the, with the Police investigation and we, like the families, were, you know, frustrated that the, the CPS seemed to be taking, eh, so long to make their decision eh, and, and that was it. I then became aware, because obviously the, the media, um, brought, brought, brought other, other issues forward, but there was another case that had gone to the Health Service Ombudsman.

DC Code A Yeah, right.

Code A had taken his, his mothers case to the Health Service Ombu, again I, I wasn't aware of what had led to that, but I was aware, eh, and I think by, I think the, the day or two after the, eh, the first media, eh, incident the Health Service Ombudsman actually produced their reports, so I was able to read that, eh, and again, um used that in the media and stuff. Eh, and then, um, I suppose it was a, a little later on, I was made aware that there was a, a third, eh, complaint, um, Code A Code A, which was going through the NHS complaints procedure and reached the stage of independent review, and that independent review was to take place, I believe, in the, the late summer of 2001.

DC Code A And, and going right to the crux of those complaints, what, what was that, what was the issue, I mean you spoke about the surrounding and the investigations, but what was the crux of those complaints?

Code A My understanding of the, it's, it's difficult to, to disentangle...

DC Code A Sure.

Code A ...what, what I knew is, what I know now...

DC Code A Know now.

Code A ...compared to what I knew then. I know an awful lot more now about the Code A case in the sense of, eh, there was a, there was a complaint that came in and I've, sort of, read that complaint, eh, I hadn't read that back in April of 2001. Um, but obviously I was aware that there was a charge of unlawful killing, eh, and I was aware that it was associated with, um, prescription of um, of (Opiate) drugs.

DC Code A Quite right.

Code A Um, as far as Code A was concerned, I wasn't aware, until I read the Health, again, the Health Service Ombudsman review, but again I suspect they were, I don't know, I, again I cant remember what was in the Health Service Ombudsman review but there were more issues around the care that was received and the way the care was, was, was provided. Eh, and again with, with, with Code A Code A, eh, I was, I was not involved in that, and it's only, I was supposed to be, oh, to be, to be fair it's only when I met Code A, eh, in her home, back in May, it

must have been April or May this year, that I, you know, was able to, to have Code A Code A explain to me and the Chairman exactly what her, what her complaints were. But I had read the correspondence, because I think the, eh, I had seen the correspondence probably in, would have been around February time, I think, 2002. And I hadn't, I hadn't seen any of the, the complaints information re, relating to Code A Code A or Code A mother or Code A I have, I didn't have that in April, eh, April, May, June time when I was trying to deal with the media stuff I was get, I was just getting briefing around it, um, to enable me to, to deal with the media stuff in the absence of the Code A

DC Code A Was it, was it clear to you, or, it must have become clear to you at some point because of the action that you took with regard to this documentation, that there was a concern about the use of Opiates and...

Code A Yes.

DC Code A .Diamorphine...

Code A Yeah.

DC Code A .in particular.

Code A Yeah.

DC Code A Because clearly you have made a link.

Code A Yeah. Oh no, I think I was, I was aware, yeah, I made, I made the link, I suppose I, I was aware of that, um, obviously that was, that was the main reason that the Commission for Health Improvement were, were coming in as well in relation to those, to those concerns. So, yes, in the summer of 2001, um, yes, I was aware that, eh, there, there were concerns over that, but I, I'll be honest, I wasn't sure whether that was a consistent theme in all the complaints...

DC Code A Right.

Code A ...I knew, I knew it was a, a concern, in the Code A case, clearly that's what, that was what the, eh, the case of un, allegation of unlawful killing was around.

DC Code A Now, you...

Code A I, I honestly cannot recall whether the Code A or the Code A

Code A information...

DC Code A Yep.

Code A ..which I contained that, eh, those, that those, sort of, sorts of, of, of, of claims. But clearly once I started talking, um, in the July time with, with, with the Police about the CPS decision, um, and when we, sort of, obviously talking about it within the, eh, within the Health Care Trust as well, it became clear with, that there were, you know, that these were, these were what the concerns were and this is one of the reasons why CHI were coming in to undertake their investigation.

DC Code A Now you didn't take until, as the, in the post of Code A until February of...

Code A 002.

DC Code A ..2002.

Code A Yep. Of the, of Fareham and Gosport Primary Care.

DC Code A Fareham and Gosport.

Code A Yeah.

DC Code A You were aware in the summer of 2001....

Code A Yep.

DC Code A .of concerns.

Code A I was aware that there were, eh, a whole range of, um, there was the Poli, there had been the Police investigation.

DC Code A Yes.

Code A I was aware then that, um, there was a Health Service Ombudsman, um, report. Um, I was aware of the Police investigation and the CPS had decided not to take any further action. I was aware that, um, the, our Health Service Ombudsman had not upheld the complaint, and I was aware that Code A case was, was going to independent review and, and that hadn't, hadn't happened yet. Eh, and obviously was aware in, I guess it was August, early September maybe that the Commission for Health Improvement had been informed of the issues and were, um, wanting to conduct an investigation, eh, into, into what was, you know, eh, going on at Gosport.

DC Code A Did you undertake, we, we spoke about investigations running along side each other.

Code A Yeah.

DC Code A But did you undertake anything or make any recommendations or research...

Code A I, I, I, I personally, I personally didn't, I was in, well, yes I, I think it's important to understand, sort of, the, the context of the, of the, of the events. Um, I ca, I was involved in April 2001 and I was in, informed that, yes, the, um, that, that information is with, is with the Crown Prosecution Service and they're awaiting a, awaiting a decision, so everybody's waiting, waiting for that decision and so until that decision, and we didn't have, I think the, I think the, eh, the other issue is, is very important, is that all we knew was an allegation had been made, and the allegation was unlawful killing. Until February 2002, um, that's when the Police report, Professor Code A report...

DC Code A Yep.

Code A ???) report was released to the Primary Care, to the Portsmouth Healthcare Trust. Prior to that time, there, there was no, the Trust hadn't seen that information, and I think it would be fair to say, as soon as that information did, did, did come to light, um, the whole series of actions then came into, eh, came into, into (inaudible) following that. Other things were happening already, eh, within, within, within Gosport, and again as evidenced within the, eh, the CHI report. There had been changes at Gosport (although the main???) Junior Medical Staff were provided, Doctor Code A eh, retired, or left the Hospital in the summer of 2000 and was replaced by a full time staff grade Doctor. Eh, the out of hours cover was enhanced, the Nursing, Nursing provision was increased, the training, all of this was already in hand by the time the, the CHI report had been undertaken. The prescribing policy had, eh, had been, had been, work on that had been, eh, commenced. Um, so all this was happening, you know, '98, '99, 2000, it's, it wasn't as if we were, you know, peopler were just waiting for, you know, sort of the Police to, to conclude and then something would be done, things were all, things were already beginning to happen,

new policies, new procedures, new Staff, new resources, etc. were, eh, were going into, in, into Gosport, eh, and continue to do so even now. Um, so the Police reports were not, were not available until February, so as a, as a, as an organisation, yeah, I wasn't im, im, immediately involved in this, there was a, a Police CPS waiting, and they then decided that there was no case of unlawful killing.

DC Code A Yeah.

Code A I think the investigate, the internal investigation shouldn't have stopped in 1998 when it did, it should have carried on and I think that's one of the key lessons to, to learn and if it happened now, that, that's, that's what would happen, but, in the context of the time, it was the first time this had happened, Police investigation. The other complaint had gone to the Health Service Ombudsman and the Health Service Ombudsman had not upheld the complaint. They take an independent...

DC Code A Yeah.

Code A ...medical legal, m, medical advice and said, you know, we don't, we, we uphold the quality of the care that was provided. So, again, and, and the same with the independent review, I know Code A was very unhappy with the independent review process, but the, the independent medical and nursing advice that was, that was provided with that independent review was, the care was appropriate and the communication was lousy and (inaudible) but the care was appropriate. So, there were these three, um, and a connection should have been made, but the, in, in terms of the outcomes of those three at that time, um, I wouldn't say they were reasonable but they were, they were, they were outcomes that were almost supportive of the care that was being, being, being provided. And I suppose, and during that time, I think between 1998 and 2001 when CHI came in, I think they were, there were ten, ten formal complaints in relation to Gosport, which is not a huge number considering there are other, the range of services that are provided there. So again, the, the numbers of complaints weren't, weren't, weren't large, and, eh, (inaudible), so, and then the, and then the CHI investigation began, eh, and obviously, you know, I think we were all expecting the CHI inve, we provided loads of information for the CHI investigation, interviews, formal documentation. Um, and again, so, and, and

clearly that um, that has, that reported, eh, and, obviously in February 2002 when, eh, was it in February? Oh, I lose track of time now, was it February 2002 when, again, the Police decided not to take the full preliminary enquiries any further. Clearly I'm, I'm not saying, well, that's where we are.

DC Code A Right. Code A is there anything you want to (inaudible)

DC Code A Absolutely nothing.

DC Code A Okay. Code A thanks very much, you've been very candid throughout the, the whole interview and I'm grateful for that. I think we've covered really what I, we summarised what you'd said in the, the first interview tape and start of this interview. But then just to really clarify what, what, what you've said, no one in your position, or (inaudible) you, you can only really speak for yourself, was aware of these initial complaints.

Code A Yes, (I was/wasn't)

DC Code A When you, when you saw, you obviously made a link.

Code A made, I made a link straight away because clearly the, the issues of the prescribing of Diamorphine, I was aware was, you know, obviously one of the, the key issue that the families had raised, had been in the media, had been in the CHI reports and, eh, by then obviously in February I'd seen, I saw the Police reports for the first time in February as well, so, eh, I'd read those, so I was aware of, um, of, of, of, of the evidence that had been, had been gathered. So when that information came to, came to me in, on, on the 16th of September, you know, clearly there was a, a link there that potentially could take the issues back much further than anybody had initially, eh, initially thought, and that's why I thought it was very, very important that the appropriate authorities were made aware of that and then received a copy of that as soon as possible.

DC Code A Okay. And your responsibilities towards, for the Gosport War Memorial Hospital began as Code A

Code A Well, I was appointed as Code A in February 2002.

DC Code A Prior to that, sorry, go on, yeah.

Code A Um, the, the, the Primary Care Trust didn't come into existence until

April 2002 as a formal organisation, so my former responsibility for Gosport as a Chief Executive commenced on April the 1st 2002, eh, when the new PCT took, took over the running of Gosport War Memorial Hospital. Prior to that I'd been Operational Director in Portsmouth Healthcare Trust for the year prior to that commencing in March 2001.

DC Code A And, and at that stage, the training...

Code A Yeah. A lot of that was already happening and in place, yeah.

DC Code A ...and management, was, was already in place.

Code A Yeah.

DC Code A Is there anything else that you have done or feel could be done?

Code A I think the o, the other things we've, as, as a PCT I think there were, there were a lot of things we did, we, I got in contact with the family straight away to understand their concerns. Having spoken to the families it was clear that, um, a lot of the families hadn't had access to medical records which they were entitled to as next of kin. Eh, so again that was one of the things I wanted to make sure did happen, um, that families were able to access through the, through the appropriate channels, the medical records, eh, because in some cases that hadn't happened, eh, and we offered, um, offered that process they could have the copy of the medical records which they were entitled to, I also made sure that, um, if they wanted an independent medical opinion on those notes, so a, a Doctor who wasn't the Doctor involved in their loved ones care, to come in and explain, because they, they can be very difficult documents to understand sometimes.

DC Code A Sure.

Code A Eh, and we arranged for an independent Doctor from, I can't remember whether it was Southampton or Chichester, to come in to some of the families as well to explain, explain some of those notes. Um, we appointed a, um, a Practice Nurse facilitator for, for the Nursing Staff at Gosport and that person took the post, I think it was July, was working full time with the Nursing Staff at Gosport on a, on a whole range of issues. I've worked with the media, I've worked with the, worked with the

Staff, worked with the families, put an awful lot of time into, eh, into, you know, trying to, eh, provide finances, and obviously was very supportive of the Professor Code A eh, enquiry and, you know, if you can see the media stuff, speak to Meridian, I'm on there, and B, and BBC, because wanting to get answers to this, um. So, and that, that's the reason I'm very happy to be here today, because I think, you know, these investigations are, are very, very important, I just hope that, you know, through this investigation, the Professor Code A investigation, the management investigation, whatever, that we can get to the bottom of this and find out, you know, what the answers are for, for the families, for the staff and for the, eh, the population of Gosport.

DC Code A Okay. Thanks very much. Code A is there anything else you wanted to ask?

DC Code A No.

DC Code A Mr Code A we're coming to the end of the interview, um, and as I said earlier you've been very full in your answers and we're grateful for that. Is there anything else that you wish to add or clarify with regard to anything you've said, or bring anything else up?

Code A don't think so, no. I think that's, unless there's things that are not particularly clear. Would it be worth going through the timings again of when I, when I did what, or, or are you comfortable with that?

SOLICITOR I think they're fairly comprehensively set out at the beginning of the interview.

DC Code A Right.

DC Code A What have we got anyway, we've got 1981 you started...

Code A Yep.

DC Code A ...in 1984 you went to West Glamorgan Health Authority...

Code A Yes, yep.

DC Code A ...as an Accountant.

Code A Yep.

DC Code A November '85 back in Portsmouth Health.

Code A Back in Portsmouth, yep.

DC Code A 1989 at St Mary's...

Code A Yep.

DC Code A ...again accounting, care of finance at the Hospital.

Code A Yep.

DC Code A 1990, the Portsmouth Community Unit as a Finance Director.

Code A Yep.

DC Code A '94 Community Unit became part of the NHS.

Code A Well, it became Portsmouth Healthcare Trust.

DC Code A Portsmouth Healthcare Trust, that's right.

Code A Yeah, yeah.

DC Code A And you were appointed as Finance Director.

Code A Finance Director, yep.

DC Code A In March 2001 you became the Operations Director.

Code A Yep.

DC Code A And in February 2002 you left to become Code A

Code A That's right.

DC Code A ...of the Fareham and Gosport Healthcare Trust.

Code A Pri, Primary Care Trust.

DC Code A Primary Care Trust. Okay.

DC Code A And anything else (inaudible) CV's we spoke about...

Code A Yeah, I...

DC Code A ..your other..

Code A ...and the other bits was...

DC Code A ...roles...

Code A ...other roles within the...

DC Code A ...which you've gone on to cover in some detail.

Code A Okay.

DC Code A I think that's it then. Alright, okay.

Code A Thanks very much.

DC Code A Thanks Code A. Time for, Code A, I'm sorry...

SOLICITOR Nothing from me, thank you, Code A

DC Code A No. Time by my watch is now at 12:22 hours. I'm turning the recorder off.

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y21

Enter type:
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: I Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1100 Time concluded: 1145

Duration of interview: 45 MINS Tape reference nos. (📼)

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

Other persons present: Code A -Saulet & Co Solicitors
Portsmouth Legal Advisor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(📼)	Person speaking	Text
	DS Code A	This interview is being tape recorded, I am Detective Sergeant Code A the other police officer present is...
	DC Code A	DC Code A
	DS Code A	Right, I'm interviewing Code A Code A would you mind giving me your full name

please and your date of birth for the tape?

Code A — Code A , Code A

DS Code A — Right also present today is....

SOLICITOR — Code A from Saulet and Co Solicitors, Portsmouth - Legal Advisor.

DS Code A — Today's date is Monday the 24th of July in the year 2000 and by my watch the time is exactly eleven o'clock (11.00). This interview is being conducted in an interview room at Fareham Police Station. At it's conclusion I'll give you a notice explaining what happens to the tapes. All the time you're in the room here Code A you're entitled to free legal advice, Code A here to provide you with that. If at any time you want to stop the interview to take some advice or to talk to Code A let me know and I'll stop the interview, also today you've come here voluntarily which means you're not under arrest and if at any time that you feel you just want to get up and go then that is your right. Okay?

Code A — Okay, yeah.

DS Code A — Right, before I start to question you at all, I have to go through and give you what we call a caution and that is, that 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 the caution?

	Code A	Yes.
	DS Code A	What do you understand by that caution?
1.31	Code A	That I don't have to answer any questions but if I, if I choose not to erm and later erm say anything then that can be used against me.
	DS Code A	Right, are you happy with that Code A
	SOLICITOR	That's pretty good for somebody who's never been questioned before.
	DS Code A	That's pretty good and it's probably a better understanding than I had of it. One other thing I need to point out is that this interview room is capable of being monitored when the tape recorder is in the record mode only and with the tape running, and a warning light would indicate when monitoring is taking place. At no other time can our conversations be overheard. Now that red light there means that this interview is being monitored and it's by Code A the chap that you spoke to a few minutes ago. Right Code A can you tell me what your job is and what you do?
	Code A	Yeah I'm a Clinical Manager which is the Charge Nurse in charge of Daedalus ward at Gosport War Memorial Hospital.
	DS Code A	Right and what are your day to day duties?
	Code A	Er I've got erm over...24 hour accountability for the nursing care of the patients on the ward er and the management of the nursing team delivering that care. So I manage a team of

nurses and support workers on day and night duty in delivering nursing care for patients on Daedalus ward.

2.51 DS Code A Right, how did you end up in that role? You didn't just apply for that as a job, you've obviously got some experience before, can you take me through your experience?

Code A Erm I've...yeah I've been nursing for erm twenty years erm training in the Royal Navy at Haslar erm working as a Deputy Department Manager and Department Manager in Haslar er I've worked for BUPA hospital at Havant as a Senior Nurse er and at Oxford Radcliffe Infirmary, Brooks University as a Senior Nurse and Lecturer er and then I applied for this position working in elderly care.

DS Code A Right, did you have any specific training in care of the elderly?

Code A Er not specific in care of the elderly, my experience is broad based across erm acute surgery and a particular type of surgery I did before this job was...phalmic surgery where the majority of patients are elderly so it's mainly experience working with elderly patients.

3.53 DS Code A Right so you've a broad based experience in nursing going back over twenty years?

Code A Yeah.

DS Code A Right, what does a Ward Manager do?

Code A Erm responsible for nursing care of patients on a

day to day basis but also responsible for the erm management of the ward erm and making sure everyone is up to date and doing their job properly erm, making sure they've got the right resources, making sure we're staffed properly, er reporting any problems to my managers erm so it's a, it's a combination of nursing care and the overall management of the ward and looking after the budget for the ward.

DS Code A Okay. Can you tell me a little bit about the War Memorial Hospital?

Code A Yeah erm it's a community hospital so we..we've got erm don't actually have medical cover on site, we've got six in-patient wards and day hospitals and outpatients er the particular ward I'm on is erm continuing care around slow stream stroke rehabilitation. We're consult...we've got 24 beds, we're consultant beds so we've got a consultant who takes over all responsibility for the patients and a clinical assistant who provides day to day medical cover.

5.11 DS Code A Who...bearing in mind that we're interested in the events of 1998, who was the consultant in charge then?

Code A That was Doctor Code A

DS Code A Right and does that continue to the present day?

Code A Yes she's cons...she's still consultant in charge now.

DS Code A Right, what contact do you have on a day to day

basis with Doctor Code A

Code A Doctor Code A attends twice a week to conduct a ward round, that's on a Monday and a Thursday erm and we can get in contact with her at other times by the telephone if required, she's actually based at Queen Alexander so erm contacting her depends on where she is at any given time er but it's usually not a problem to get in contact with her if I need to.

DS Code A Right and when would you get in touch with Doctor Code A

Code A Erm if we had any particular problem that we couldn't erm sort out with the clinical assistant erm, erm or we needed, particularly needed consultant advice for any particular reason.

DS Code A Right and that's over a whole range of...

Code A It could cover a whole range of things, usually it would be if the patient was particularly poorly and we weren't sure of what other action to take and that either because er we couldn't get in touch with the clinical assistant because the clinical assistant obviously could be on house calls or duties erm or because the problem couldn't be sorted out with the expertise of the clinical assistant.

DS Code A Okay. Tell me about the clinical assistant?

Code A Er at that point in time it was Doctor Code A Code A er and she's a local GP, works in Gosport er and she comes in Monday to Friday

on a daily basis erm to see...to review all the patients er and then midday to clerk in any admissions and then outside those hours during working hours, office hours we would call on Doctor Code A if she's not on duty er and then weekends and evenings we would call on one of the other partners in the practice that she works in.

DS Code A: As in Doctor Code A practice?

7.14 Code A: Doctor Code A practice, yeah.

DS Code A: Okay, does Doctor Code A receive patients or did she receive patients or is it just....?

Code A: For ad..for admission?

DS Code A: ...Yeah.

Code A: They'd all admissions go through the elderly services office and either Doctor Code A or one of her colleagues actually agree to admit them so they all have to be...the admission has to be agreed by a consultant from elderly services.

DS Code A: Right and where do you take your patients from?

Code A: Er nearly always from transfers from other wards erm so that's either in Queen Alexander or Haslar, sometimes from other hospitals occasionally we take admissions from the er day hospital or outpatients and occasionally we've taken admissions from home but that's, that's quite unusual, nearly always transfers.

DS Code A: Right and are those transfers normally for ongoing medical care?

Code A There usually for assessment or rehabilitation but sometimes patients just aren't well enough for rehabilitation but the, the plan was always to assess them and see erm what we can do in the way of rehabilitation.

DS Code A Okay. As the ward manager you're obviously responsible for the staff that are in there, can you tell me a bit about the staff, how many you have? Who works on...?

Code A It's approximately thirty staff because it depends whenever I've got vacancies and when I've done with the hours but I've got on days at the moment I've got five trained staff who are either registered general nurses or enrolled nurses and eleven health care support workers so it's nursing auxiliaries they were previously known as and on night duty I've got four trained staff and I think six health care support workers, the numbers vary a little bit from day to day with people on maternity leave and so on.

DS Code A Okay and how many patients would you be expected to provide care for?

Code A We've got twenty four beds on the ward, we are...we've only actually been full on about three or four occasions in three years I've worked in the War Memorial but usually we run about seventeen, eighteen patients.

DS Code A Right, is that adequate staffing then?

9.23 Code A For eighteen patients the ward gets very busy

erm so you have to prioritise your work erm if we went above eighteen we need to bring in banked staff to, to have enough staff.

DS Code A So (inaudible) like all things there are occasions when you're pressed and...

Code A Yeah, yeah.

DS Code A ...there are occasions when you cope? In your own estimation where does that figure...where do we cross the line between coping and not coping?

Code A We shouldn't, we should never cross that line because I can bring in banked staff but occasionally and it also depends on not just the number of patients but what's happening at any time, so if you get erm several patients being poorly at the same time or needing attention for one reason or another er a lot of our patients aren't continent erm we can have patients who erm fall out of bed or those sorts of things so if those sort of things, or relatives that are very anxious who need to speak to us so sometimes when you think you're going to manage things occur and then that means that you're actually very, very pushed. That doesn't happen too often because I usually try and ke..that's my responsibility to make sure the ward is properly staffed and the work is properly prioritised and managed so I'm, probably we...occasions when we sort of cross the line when we're not

		managing and really need to, to do some, to do something to make sure we are coping, once a month or so erm which compared to places like Queen Alexander and (inaudible) I expect that happens, where I know that happens a lot more er on the busier acute wards.
10.55	DS Code A	Right, is it your responsibility to get banked staff?
	Code A	Yeah, yeah erm I delegate that as well so my Senior Staff Nurse and Staff Nurse's know that they can call in banked staff if they need to as well.
	DS Code A	Right so they're empowered to make that decision?
	Code A	Yes, oh yeah, yeah.
	DS Code A	Okay, am I right in just...to the hierarchy as it's established is that in overall command is Doctor Code A then perhaps assisted by the clinical assistant who at that, the time we're interested in was Doctor Code A.
	Code A	Yeah.
	DS Code A	...then yourself...
11.29	Code A	Yeah.
	DS Code A	...then you've got your registered nurses....
	Code A	Yeah.
	DS Code A	...and your auxiliaries...
	Code A	Yeah.
	DS Code A	...Is that about right?
	Code A	Yeah.

DS Code A Okay. Who's responsible for prescribing the drugs that you use on the wards?

Code A Doctor Code A or Doctor Code A and also the other erm doctors in Doctor Code A practice if they come in, if we call them in.

DS Code A Right and they would assess each patient and prescribe...

Code A Yep.

DS Code A ...(inaudible) okay. Can you explain to me the procedure that happens when you're approached by QA or Haslar to accept a new admission, what processes do we have to go through?

Code A They erm the...either Haslar or QA would contact the elderly services office and ask for a consultant to assess a patient and take them on. One of the consultants, erm I think sometimes they use a Senior Registrar as well would go and see the patient, assess them erm and if appropriate agree for them to come to erm the War Memorial er they would then give that to the elderly service office who will actually phone us and arrange a date erm a date for the admission and give us all the details, and a copy of the er letter which the consultant's have written which gives us all the information of the patient erm and then we we're, on that date, agreed date then the patient will be transferred across to us and we'll take over their care.

DS Code A Right, are there occasions when the consultant or

in your experience says no this person's not fit to come to us?

Code A There might be but we wouldn't know because they wouldn't get as far as us...

DS Code A Right

Code A ...if that had happened because they would, they would, like they would...that information would be directly between the consultant and the particular ward. I do know that does happen from time to time, either the patient is too well to come to us and doesn't need rehabilitation or the patient isn't well enough erm the other thing that happens is patient...is that conditions on the patients progress are made before transfer so the same patient can come to us but these things, these tests or these things must be sorted first before they come over to the War Memorial.

13.46 DS Code A So generally speaking a patient arriving at the War Memorial is stable and able to be nursed?

Code A They should be, yep.

DS Code A Okay. What paperwork accompanies a person?

Code A Erm if they come...at that point in time if they came from QA they would come with their notes, if they came from Haslar they would come with their Haslar notes and we would obtain the Portsmouth notes and there should be a transfer letter as well and they should have any medications which they're required to be on, what we call T-T-O's.

DS Code A — So and what is a T-T-O?

Code A — Er to take out so that's...so as if they've been discharged to home they come to us with the tablets and medicines they're on because we haven't got a pharmacy on site so they need a weeks supply of whatever medication they're actually on.

DS Code A — Okay. Can you tell me about the pharmacy side?

Code A — We, all our pharmacists are supplied by Queen Alexander Hospital in Portsmouth so we're, we have our own stock of things that we use regularly erm things that we don't, that we don't hold as stock then we order on a named patient basis erm and we have a weekly delivery and then we can phone up daily and order extra supplies if we need them and they get delivered just after midday.

DS Code A — Right, did you have a pharmacist?

Code A — We've got a pharmacist who visits once a week and her name's Code A and she, she goes through all the drug records and all our stocks and just checks everything erm in terms have we got the right stock and the medication the patients are actually on.

DS Code A — Okay, does she advise?

Code A — Yes, yes if erm if she see's erm medication which contradict one another or the doses are erm above or below or not what would normally

be prescribed erm or things that might interact then she points them out to us to point out to Doctor Code A er and we pass that information on and act on it.

15.48 DS Code A In your experience of twenty years, can you individually identify when the drug regime isn't proper?

Code A Yes, you would usually you'd know when something isn't proper erm the exception would be some of the more unusual drugs erm and then you would have to look it up what we call the BMF, which is a book which tells us all about medications...

DS Code A (inaudible) Formary

Code A ...yeah and we would do that if there's a drug that you haven't encountered before you would do that as part of your normal regime before erm actually given the drug to a patient.

DS Code A Would you consider that to be part of your role...

Code A Yes.

DS Code A to keep an ongoing...

Code A Yeah because when you give out a medicine you, what..your responsibility is to know that you're giving it to the right person at the right time and that you know what that medication is doing so if you don't know what it's doing then you need to look it up and make sure you do before you give it erm and that the dose is the normal dose because you can appreciate it's

quite with the range of dose that's given and it's quite easy for someone to write up erm an extra nought or whatever to and prescribe an incorrect dose.

DS Code A Right so I mean part of your role you'd see it as being in some way responsible for just for ensuring is that, that last safety check?

Code A Yeah, yeah and that's the role of any trained nurse on the ward as well because any...we all erm undertake the drug erm round at different times.

DS Code A Right so am I right in saying that individually there's a number of (inaudible) if any individual thinks that the drug regime isn't right they can highlight that?

Code A Yeah.

DS Code A Who would they highlight that to?

Code A Erm well initially you would check for your own sake when you're giving the medication if you then think it's wrong then you would report it to someone senior on the ward so if it was one of my staff they would report it to myself or a senior staff nurse. If it was myself, I would, or they could go directly to the doctor and check it with them, if I thought it was incorrect I'd go to a doctor or I could go to one of my er senior nurses, usually the sorts of things you encounter you can go to a doctor and check er as to and either correct it or understand why a particular

dose has been given because sometimes doses are given that aren't in the er formary range for but for particular reasons erm or, and or it might be a mistake and that can be corrected.

18.08 DS Code A Right, why would that be? Why would people be given doses outside of those guidelines?

Code A Erm because those are guidelines but there are drugs where tests have been done in particular situations with particular patients where erm there are established erm doses outside of those regimes which are appropriate er and there's lot's of examples but one would be in the turn pin, in erm when people have a mental health problem and mental health team regularly give er doses of drugs which are actually much higher than you would normally give er to patients because it's knowing that the higher dose is necessary to actually erm treat the patient effectively.

DS Code A Right so I mean the guidelines are only guidelines...

Code A Yeah.

DS Code A ...they're not ....

Code A Yeah, yeah.

DS Code A ...hard and fast rules?

Code A Yeah.

DS Code A And on your wards there's three definite checks that a dose is right, your nurse can highlight it...

Code A Yep.

DS Code A ...You can highlight it...

Code A Yep.

DS Code A ...and as can the doctor highlight it but ultimately the consultant is...

Code A Overall responsible.

DS Code A ...is overall responsible but there are a number of checks before we get there....

Code A Yeah, yeah.

DS Code A ...and a number of opportunities for people to identify...?

Code A Yeah.

DS Code A Okay. Can you tell me about named nurses and what that's all about?

19.32 Code A The named nurse is actually the nurse with the specific responsibility for individual patient and each patient has a named nurse erm and we allocate it so we each have usually about three or four patients erm and that nurse will be responsible for generally overseeing the patients care so any major change that takes place in, in..take effect in how we care for a patient er they will be involved in the decisions erm and also things like referral to Social Services, erm communicating with relatives and so on erm because we work a shift pattern, we also work in teams erm and other nurses can actually erm be involved in that patients care as well so erm if something is happening with the patient and the named nurse is off for two days then someone

else will automatically take over so it doesn't, we use it to make sure patients get the best care and they have someone specifically responsible for their care but we make sure that that doesn't prevent the patient having erm their care reviewed or decisions made or actions taken when they're not around.

DS Code A — Okay so I mean the named nurse is the person who is expected to take a day to day responsibility...

20.47 Code A — Yeah.

DS Code A — ...but then people are not on duty 24 hours a day...

Code A — Yeah, yeah.

DS Code A — ...Right, how are they allocated?

Code A — Erm we've got three teams, one for slow stream stroke patients and then two for continuing care each with a roughly equal number of nurses and what we do when a patient comes in, is we look at what team they're going to go, need to go in and who's got a vacancy so we've roughly got all...an equal responsibility erm so if one pa...if one persons got less patients than someone else at that point in time because someone's been discharged or died then usually we've been allocated to them...

DS Code A — It almost picks itself?

Code A — ...Yeah, yeah it's on who's got the space really erm or if someone's likely to have a space

because we've got a discharge pending those sorts of things.

21.41 DS Code A Right. What paperwork accompanies a patient?

Code A When they come to us?

DS Code A Yeah.

Code A Erm when they come from Queen Alexander they would come with erm their nursing notes and medical notes and drug record, if they come from, sorry did I day Haslar or QA there?

DS Code A You said QA but I mean if ...

Code A QA they would come with notes, Haslar they would come with their Haslar notes and they would come with their Haslar nursing records and the transfer letter and drug record, so it's the same, if it's a QA one we, we erm keep hold but if it's a Haslar one at that point in time we kept it for a week and then returned it and raised our own documentation.

DS Code A Okay I understand. So the patient arrives on the ward and you know what their history has been and you know what the plan is...

Code A Yeah.

DS Code A ...Can you tell me about the plan and how many plans are there and..?

22.34 Code A Erm they..usually the medical nursing plan should run together and we would look for it, that would be summarised in the transfer letter so we would usually use the transfer letter from the nursing staff to...and the consultants letter to

give us a broad view of what was happening. If there wasn't anything we weren't sure about and we needed to clarify such as drug routine patients on or what, any aspect of their care then we could go back into the, the medical nursing notes and actually read through that and find specific information that we needed erm and then from that we would raise our own nursing documentation and then in assessing the patient and in discussion with them if we could and their relatives look at the plan of care while their on Daedalus ward.

DS Code A Right and how many sort of separate plans are there?

Code A Erm well there's usually an overall plan of what we hope to achieve with the patient and that may be er developed over a period of a few days 'cos it usually takes time for a patient to settle in with us and to see er to assess and see what's practical and what we might achieve and then that's sub divided into specific care plans for specific aspects of the patients needs such as nutrition, er preventing pressure sores, er continence, er hygiene, night care so that's what...and that's what we would call the nursing care plans, so that's the...and we actually base that on the activities of daily living so that erm up to twelve things the patient may need to do for day to day living.

DS Code A — Up to twelve things, I mean it's not an exam, I wouldn't want to...could you sort of as many of those as you can name for me?

Code A — Er so nutrition, erm breathing, erm feeding, erm elimination which is continence er hygiene erm relationships, communication, erm sexuality, erm religious needs, sleeping so that's the and there's another two there somewhere but I'm not sure but we would...not all of those would be applicable to all patients so...

DS Code A — No so I mean is there a mobility?

Code A — ...Mobility is one, yeah.

DS Code A — Is it?

Code A — Yeah.

DS Code A — So and when a person comes in who assesses how many of these plans are applicable to a patient?

25.10 Code A — That would usually be the named nurse and if not someone acting on their behalf so it would be a qualified nurse and we would assess and initiate as many care plans as we could initially the patient came in but it might...but that doesn't have to be done immediately, we usually...I would expect all our patients to have a full set of care plans within 48 hours of admission for some of the things it may take a day or two to assess what their needs are and to actually erm introduce the care plans properly.

DS Code A — Right so the care plans are something that

develop...

Code A Yeah.

DS Code A ...over a period...

Code A Yeah and then they're reviewed and cha...and changed as, as time goes by as well.

DS Code A ...right so some are quite deliberately not installed...

Code A Yeah.

DS Code A ...in the early stages...

Code A Yeah.

DS Code A ...but perhaps we could expect them to...

Code A Later on, yeah, yeah.

DS Code A Okay, are they...what I'm intending to was just get an initial overview of what your job is and what your job is all about. I think I've covered the points that I wanted to initially, if I go to Code A if there's anything that...in that area.

26.19 DC Code A Just a couple of things just to get...you mention in relation to Doctor Code A and the set up when she comes in every morning and there's a single clerk admissions...

Code A Yeah.

DC Code A ...can you just describe what that is?

Code A Clerking admissions?

DC Code A Yes please.

Code A Erm admissions come to us, should come to us before midday erm and they need to be seen by a doctor when they arrive so when the patient arrives we would call Doctor Code A and she

would come and see them usually within an hour er and look at the transfer letter, see the patient, write up the medications on one of our charts er from the prescription that we got from erm (inaudible) that comes with the patient er and just cover any, any details that we need to such as erm medical advice on how we care for the patient really between then and the next consultative ward round.

DC Code A So she would generally oversee what had been instigated...

Code A Yeah.

DC Code A ...or reported to instigate...

Code A Yeah.

DC Code A ...treatment...

Code A Yeah.

DC Code A ...from the point they were admitted...

Code A Yeah, yeah.

DC Code A ...Okay. I think that was it for the moment.

DS Code A Right, I've a couple of other things that I wanted to cover that I didn't but having had the opportunity for that quick break I've got them again. One of the things that will become important in this particular case I understand is the use of a syringe driver at some point. Can you explain to me what a syringe driver is? What experience you have of it, training and stuff like that?

Code A Right erm syringe drivers are, it's used to give

erm to give medication over a continuous period of time er there's various models but in Portsmouth, in Gosport we use only one model which is the MS26 and that's a 24 hour driver and it's used to give any medication barr...but the medication has to be erm soluble and given subcutaneously so it goes under the skin and then that can deliver the dose over usually a 24 hour period erm we can set it for a shorter period if we want to and the idea is that the medica...rather than giving erm a dose of medication which then wears off and then giving another dose which then wears off, we can give a very small dose over a continuous period of time over can be 24 hours erm. Various medications we can use it for but the most common one is for pain control, sedation and control of secretions when people are erm in a great deal of pain and usually when they're having palliative care which is when we would recognise that the patient's dying and erm that death is a painful process for them erm so we usually use analgesia, sedatives and sometimes erm medicine to erm reduce secretions erm and it loaded into the driver, delivered subcutaneously over 24 hours so the patient always has a continuous amount erm of pain relief, we can vary that amount according to the patients needs reducing it or increasing it er if

the patient is either sedated or is in pain er and we can monitor that very carefully erm and change it quite effectively and the benefit for the patient is that they get continuous pain relief and shouldn't become anxious or in pain at any time once we've got the dose right and maintained it at the right level. Erm they do start getting any pain it's not in...they're not in absolute agony and a lot of pain because it's usually what we call breakthrough pain which is when they're just getting a little bit of pain but obvi...so they're obviously not quite enough analgesia erm rather than the full pain they would be in if they...if they'd had a four hourly dose of analgesia which had worn off erm or not had any analgesia whatsoever.

30.09 DS Code A Right you used the term over sedated, how would you know if someone's over sedated?

Code A Erm it would depend what sort of care you're giving to the patient 'cos usually with palliative care people erm the level of sedation that keeps them pain free, keeps them sedated and, and conscious or semi-conscious but sometimes you might use it for other reasons so if we were us...we often use a drug called midazolam for people who are fitting erm and we can give that via a syringe driver erm and in that case we'd want to prevent fits but we wouldn't want to erm like render the patient unconscious so we, we

would just let...judge that on level of consciousness and ability to communicate and so on.

30.52 DS Code A What's an ideal state for someone to be in?

Code A If depend...it depends on what, what the problem is that you're, you're managing erm if it's palliative care then there is..there isn't really erm if you're managing a transient problem erm then you would try and reach a level where the patient's pain is or the problem is controlled but they're not, not asleep or unconscious.

DS Code A So again it's dependent on the patient?

Code A Depends on the patient, yeah, yeah. We usually find in palliative care which is when we recognise that someone's dying and we're keeping them comfortable erm then we use, when we usually achieve the right level of pain control, they're usually fairly heavily sedated as well.

DS Code A Right. What is Palliative Care?

Code A That, that's when we recognise that someone is dying erm (inaudible) various, their overall condition and what we know to be wrong with them erm and it's the care of someone during that process of dying, you keep them comfortable and pain free and clean and dignified so it covers everything in looking after someone who is dying.

32.04 DS Code A Right, when you say that we recognise someone

is dying, who's we?

Code A That's the, the medical and nursing team erm and, and in consultation with the family so although the family wouldn't necessarily recognise what's going on but we from our nursing and medical experience would recognise that.

DS Code A Is it fairly easy in your experience with..to recognise when that moment comes?

Code A Yes, yeah.

DS Code A And what kind of things are you looking for?

Code A Erm usually er could be a whole range of things erm but erm uncontrollable pain, erm difficulty with breathing, erm refusing to eat and drink, erm poor mobility, erm very anxious and it could be other things as well but those would be the, the sort of key things.

DS Code A On a day to day basis at the War Memorial Hospital, who would identify that in the majority of patients?

Code A It, it's a combination of medical and nursing staff but the nursing staff are the one's that work closely with erm patients whereas the medical staff are coming in so we would see how the patient has been over a continuous period of time erm so over a shift or over several shifts so we would...it's the nursing staff who really have the full picture about how a patient has been and then we would discuss and talk about how we'd

do it with the medical staff in making decisions about care.

DS Code A So initially if the patient reaches that point, I mean that may be 20 odd hours away from seeing a doctor but are you empowered to move to palliative care without reference to the doctor?

Code A Yeah, I mean we could, we could call a doctor if we needed to erm but we would have discussed the patients ongoing care and prognosis and outlook on each occasion we saw the doctor so we are empowered to initiate a syringe driver erm because what would have happened is on a previous occasion when they've been reviewed by the doctor where the patient hasn't been looking good erm we think their condition may deteriorate erm and the syringe driver would be written up or have been written up and the instruction would be if this patient condition worsens and you can utilise the syringe driver er to keep that patient pain free.

34.33 DS Code A Right so it's once again you're empowered to make that and the doctor says that you know this is perhaps a natural route to go down...

Code A Yeah.

DS Code A ...and it's an individual decision for you that we've reached that point now and perhaps...

Code A Yeah.

DS Code A ...and you're empowered to initiate a syringe driver on...

Code A Yeah, yeah, yeah because the controlled drugs have to be checked by erm two nurs...two qualified nurses erm then actually the decision is a team decision erm and you'd make it in discussion with erm a nursing colleague before actually initiating that so we're empowered to but it's usually done by two people rather than just the one.

DS Code A Okay, to the untrained mind, is the onset of using a syringe driver normally a signal to all concerned that...?

Code A It normally is but not, that's not absolute and I, I've not say for the majority of patients that we initiate a syringe driver then we're going down the palliative care route but I have seen syringe drivers used and discontinued on erm some occasions when a patients made an improvement.

35.46 DS Code A Okay so that is a decision that's reversible?

Code A If, yes certainly if the patient no longer needed to be on a syringe driver they could come off it.

DS Code A Right but in your experience it's unusual?

Code A That's unusual.

DS Code A Is that peculiar to that hospital or is that peculiar to nursing in general?

Code A That's, that's nursing in general.

DS Code A Okay so and I guess the doctor would invariably agree with your decision because it's all part of the plan?

Code A Yes, yeah, yeah.

SOLICITOR Can I just clear up a point on syringe drivers because I think the view at the moment is if you're on a syringe driver that's the end of it. Can you confirm that syringe drivers are used for other things?

Code A Oh it can be used for a whole range of other things as well so yeah, I mean we're...the patient group we're dealing with then we're common using it for that but, but there's a whole... all sort of other things and tip...the other thing that we use them a lot for is erm a drug called Appamorph which is for Parkinson's so someone might be on a syringe driver for Parkinson's Disease and that's to deliver the Parkinson's medication. Erm over a period of time we could use er midazolam to control fitting erm and then when the patient, when the fitting has settled down then er we might go on to oral medication or discontinue altogether so.

37.03 DS Code A Right, but in the case of palliative care generally that's one of the last thing, one of the last stages?

Code A Yeah.

DS Code A So although it's fair to say that syringe drivers have a whole range of uses...

Code A Yeah.

DS Code A ...in your hospital and the use of the syringe driver in palliative care generally is one of the later stages?

Code A Yeah.

DS Code A You spoke briefly about handovers and there...do you have a briefing process, you know if I'm the late turn nurse and your the day turn do we have an opportunity to discuss what's gone on?

Code A Yeah we have a, we have four shift handovers a day so we handover from night staff to day to morning shift, morning shift to afternoon shift, erm and then afternoon shift to night shift and that inter...that er handover is erm nurses who looked after the patients going through all the, all the patients and what's happening and if there are any points for discussion erm they can be raised at that one and in particular on midday handover we have a little bit more time and the patient are being, we've been heavily involved with the patients throughout the morning then with our little bit of extra time there for discussion of any particular points that we need to work on or consider or think about both that day and in the ongoing care of the patient erm and we usually have a little update about half nine in the morning as well after the doctors been round as to what's going to happen with the patients that day and in general as well if there's any new information we need to discuss or work on.

DS Code A So having that many opportunities to discuss the

day it's fairly safe to assume the majority of the staff on the ward at a particular time are fully aware of what's going on to all the patients not only their own?

38.50 Code A Yeah, yeah, they should know specifically because we work usually in the mornings particularly we look after a group of patients but all staff should know what's happening and certainly qualified staff erm should have an overview of what's happening of all the patients on the ward erm and what we usually do as well is at some point in the morning or afternoon wander round the whole ward and just see all the patients and see that all is well as well. So we do that on one or even more occasions as well as when we go round with the drugs as well that's an opportunity when you see every single patient and just check that all is well and you're up to date with what's happening and what's going on.

DS Code A Okay and the other thing I haven't covered is the nursing notes and on those we've got Code A Code A one's here. Can you explain to me who...the entries are they...in policing and Code A will understand what I mean we've got a thing called a custody record...

Code A Yeah.

DS Code A ...now where everything happens to a person who's in police custody gets recorded and written down obviously...

Code A Right.

DS Code A ...in nursing it's along similar lines but perhaps I mean is there a requirement to write everything that happens down?

40.00 Code A Erm there should, anything that's relevant erm and erm needed we should er these are the nursing care plans which, which cover specific aspects of the patients care, the other activities of daily living so nutrition and elimination and there should be a record of any significant, any significant that happens on the shift all day erm and then the contact record here erm is erm is anything that's not covered by the care plan so that's other events such as discussions with the family, erm accidents, er particular investigations, erm information from the doctor,erm patients condition in general and so on. One of the things that was picked up on this when we had the investigation, the initial complaint by the family is that the nu...the medical, the nursing records weren't terribly good and we acknowledged that and we knew that erm and there were, there were some mitigating circumstances why the records weren't as complete as we would have liked them to have been.

41.10 DS Code A All right what we'll do is we'll talk about that later. I think what I want you to do initially was just to get I mean what are you expected to write

and when are you expected to write it?

Code A Yeah, anything really that's significant that happens in the care of that patient, we should have a record of erm us...in summary if possible but it might need to be in more detail.

DS Code A Right, but the key word is significant?

Code A Yep.

DS Code A It's not...

Code A Yeah 'cos there's a whole..I mean there's all sorts of things that happen with a patient over a 24 hour period erm and you needn't necessarily record every single thing happens so if someone's having erm ongoing rehabilitation they'll make, we would expect them to make er daily or weekly progress erm but what we record is when there's been a significant change so when they've gone from erm walking with assistance to walking unaided would be a significant change which you would want to record...

DS Code A Yeah.

42.06 Code A ...erm and you might have conversations with a family on a day to day basis but they, they might just be a erm yeah things are as we expect them to be but if there was a specific conversation about some particular aspect of care that we ought to...that we felt needed a record kept of it then we would put it in there because we obviously talk to, talk to relatives and patients all

the time but we wouldn't necessarily record everything we'd said....

DS Code A No and I guess some families are more demanding than others?

Code A Mmm, yeah, yeah. Erm some you spend an awful lot of time with and others erm you rarely see so it really varies.

DS Code A Right, okay, what you've done is you've given me a nice overview of the day to day regime that's employed at and I can't say War Memorial without stumbling over it. I think what I'd like to do now is just to stop for five minutes, take a quick break, make sure that I haven't missed anything and then perhaps we'll come back in a few minutes and we'll talk specifically about Code A and the care plans that were appropriate to her and her treatment but Code A has got something that he's just got to say.

DC Code A Just to clear up the background to it. In relation to the syringe driver, what's the level of training you receive?

Code A Erm well qualified nurses will have used syringe drivers in various settings and I, I've used them in, in this hospital and last two hospitals I've worked in erm for various things. When I came to Portsmouth I..part of my induction programme I spent on George ward which is the palliative care ward over at Queen Alexander erm and I've sent several of my staff over there,

there's also training days which are put on by the local hospice who use syringe drivers even more than we do in updates and that and how they're used and what happens and in the year prior to my coming to the ward there was a training day put on particularly..specifically for our ward so all staff have had a training day somewhere at some point er and then new staff that come to us we actually spend time er when we have a patients going on a syringe driver going through how it's used, how it's set up, the situations in which we would use it and making sure that they're familiar so they...new staff would use it with supervision with us...

DC Code A Right.

Code A ...erm and then when they feel they were competent and we feel they're competent then they would use it, erm then they would be able to, to initiate a syringe drivers (inaudible).

DC Code A Okay so in terms of updates and training, do you receive regular updates?

Code A We, we have a regular update on using...on drugs in particular but the syringe driver would be erm regular but depending on, on what particular needs are because there's a whole range of things that we (buzzer sounded) erm update on.

DC Code A That buzzer just tells us that we've got a couple of minutes left so I'll leave it there.

DOCUMENT RECORD PRINT

DS Code A	Okay, are you happy with that, the syringe driver part of it?
Code A	Yeah.
DS Code A	Yeah, okay is there anything else we need to know about the syringe driver before we turn the tape off.
Code A	Don't think so.
DS Code A	No is there anything I've forgotten to ask you? Okay it's quarter to twelve, what I'll do is I'll turn the machine off and we'll have a five, ten minute break. Do you want a cup of tea or something?
Code A	Yes please.
DS Code A	Do you?
SOLICITOR	(inaudible) the tape is listening.
DS Code A	He's listening.
SOLICITOR	Coffee with no sugar.
DS Code A	And what about you?
Code A	Tea with two sugars please.
DS Code A	Right we'll do that, give us five, ten minutes and we'll sort that out for you.
Code A	Right.
DS Code A	Right quarter to twelve and I'm going to turn the tape recorder off.
	END OF TAPE

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21A

Enter type:
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1214 Time concluded: 1250

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

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

Other persons present: Code A - Solicitor Saulet & Co, Portsmouth

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

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

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

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

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

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

DS Code A I've not been in a position to disclose to you this but I have had a sight of Dr Code A report which says that Dr Code A was asked to do a report on behalf on the hospital and she said that during that week she had no knowledge of

Code A because she was on a course. Now I can't formally give you anything to prove that but please accept that that does exist. Is there any particular about that week that might ...

Code A In terms of consultant cover?

DS Code A Yeah.

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

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

Code A Right.

DS Code A But we will get ... you'll get every opportunity in a few minutes to get on with that. But one of the things they were keen to clear up was what

formal arrangements are undertaken at Gosport in the training of use of the syringe drive. I know you said that you send people off to the George Ward, but are there formal training requirements in place?

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

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

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

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

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

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

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

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

Code A It's a ... well it's a 24 hour driver, it's a grade B MS26, and for most ... for the common doses we use, we use a 10 ml syringe but the important thing is the amount of medication which is in it which is actually 60 millimetres in length. So you can use any size syringe but the total travel of the syringe is 60 millimetres which you measure up against the gauge on the syringe driver itself. And the doses we were using on Code A we would use a 10 ml syringe.

DC Code A What would you use generally across the

board?

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

DC Code A What other sizes do you use?

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

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

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

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

Code A Yeah.

DS Code A — How long for?

Code A — Usually for about 20 to 30 minutes.

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

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

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

Code A — She wouldn't specifically see every patient every day only patients which as nurses we've identified need to be seen or Dr Code A feels that she needs to see.

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

Code A — Yeah.

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

Code A — It varies but in our particular ward it's quite relevant because most of our patients are fairly

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

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

Code A From the information we supply to her.

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

Code A The nursing staff actually work very closely with the patient so we actually get a very good picture of how a patient is doing and any particular problems they have and how they are. So they are actually getting a better picture

talking to us about how the patient has been over the past 24 hours than actually seeing the patient at one point in time. So it's about working as a team working together and we work very very closely with our medical staff and the care of patients.

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

Code A Yes.

DS Code A How long have you worked with Dr Code A

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

DS Code A Three years?

Code A Yeah.

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

Code A Yes.

DS Code A Is there a social element to it?

Code A No.

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

Code A Yes.

DS Code A Have you ever disagreed?

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

appropriate course of action is.

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

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

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

Code A Certainly there's times when looking at whether patients should go home or not. A lot of our discharges home are very very risky and the patient is wanting to go home but the safety of the patient and their likelihood of success at home is very questionable. One of us may think yeah they should go, go ahead and give it a try and the other just saying we shouldn't even be contemplating at home. So quite often that's an area where we would say ... where one of us would be saying one thing and the other saying something different and would have to decide what we were going to do. Although usually the agreement is in line with what the patient wants to do.

13.17 DS Code A That's one of the other points I wanted to clear up with you is are there many instances where

the medical opinion as to the course of treatment differs from that of the family and how do you reconcile that?

Code A There are a lot because of the nature of the work we do and we've got people who are very dependent, often with very poor prognosis and relatives often are quite unrealistic as to what might be practical and achievable. So that's ... the way of dealing with that is one to pick it up very early to know what the family ... say one of my first things would be talk to patients and their families and find out what they're expecting and what they think will happen, hope will happen. And carry out our own assessment with the medical staff and Physiotherapist and Occupational Therapist as what we might actually be able to achieve. Then you have to go into discussion and also the care we do is often geared around actually exploring what people ... you know what can be achieved and what might happen. So it's a matter of working together, it's what we call multi-disciplinary team on trying to get the best outcome for the patient within the scope of what's possible.

14.36 DS Code A Can families influence that decision?

Code A It depends what the decision is, but if it's a very ... we would always want to make decisions which are right for the patient and if a family is

really wanting something which is not right for the patient and not in the patient's best interest then we would have to be quite up front about what we need to do and what's appropriate. But we would still always take into consideration the relatives and try and work towards meeting what they and the patient want and where we can't making sure they understand what we can't ... what we need to do or what we can't do or what we have to do.

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

Code A If it really came to a difficult decision then it would be passed on to the consultant. So where we get into a real difficult decision that we can't ... I mean if it can be resolved at a nursing level or a medical assistant level then that's what we do, but if it really can't be resolved then we pass it up the level to the consultant who will make the final decision and convey that to the family.

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

Code A We would also try and work with the patients and the family and there's been lots of occasions where we try to do things which we

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

DS Code A It's difficult ...

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

17.02 DS Code A It's a skill that you develop over ...

Code A Over 20 years and will continue to develop over another 20 years I suspect.

DS Code A I think as far as the background goes I'm fairly happy. I've a nod from Code A whose not got any supplementary questions for me.

DC Code A Not at the moment no.

DS Code A The notes are on the tape in front of us and we're here because of Code A Can you just in your own time and take your time, you know you said that there were perhaps some things in her notes that weren't fully recorded. Make reference to the notes

please do, again it's not an exam, but can you just tell me all about this particular case, nice and slowly.

Code A Has this got the duty rotas in it as well?

DS Code A I'm sure we can get hold of ...

DC Code A I've got a copy of the duty rotas here.

Code A Cause that would just give me an idea of the dates we're talking about.

DS Code A Now this particular tape has got about 30 minutes on it, is that gonna be enough time for you to do that?

18.07 Code A I think so yeah.

DS Code A What I want you to do is really as much as you can and get as much detail and information out of you as I possibly can.

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

Code A Code A was transferred to us on the 11th August which was a Tuesday, that was Code A who was on a late shift with an enrolled nurse by the name of Code A She came to the ward sometime around lunchtime and was admitted by enrolled nurse Code A when she came on duty at 3.30. She was a very confused lady, very agitated. She'd had a fractured neck of femur fixed surgically at Haslar and had come to us for assessment and gentle rehabilitation. The note from Dr Code A who is a consultant who saw her

in Haslar gave us the background information about her confusion, her falls over the last six months and the fact that she was already in a nursing home and that the family were unhappy with the nursing home and didn't want her to return there. So our overall picture at that time was someone whose prospect of regaining mobility was going to be limited because of her confusion and her poor hearing and the fact that she already had a history of falls. So even when we got her mobile that history of falls wasn't likely to change and that if we were able to provide her with some rehabilitation we would have to, with the family, look for a nursing home which was suitable to her needs and acceptance of the family. She was in a single room. We screened her for MRSA which is a anti-biotic resistant bacteria, I mean that's routine for patients coming from an orthopaedic ward. It was very apparent that she was quite confused. She was also, in my judgement, in considerable pain from that hip and myself and Code A actually gave her some analgesia and that was oromorph and we gave her a fairly small dose. We gave her a 10 milligram dose of oromorph that afternoon to try and make her comfortable. Her daughter came in later that afternoon and talked about not wanting her mum to go to Glenheathers and

also talked about the fact that she felt her mother communicated and when she was getting agitated it was because she wanted to go to the toilet. My professional view was that if she could communicate with her daughter, it wasn't certain, but she certainly wasn't ... Code A Code A certainly wasn't able to communicate very effectively with us either understanding what we were saying or pass anything meaningful to us. She had a further dose of oromorph at a quarter to midnight given by the night-staff, that's Staff Nurse Code A at night and a further dose at 6.15 in the morning. I was on a half day on the Tuesday and really saw no great change in her that day. On the Thursday I was actually a day off and I came back to work on the Friday morning to work a long day which was a 7.30 start and was advised on arrival at the ward that this lady had a fall from her chair the previous day, which initially had looked to be, not to have caused any injury or any problem and was actually helped back into a chair, but later on in that evening had noticed that the hip appeared to be dislocated. So the nurse in charge that evening had contacted the duty doctor whose advice had been to keep the lady comfortable over night and to arrange an x-ray and treatment the following morning. Dr Code A was on

the ward not long after that so we immediately saw her examine the lady, made sure she was pain free and started plans to arrange an x-ray. Her daughter had been contacted the night before and arrived in ... whilst Dr Code A was there so advised her what we were planning to do. I arranged an escort to go with Code A Code A to x-ray and her daughter accompanied her as well. That x-ray was completed later on in the morning and confirmed that the hip was dislocated. So Dr Code A came back to the ward and we arranged for the lady ... Code A to be transferred to Haslar with a view towards having dislocation reduced under sedation. Talked to the daughter Code A and explained what we planned to do. Gave Code A Code A oromorph analgesia again to make her comfortable with her hip and that would already initiate the sedation process so hopefully they wouldn't have to wait too long for her to be sedated when she got to Haslar. I then arranged transport and then arranged one of my nursing staff to actually escort the patient to Haslar and she went accompanied by .... went to Haslar accompanied by one of my nursing staff and daughter's followed. Later on that Friday Code A daughter Code A came back to the ward to collect some wash

gear for her mother who was going to stay in Haslar, certainly overnight. I think at that time it was thought that she would come back to us on the Saturday and advised us they'd reduced the dislocation and would place her mum back. I knew that Code A was very angry about the fact that her mum had dislocated her hip and that there had been a delay in notice.. when that dislocation had been noted and x-ray and treatment. And one of the things I specifically asked Code A is whether she was happy for her mum to come back to us which she said she was and I was quite clear in that in that she had the option of looking to alternative arrangements if she didn't want her mum to come back to our particular ward. I was at that point not only looking after Code A but actually looking after Code A and her sister Code A who were getting quite upset and fraught and I could see potentially they could be quite angry and difficult relatives. I knew that we needed to make sure we've provided them with the care they need as well as their mother. Code A actually came back ... didn't come back to us straightaway cause I knew that she didn't recover from the sedation very quickly at Haslar so she actually came back to us on Monday lunchtime. I was on duty at 12.15, I'd probably ... I usually arrive for my

shift a little bit early just to make sure I'm all sorted out and ready to start and Code A Code A arrived round about the time I arrived on the ward and was uncomfortable and in pain really from the time she arrived on the ward. Her daughters arrived a little while afterwards. The nurse actually looking after ... the nurses were already on duty actually settled her into her bed and I quickly became aware that there was something going on there with daughter saying that ... 'why is mum uncomfortable and what's going'. And really from that point in time I made sure as nurse in charge that I was heavily involved with Code A Code A care cause I could see potential difficulties with the both the patients care and the family. One of my nursing staff looked at the position of the leg and couldn't anything appear to be dislocated which was one of the concerns the family were bringing up that the hip had dislocated again as soon as she got back to the ward. But nevertheless what we did was got in touch with the doctors ... I'll just refer to the notes because I think ... I think she settled down after coming to us. One of my difficulties is that it's so long ago and the sequence of events is ... I believe what happened is she actually settled down whilst Dr Code A came and clerked her in and then as soon as Dr

Code A had left the ward again she was again screaming in obvious pain and distress. So we contacted Dr Code A and agreed to have another x-ray of the hip taken to check whether there was anything we needed to do or if all was in order there. There was a difficulty in getting that x-ray done because we needed a doctor's signature on the x-ray form and we don't have a doctor actually on site, and it took a while to get a doctor to actually come into the hospital and sign the x-ray form. But the x-ray took place at quarter to four and we gave Code A some pain-killer 2.5 milligrams of Oramorph prior to that just after 1 o'clock to try and make her comfortable. The x-ray was done, the daughters were upset they weren't allowed into the x-ray room but that's not a decision that I'm responsible for that's up to the duty radiologist. That was seen by Dr Code A who is one of the partners in Dr Code A practice and he looked at it and said there was no dislocation and that we need to make sure Code A has proper pain control, and for Dr Code A to review her the next morning. Code A at this point was in a lot of pain, a lot of distress, generally looking unwell. She was refusing to eat and drink anything other than a very small amount, any attempt to try and provide her with the nursing care she needs so

she was incontinent or needed washing or needed repositioning was making her ... causing even more pain and distress, it made it very difficult to nurse her. We used the oral medication overnight so we gave her oromorph at 1 o'clock, again at quarter past three, yeah I gave a dose at quarter past three and that wasn't effective so I actually had to give another supplementary dose at quarter to five to increase the effect of that and another dose at eight thirty and then more overnight. Throughout that time I was talking with the family about mum being poorly and what we were going to do and the fact that priority ... the agreement with the family was the priority here was to keep the mum pain free and comfortable. There was a certain amount of difficulty in that ... there was obviously something going on between Code A and Code A in that they were saying ... different daughters were saying different things to me at different times and it was an obvious dispute and disagreement going on between them but I tried to keep them both involved and both informed of what was happening and what I needed to do. There was really no improvement overnight and the pain control was obviously keeping her comfortable but still not eating and drinking and still looking unwell. She was reviewed by Dr

Code A on the following morning which would have been me Tuesday 18th at which point the view was that the transfer to Haslar wasn't appropriate because there was dislocation that was going to be fixed and that the likely cause of the pain was a haematoma and that the pain control wasn't effective as it was and this lady's overall condition was very poor and likely to deteriorate further and the appropriate course of action was to use a syringe driver so we would could give continuous analgesia, kept Code A comfortable as opposed to giving doses which we were having to give every four hours and top up if they weren't quite right. The family arrived ... I held off initiating that because we knew that it would ... that sedation would cause a drop in level of consciousness. I wanted to discuss that with the family before we actually started it so when the family came in that morning I presented the overall picture to the family, discussed with them just how poorly mum was and that we were looking at palliative care to keep her comfortable and that we wanted to use a syringe driver to keep her pain free. The family agreed to that and we started that at 11.30 in the morning and that quickly established a level of pain control which allowed us to look after Code A

properly, keep her clean, keep her dignified. And really from there through to the rest of the week we kept Code A comfortable and looked after her needs and made sure we looked after the family. So the daughter stayed with her throughout but we made sure they somewhere they could rest, they could eat and drink, but they were looking after themselves, kept them informed as to what was happening, tried to provide appropriate level of support as they were going through a difficult time. They did require an awful lot of our time and we have to balance our time between all our patients and relatives and if people ... some people need more time than others then that's what we give but they did tie up an awful lot of my time, our time. Myself and one of the night staff were spending a much larger amount of time with them than we perhaps would with other relatives. I knew they were ... I was fully aware that one of the daughters was intending to make a complaint about the incident when mum, Code A Code A, had fallen from the chair. I spoke to her myself about it and what we'd done and what we'd not done and when you're dealing with a complaint if you can resolve it on ward level you do but if you can't resolve it then it needs to go on to a higher level and Code A clearly decided that she wanted to take this

complaint to a higher level. So my role at that point, although like complaints, is to actually support her in doing that and I'm quite happy to do that so I actually put her in touch with the appropriate people to take her complaint to and gave her the resources to photocopy the complaint and I actually looked through the complaint that she'd made but I didn't ... other than the things I'd already discussed with her I didn't respond to it at that time cause I knew that it would need a proper investigation. Really it was then a matter of looking after Code A Code A as her condition gradually went down hill over the next five days. I think I was mainly on late shifts thereafter so ... spending time with her and she eventually passed away late on Friday night, and the nursing staff on duty at that time would have just dealt with that in the normal way we deal with. The family wants to be very involved with ... after mum had died with ... laying her out and taking her to the mortuary and so on. The time we spent with the family did make it difficult to keep nursing records up to date and we knew that was a problem at the time, particularly that the ward was very busy at that time, I don't think any patient didn't get the care they needed but when the ward is very busy you have to sort of prioritise your work and decide what you're

going to do and what you're not going to do and make decisions in that respect. It certainly was a very busy time for us, I had people on annual leave and loads of people go off sick as well which made hard work. Anything else you need to ....

37.36 DS Code A I think on that you've led us through. Obviously we're gonna come back to you on some points and just say can you explain this in a bit more detail, can you explain that in a bit more detail. It's ten to one, you've spoken for twenty minutes, do you want to take a break?

Code A I don't mind.

Code A It's all in your hands.

DS Code A I tell you what let's take a break for lunch and then we can sit back and see what we want to come back and you can have a stretch anyway. Okay. If everyone's happy with that by my watch the time is ten to one and we're turning the tape recorder off.

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21B

Enter type: ROTI
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1412 Time concluded:

Duration of interview: Tape reference nos. (📼)

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

Other persons present: Code A - Solicitor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(💻)	Person speaking	Text
	DS Code A	This is a continuation of our interview with Code A, the time is now 12 minutes past 2 o'clock in the afternoon, we've had a lunch break and we've not communicated about this at all have we since you went to lunch.
	Code A	No.

DS Code A Right, and the same people are present and the same things apply, still under caution as is interview and once again you're free to leave at any time or to seek the advice of Code A Code A Code A on the tape before lunch we gave you the opportunity just to read through all of the history of Code A , without interruption from us and you appreciate that there's perhaps some questions that we want to ask and what we'll do now is, with your permission is perhaps just to just re-cap on that but both myself and Code A will ask a couple of questions, as and when we see relevant.

Code A Right.

DS Code A And pertinent to it. If I can perhaps start the clock at a point on the morning of the 11th when you first had word that Code A is about to arrive at the hospital, can you take me through that, and feel free to make reference to the notes again.

1.25 Code A Right, well we would have known erm prior to that that she was coming, we usually know of an admission at least a day in advance, so we would have had a room allocated and the bed prepared, everything in place and then the time that the patient arrives is really dependent on when the ambulance is available, so we really expect them any time from 9.30 in the morning till, should be before midday, sometimes a little

bit after, so she would have just arrived at some point around midday, I can't remember now what time she actually arrived on the ward.

DS Code A — Okay, and she's accompanied with paperwork.

Code A — Yes.

DS Code A — And I understand in the case of Code A Code A on that day it was a letter from Doctor Code A

Code A — Yeah, the letter from Doctor Code A would have come separately from our elderly services office, so we would have had that in advance of Code A coming, so we would have been able to read through that ahead.

DS Code A — Is it on the notes.

Code A — The letter from Doctor Code A

DS Code A — Yeah.

Code A — It should be there. That looks to be the first half of it. Yeah, that's that letter there.

DS Code A — Okay, so it shows, what does that tell you about the patient you're receiving.

3.00 Code A — It gives, it tells us, erm, about her, this is from when he visit, Doctor Code A visited Code A Code A in Haslar on the 5th August, so that was 6 days before, about her history, that she's had a fall, is confused that he felt the medication had knocked her off, he'd actually stopped the triazadom, erm, deteriorated mobility, erm, the actual incident that brought her into Haslar which was a fractured neck of

femur, that she's incontinent, that's she's on Haloperidol to help with her confusion, he's said that she's clearly confused and unable to give a coherent history, erm, he found her pleasant and co-operative, moving her leg freely and lifting it, lifting the right leg from the bed and that he says he, we should give her the opportunity to try and re-mobilise and that he recommends transfer to the War Memorial and that the daughters are unhappy with care at Glen Heathers nursing home and that want to arrange for her future care to be in a different nursing home.

DS Code A Okay, so that letter arrives with you, on your ward before Code A

4.30 Code A Yeah.

DS Code A So you're , so what's your expectation.

Code A We have an overall picture from, from, from that sort of picture I would expect someone confused and with limited mobility and I would prepare, because it's from an orthopaedic ward I would prepare a single room so that we can screen and isolate MRSA bacteria, if she's carrying it, an air mattress, I would make sure it was under a hoist so we can hoist her in and out of bed and onto a toilet if we need to, erm, and make sure, erm, and I'd know that she's, and, and, somewhere where we can keep a reasonable eye on her, it's difficult to keep an

eye on all of our patients all the time but the rooms closest to the office and the nursing stations are the ones that we can most easily observe on the most frequent basis, er, in fact the room that we got ready for this lady was room 3, which is immediately adjacent to the ward office and the nursing station.

DS Code A Right, so your expectation was for a lady who was stable enough to be transferred and therefore you could make plans about.

Code A Yeah.

DS Code A And were any plans made on that occasion.

5.43 Code A Well we were still need to wait and see the actual person theirself to see exactly what we could do, and it usually takes the patients 2 to 3 days minimum to sort of settle into the ward so you can't really make any firm progress on rehabilitation until the patient's had a chance to settle into the ward.

DS Code A So it wouldn't be upmost on your list of priorities to, to think of a plan for the future, immediately.

Code A No, no, not until we've actually met the patient and had a few days to assess them and see how they are.

DS Code A Okay, Code A arrives at the hospital, erm, what happens next.

Code A The ambulance crew would take her to room and pop her into either bed or chair depending

on how she is, I know she was in a chair that afternoon so I think we probably put her straight into a chair rather than a bed, er, we would..

6.34 DS Code A Would that have been out of choice.

Code A We would choose whichever, if the patient came laying flat on a stretcher we would probably put them into the bed, if they came onto the ward in a wheelchair we would probably put them into a chair, unless they were indicating to us, so, if, if, we want, unless they indicated to us I would rather be in a chair or I would rather be in bed.

DS Code A I don't know the answer to this question, is there anywhere in the notes that indicate how she was transferred.

Code A Erm, no there wouldn't, wouldn't be, expect, and I can, I can't remember whether I was there when she actually arrived on the ward or not, so I don't know, er, if she was transferred immediately into a chair it's likely that she actually came to us in a wheelchair but I can't, I don't know cos I can't recall and I'm not sure whether I was there or not at that time.

DS Code A Okay, what's your first contact with Code A Code A

7.26 Code A I would have seen her sometime after she'd arrived on the ward, I can't remember how soon but it would have been sometime between 12.15

and 3.30, I would have gone to, and sometime fairly soon after she'd got there to see how she was and to assess her and see whether she had any immediate needs that she needed taking care of.

DS Code A Is there a Doctor available for admissions, I think you said earlier on..

Code A Yes, we called Doctor Code A so we, once we settle the patient into the room one of the first things we would do is call Doctor Code A actually let her know that Code A Code A has arrived on the ward.

DS Code A And what's your expectation of Doctor Code A

Code A Usually would come in within half an hour, erm, if she was actually doing something then it could be later than that she would usually tell us that, erm, and I would, I would, if there was any problem with the delay I would let her know, on this occasion I know she was in fairly promptly and she would come in, see Code A, write the notes up and write the medication charts up.

DS Code A and you can tell that from the notes can you, that the Doctor arrived when.

Code A Erm, I can't tell what time she arrived, erm, because, except for, erm, I, I gave a dose of analgesia at 14.14, er, so Doctor Code A must have been and gone by 2.15, because I

couldn't have given that without the chart being written up.

9.03 DS Code A Okay, so relying on your notes there and message, tell me about Code A when you did see her.

Code A Very anxious, very confused, and appeared to be in pain from the hip that she'd had operated on, erm, difficult to tell exactly, what, what was going on because she was so confused but I, I felt that she was in pain and certainly very difficult to communicate with.

DS Code A Can you distinguish between pain and dementia.

Code A It's, it's, sometimes very difficult, erm, one of the things that would tell us is if that, erm, the shouting got worse when we went to transfer the patient, and we would have had to do that at some point in the afternoon to pop her on a commode, if she wanted to spend a penny and, erm, daughter was actually saying that when she's agitated she want to use the toilet, so that would be one indication, erm, sometimes it's very difficult to distinguish.

DS Code A Did you have much experience of, of, erm, patients who have dementia.

Code A Yeah, I have, I, all my previous posts I've look after patients with dementia so I've seen lots of patients with dementia and it presenting in all sorts of different ways.

DS Code A Does it present itself in difficult grades, different severities.

Code A Yes, yeah, you can have patients who've got mild dementia, erm, or dementia that's sort of worse at some time than others and are rational in between and patients who have dementia and are just quietly confused with it and you can have patients who are very noisy and very agitated and Code A would come at the severe end of the scale.

DS Code A Right, is there any doubt that that could be confused with pain.

Code A It's difficult to differentiate but I, I, the sort of actions that I was seeing from Code A and the difficulty with transferring her and so on indicated to me that as well dementia and confusion that she had pain.

11.06 DS Code A Right, okay, does Doctor Code A etter give you any indication, he goes on about some drugs there, was it, how, Haloperidol and Trasadom, what do they do.

Code A Erm, Haloperidol is, is, erm, sedates people and helps the confusion, Trasadom does much the same things, it's a anti-depressant and, and helps with confusion.

DS Code A But they're (inaudible), the Trasadom anyway.

Code A Yeah, stopped the Trasadom, the family said that that, that they felt that had over sedated her, so, so he's actually discontinued that, and that

had been discontinued before she came to us.

DS Code A — And that regime, I mean what he says and what he can see, she'd been much brighter mentally.

Code A — Yeah.

DS Code A — So perhaps there was an element of accuracy in their diagnosis, the family's.

Code A — Erm, certainly if you reduce the sedation then, then the patient is going to be more responsive, one of the, one of the difficulties there is that you may increase the risk of falling along with that, so that might have been one of elements in, in the initial prescription of Trasadom, to perhaps try and reduce the risk of falls.

12.24 DS Code A — Okay, but initially you see Code A sometime between 12 and 2.15 then.

Code A — Yeah, yep.

DS Code A — That would be most likely.

Code A — Yeah.

DS Code A — And she presents herself to you and you're concerned that she's in pain.

Code A — Yeah.

DS Code A — And you're happy that the pain outweighs the..

Code A — Confusion.

DS Code A — The confusion and dementia.

Code A — Yeah.

12.47 DS Code A — So what do you do next.

Code A — I gave some analgesia, I gave, erm, 4 at 2.15 and I gave Oramorph, I gave 10 milligrams in 5 mils, orally.

DS Code A Right, to the layman is that a big dose, is that a small dose.

Code A It's a fairly small dose.

DS Code A I mean there's obviously grades of analgesia, as I understand it it's sort of aspirin is perhaps at the bottom end of the scale to Diamorphine at the opposite end, how did you gauge the appropriate level.

Code A It's on the amount of pain the patient is in, so you've got a scale from, from minor discomfort up to very severe pain, intolerable pain, erm, and you'd go on that scale, so Oramorph would be for more severe pain.

DS Code A Right, so you considered at that time that she was in severe pain.

Code A Yep.

DS Code A Right, would Haslar have let her go in severe pain.

Mr Code A I think that's a question you should be asking the hospital.

Code A Yeah, you'd have to ask Haslar that really.

DS Code A Right, in your experience, do Haslar send patients to Gosport in severe pain.

Code A Well, the actual transfer can cause discomfort and pain and upset patients, so that the transfer itself can be quite a difficult thing for patients, it can actually bring on pain, I have had patients transferred from Haslar who have been very poorly, erm, on numerous occasions so it

wouldn't, it doesn't, it wouldn't surprise me to have a patient with me and find that they're in a lot of pain. I would expect them to be comfortable but in my experience that's not always the case.

15.00 DS Code A Have you challenged Haslar about that...

Code A Yes.

DS Code A ..in the past.

Code A We always, we, we, go back through that with our Consultant, erm, because it is the Consultants who deal with the transfers, so if there's aspects of the transfer we're not happy about, erm, I talk to my Consultant, I've also memo'd my manager on several occasions when I've had a transfer which I've been unhappy about on a particular aspect and that's it, and over 3 years I've probably, I mean, there's varying degrees of being unhappy, there's things that, that you might leave, let ride and there's things that you need to challenge and I've probably sent about 5 or 6 memos about different issues of transfers which I've not been happy about and need to be brought to Haslar's attention.

DS Code A Did either of Code A subsequent admissions provoke you to, to write.

Code A The fact that she was in pain, because of the fact that she'd had the hip operated on and she was very confused, that didn't actually, I, I, felt

		that amount of pain was appropriate to the sort of surgery she's had and her general condition. On the second transfer she was in a lot of pain when she came back and there was an issue about how she was transferred and the fact that she was on a sheet rather than a canvas, the other issues that were involved in dealing with Code A and her family actually really foreshadowed worrying about whether Code A Code A should have been on a canvas when she came to us, so that wasn't something that I actually took up with Haslar at that point in time.
	DS Code A	Okay, so quickly winding the clock back, I don't mean, I don't mean to jump from one thing to the next, Doctor Code A sees Code A Code A prior to 2.15.
	Code A	Yep.
	DS Code A	Because she needs to do the prescription.
	Code A	Yeah.
16.49	DS Code A	Have I understood that correctly.
	Code A	Yeah, yeah.
	DS Code A	So was it a shared decision to give Oramorph or was it your decision.
	Code A	She wasn't actually in pain at that point in time when she was seen by Doctor Code A but she was written up for analgesia if she should become in pain and she did subsequently to Doctor Code A leaving.

DS Code A So she wasn't in..

Code A Immediately on arrival at the ward she wasn't in pain, it was a little while later after she'd sort of settle in that she was in pain.

DS Code A Is that unusual.

Code A No, not really, quite often see patients presenting differently when they're examined by a Doctor than they do half an hour, hour or so later, erm, for a variety of reasons.

Code A So Doctor Code A sees Code A who isn't obviously in pain.

Code A At that point in time.

DS Code A That comes on at some point.

Code A Yeah.

DS Code A Probably over the next hour.

Code A Yeah.

DS Code A Is that too fine a time.

Code A No that's, that would probably be about right.

DS Code A Would she have written up a prescription for someone who wasn't in pain.

Code A She would, cos the history of erm, erm, recently having a, a hip repaired is something that could cause pain, we, we look after quite a few patients who've had broken hips repaired and it can be quite painful, even several days post-operatively, particularly if we try to mobilise and transfer them, say getting them from chair to bed and chair to toilet and so on, so it would be appropriate for them to have analgesia

should they require it.

DS Code A Right, would Code A have been subjected to much in the way of moving about.

Code A We would need, because she didn't have catheter we would have needed to move her whenever she needed toilet and we have needed to move her to the bed and in and out the bed, so moving about but within the confines of the room at that point in time.

18.48 DS Code A But she didn't go into a bed initially did she..

Code A She was in a chair initially, yep.

DS Code A So at some point it manifests itself that she's in pain.

Code A Yeah.

DS Code A And the prescription is already written up.

Code A Yeah.

DS Code A So you give, what you consider to be an appropriate measure relating to her condition at that particular time.

Code A Yep.

DS Code A Have I missed anything in that first bit.

DC Code A Not really on the general admission, I mean we've covered the general admission here, do you know who was responsible for filling in the paperwork in terms of care plans.

Code A Yeah that was enrolled nurse Code A Code A cos we're very, she came, she was on duty as well that afternoon, and I actually asked her to do the admission when she came

on duty.

DC Code A — So it was done a little later.

Code A — Yeah, yeah.

DC Code A — In the afternoon.

19.58 DS Code A — Initially Doctor Code A writes up her note on the 11th.

Code A — Yep.

DS Code A — Can you go, and refer to the notes for that.

Code A — Yep.

DS Code A — Now I understand that the reason for her transfer to Gosport is, how did you describe it earlier on, it's for gentle.

Code A — Assessment and gentle rehabilitation.

DS Code A — Gentle rehabilitation, if, can, would you mind reading that note out and telling me what that means to you.

Code A — Transfer to Daedalus ward, continuing care, the hemi-arthroplasty of her right hip on the 30th July, history, hysterectomy in 55, cataract operations, deaf, Alzheimer's, so from that, that she's, her hearing is poor and that she's confused, on examination impression frail, demented lady, not obviously in pain, please make comfortable, which is, she's not in pain at that time but if she is in pain or if her condition worsens then we should give analgesia, transfers with hoist, erm, we would have been looking at using a hoist to transfer initially and maybe try her out without the hoist and see how

she got on, we have to be very aware of Health and Safety for the safety of patients, usually continent, needs help with activities of daily living, Bartel of 2 and 2, that's the index of what she can and can't do for herself.

DS Code A Who does that.

Code A That's done by nursing staff, at that point would have been taken from the transfer information, cos we would have re-assessed the Bartel later, erm, because when we assessed it later in the day we made it to be 3 rather than 2, but, but 3 is, anything below 4 is very highly dependent. That was assuming that she was continent of urine in fact and it made her 3, if she wasn't then she would have been below that, erm, I'm happy for nursing staff to confirm death.

22.42 DS Code A To us as lay people that seems to be an awfully massive.

Code A Statement.

DS Code A Do you agree with that.

Code A It's to do with the fact that at the War Memorial, because we don't have on call Doctors, erm, that patients conditions can worsen and nursing staff can confirm that death has taken place and then a Doctor, a Doctor actually certificates death at a later stage and the way I always interpret that is that if a patients condition worsens and I feel that they need to see a Doctor or a patient's condition

worsens and they die and I need a Doctor I will call one and my staff are instructed to do likewise. Sometimes, with someone who is very elderly and frail their condition deteriorates and they die but, but, in caring for the patient you don't necessarily need the support of a Doctor, because you can see what's going on, their being seen by a Doctor doesn't mean, and it's about their care throughout their stay not just at that point in time, erm, so had Code A condition deteriorated significantly that afternoon or that evening, with it being so soon after admission and not expected I would have called, erm, the Doctor in, but if erm the condition worsened over the period of a few days and we'd spoken to the on call Doctor each day saying not as well as yesterday do you want to see her and what do we want to do, erm, her condition had continued to worsen and then she died in the middle of the night, erm, and we'd seen that and we'd spoken to family and it was expected we wouldn't then call a Doctor out in the middle of the night to confirm something which we'd seen happening and was known to happen.

24.28 DS Code A The way it gets read by someone like me, this lady gets sent to you.

Code A Yep.

DS Code A To recover from a hip operation and then it says

I'm happy for you to tell me she's dead.

Code A I can see that, it's, it means something different to us or to me as Clinical Manager then it does to, to a lay person.

DS Code A Would that be a regular entry on notes.

Code A It would depend how the patient is, if the patient is, is, erm, obviously fit and well then no but anyone with any degree of frailty it would be, but, erm, if, but otherwise it would be left and it would be entered in at a time when the patient became poorly, if that happened, I think one of the reasons Doctor Code A probably does it there and then, well you'd need to speak to Doctor Code A really as to why but there is, if it's, if it's not put in it could be then that there's a time when it needs to be written in and it's overlooked, erm, so if the lady had worsened, say over the course of the week, erm, we could then end of calling a duty Doctor in on a, on a, over a week-end for something that actually doesn't need a Doctor in, erm, because we could have seen that situation arising so it's sort of written then but not actually, erm, necessarily relevant at that point in time, it's looking at the overall likely pattern of what may happen with the patient, their condition may worsen, it may stay the same or they may get better over a period in time and obviously if the patient is getting better then it becomes a totally

irrelevant statement.

26.08 DS Code A Yeah, it does. Does anyone have access to those notes, can..

Code A Not the, the medical notes, relatives can see, on request, erm, and what would, if they do request to see them, erm, it usually gets done through the elderly services office and they usually get to see them with a Doctor present to explain and help them with anything that they don't understand so that, that the meanings of things can actually be made sense of for them.

26.44 DS Code A It's still a fairly significant thing to write in someone's notes.

Code A Yeah, yeah.

DS Code A ..within 2 hours of them arriving for rehabilitation, is it, is it not.

Code A It is, erm, but I would see it in the context of that patients overall care and the likelihood of what may or may not happen, erm, patients come to us some of them get better and some of them don't, given their overall condition.

DS Code A What sort of percentage get better and what don't.

Code A With stroke patients, and this lady wasn't a stroke patient but stroke patients it's roughly a third, a third get better and go home, a third plateau and don't do anything and a third die. I can quote those figures fairly accurately, I think probably of the continuing care patients, erm,

the likelihood of getting better is slightly less.

DS Code A Is it.

Code A Yeah, but they may, they may stabilise or they might die, I couldn't give you exact figures.

DS Code A Okay, right, so if, if we sort of move on a bit now then, we've got the Doctor's been, she's signed up that initial regime, she's prescribed Oramorph should it become necessary.

Code A Yep.

DS Code A Code A is, becomes in pain.

Code A Yep.

DS Code A So you prescribe Oramorph at the rate of 2.5.

Code A Erm, I gave 10 milligrams in 5 mils.

DS Code A And you say that's a reasonable dose because of the level of pain that she was experiencing..

Code A Yeah. yeah.

DS Code A ..at that time.

Code A Yep.

DS Code A And that's the overall effect of dementia versus pain and, okay, do you know what effect that had on her.

Code A Erm, well that kept her comfortable, erm, and throughout the rest of the afternoon she was comfortable and she certainly, at that point in time, wasn't over sedated.

DS Code A Yep, can you tell me what level of sedation she was in, was she conscious, unconscious.

Code A She was conscious, she was eating and drinking, she was communicating as much as

		she was able to do, I mean her communication was very poor but she was conscious and with us and just more settled and appeared to have been reasonably pain free.
	DS Code A	Right, but demented never the less.
	Code A	Oh yes, yeah.
	DS Code A	So was there a change in the way that that manifested itself.
	Code A	Only in that she was more settled, noticeably less agitation.
29.16	DS Code A	Is that a side effect of Oramorph.
	Code A	Well she was on Haloperidol also, she had erm, she had Haloperidol also at 1800, so the Haloperidol and the, the Oramorph principally was to keep her pain free but it does actually relax and settle people down as well so it would have helped with her general agitation as well.
	DS Code A	So it's just two pronged.
	Code A	Yeah.
29.52	DS Code A	On the drug sheet there in front of you, has Doctor Code A prescribed all of those drugs.
	Code A	Erm, yeah.
	DS Code A	Is that all of those drugs on the 11th, on admission.
	Code A	Erm, she's prescribed the Oramorph, she's prescribed drugs which we could give via a syringe driver on the 11th, the regular drugs, the lady was on Lactlose, Haloperidol, yeah, she's prescribed really up to there on the chart on the

		11th.
	DS Code A	So when you say up to there that's the second set of drugs down on the middle page.
	Code A	Yeah, yeah, so the Lactlose, so Oramorph, Diamorphine, Hyoscine, Midazolam, Lactlose and Haloperidol have been prescribe on the 11th.
	DS Code A	Did you take that as an indication that perhaps she, that perhaps Doctor Code A would be amenable to the use of a syringe driver that early.
30.53	Code A	Again, the syringe driver is something which often gets written up if the patient looks overall to be very poorly that can be used if, erm, in the judgement of nursing staff patient's condition deteriorates and that's required to keep them comfortable.
	DS Code A	Right, so what it is, it's an authorisation to proceed to that if..
	Code A	If we think it's necessary.
	DS Code A	If in your judgement.
	Code A	Yeah.
31.12	DS Code A	So Doctor Code A gives you on the 11th the flexibility to adopt that regime.
	Code A	Yeah, yeah, and again, I mean if, if, if, Code A Code A condition was to worsen in the middle of the night it would have meant we could have used that without the need to call out a Doctor, or if we didn't, or alternatively leave

the lady in pain overnight and not being able to do anything until the following morning.

DS Code A — You mentioned she was drinking and did you say eating or have I imagined that.

Code A — She was eating and drinking but only with assistance and her daughter came in and actually erm fed her that evening, so, erm, she was needing help to eat and drink and it wasn't very big amounts.

DS Code A — Right, but her swallow reflex was fine.

Code A — Yep, yeah. The reason she wasn't eating was partly due to her confusion as much as anything.

DS Code A — Because she'd never been there before had she.

Code A — No, no, it was a strange environment for her.

DS Code A — Okay, right, I don't think I've been that dis-jointed, we've got the 11th is, she's been seen by the Doctor, the drug regime has started, you're able to go down that syringe driver route if you feel it's appropriate but she has a swallow reflex, she can eat and drink and the family are in taking care of her. Is there anything else significant about the 11th of August, are there any things that you feel I should know about.

32.40 Code A — That was when I first met Code A her daughter.

DS Code A — Tell me about that.

Code A — Just generally talked with her about how her mother was and she informed me about Glen

Heathers nursing home and not being happy with that and that erm doesn't want her Mum to return there and she also said that Mum takes medicine that she takes it best off a spoon, so I've written there, she also talked to me about the fact that she thought her Mum could communicate with her and that when she was agitated it was meant that she needed the toilet.

33.22 DS Code A Okay, was there any discussion about the dementia and pain angle then.

Code A In, within erm her saying about her Mum she felt that her agitation was due to Mum needing the toilet rather than erm, rather than general confusion so having put her on the toilet when she was confused I wasn't sure that I entirely agreed that the agitation meant she wanted the toilet cos I'm, I've a recollection of putting her on the toilet when she was agitated and not actually getting any result, so, I didn't quite seem to tally with what her daughter was telling me.

33.56 DS Code A Were her family aware that you'd gone onto Oramorph.

Code A I did tell erm the daughter that I'd used Oramorph to pain, to keep comfortable..

DS Code A And what was her reaction to that.

Code A I, I really can't remember, in time.

DS Code A Were you aware that she'd taken Oramorph on previous occasions.

Code A No, don't think so.

DS Code A Right, okay, has that .....

Code A I would have, I would have looked back through her Haslar notes but I can't, I can't remember.

DS Code A Okay, but it's not an unusual drug.

Code A No it's a fairly common.

DS Code A Was she sensitive to Oramorph.

Code A Erm, well at that, Doctor, er, we actually continued using Oramorph to keep her pain free for a couple of days and actually one of my colleagues, staff nurse Code A actually discontinued that, erm, on, erm, I think on the, on the 13th or 14th, erm, and Doctor Code A at that time wrote that Code A was quite sensitive to Oramorph.

DS Code A Right, what does sensitive mean.

Code A It, it has a more sedating effect on some people than it does on others, so, erm, and of course it can build up in the system a little bit so staff nurse Code A actually thought that we'd actually probably given a little bit too much pain killer to Code A and it wasn't appropriate, the appropriate thing to do was to stop it at that point in time.

DS Code A What to enable it to..

Code A To come out of her system and then review what we gave her in the way of pain control from there.

DS Code A — Okay, so what drugs did she take over the next couple of days, we're on the 11th.

Code A — Yeah she had a further dose of Oramorph at 1145 at night on the the 11th, a further dose at 0615 in the morning on the 12th, erm.

DS Code A — Had she been reviewed by any member of staff, had her pain lessened.

36.16 Code A — She'd, erm, what we'd have done was looked at her overall condition and, and erm, whether she was in pain and erm how the pain was, so whenever you go to give a dose of analgesia erm you look at the patient's pain and how well that's controlled and whether they, they need, so you always carry out a review before and when you're giving pain control.

DS Code A — So what you said earlier was that the beauty of the syringe driver is the fact that you can ensure there's constant level.

Code A — Yeah.

DS Code A — But with Oramorph of course it's a quick fix.

Code A — Yeah and then it would wear off.

DS Code A — So is it recorded that on each and every occasion that the effects wore off that she needed more.

36.54 Code A — It wouldn't necessarily be recorded specifically.

DS Code A — Is that unusual.

Code A — Erm, it wouldn't give, if I look, what I need to do is look at the night care record cos that might, erm, we haven't actually made a specific

record of it but we can give, we can give the analgesia up to 4 hourly, erm, you usually do 1 or 2 things with analgesia, either you give it regularly every 4 hours without fail so that the pain doesn't come back, erm, or if you're not sure then you give the analgesia when it's required, erm, and the fact that we gave it at 0215 and it wasn't given until 1145, erm, would make, to me would give the conclusion that the staff nurse who was on duty that night actually found Code A to be in pain, the analgesia having worn off and then would have given some more to settle her and keep her comfortable over night.

38.10 DS Code A Yep I understand that, I mean had she been in pain at 8 o'clock in the evening you'd have been quite entitled to give her more.

Code A I would have given her some more, yep.

DS Code A But the lady in charge of her care then thought it appropriate later on, that's fine, and again in the morning.

Code A and again in the morning, yeah.

38.28 DS Code A What other drugs is she taking at this time.

Code A At this, on, at this time, erm, Lactlose, which is to keep her bowels regular and Haloperidol which is on 1 milligram twice a day.

DS Code A Okay, so that's not an unusual drug regime..

Code A No.

DS Code A ..for this lady.

	Code A	No, no.
	DS Code A	Okay, is there anything else we need to know about the 11th August.
	Code A	I don't, I don't think so.
	DS Code A	Right, so the 12th, you on duty on the 12th were you.
	Code A	Have we got the duty rotas.
	DC Code A	Certainly.
39.12	DS Code A	I have them here.
	DC Code A	To hand.
	Code A	I know I was on duty, I can't remember what time I was on duty.
	DS Code A	Does it help referring to the notes at all.
	Code A	I think I was on duty from 0730 till 0100 but I.
	DS Code A	Whilst we're looking for that, this tape is rapidly coming to an end, if I hit the button to save anyone from further embarrassment we'll come back in a couple of minutes, is that okay.
	Code A	Yeah.
	DS Code A	Right by my watch the time is 1452 and I'll turn the tape recorder off.

K

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21C

Enter type: ROTI
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1458 Time concluded: 1541

Duration of interview: Tape reference nos. (📼)

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

Other persons present: Code A Solicitor Saulet & Co

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(💻)	Person speaking	Text
0.09	DS Code A	This is a continuation of our interview with Code A Code A and the time by my watch is 1458 hours. Same persons present. I'm glad to announce that we've found the missing duty roster. And the question was Code A on the 12th of August.
	Code A	Yeah.

DS Code A Can you go through your duties and Code A notes.

Code A I was on duty from seven thirty till one o'clock on Wednesday the 12th, Code A would have been reviewed along with all the other patients that morning and at that point um Doctor Code A actually written up, because we needed to give the analgesia through the night she's actually written it up on a er a regular er four hourly basis with 2.5 mils through the day and 5 mils at night. Although and it, but that's written up PRN so we don't give it unless we need to and in fact.....

DS Code A Sorry what does PRN stand for.

Code A Means as and when required, um, in fact we've never, we've, all we've done, other than the dose at six fifteen in the morning on the 12th we've not actually needed to give any more out during that day so although it's been written up regularly, er PRN, we haven't given it. Um.....

DS Code A This is Oramorph?

Code A Yeah the Oramorph.

DS Code A So it's safe to say that that the Oramorph has had the desired effect and her condition perhaps has stabilised and she isn't presenting in pain.

Code A No.

DS Code A On the 12th.

Code A Yeah.

DS Code A Right.

Code A Yeah. Um I can't remember any other specific

		aspects of um Code A care um during that day, um and I probably wouldn't have been greatly involved because my um biggest priority on that particular day was making sure the ward was staffed adequately the next day because I knew it was going to be a very busy shift, um, so that, that would have been the major priority for me as Manager of the ward.
2.28	DS Code A	Ah ha, and indeed she's, she's stabilising.....
	Code A	Yeah.
	DS Code A	So she's.....
	Code A	Yeah.
	DS Code A	.....so she's not a problem.
	Code A	No.
	DS Code A	Okay. Do, is there anything else in the notes for the rest of the twelth that, that perhaps with hindsight alerts you to something being amiss. (fire bell starts ringing). I hope that's a test.
	Code A	No nothing in particular, everything was very fairly straight forward on that day.
	DS Code A	Okay and then the 13th I understand that she has a fall.
	Code A	Yeah.
	DS Code A	And do you know much about the circumstances of that.
	Code A	I, I do but, but from coming on duty the following day when um staff involved sort of filled me in the background.....
	DS Code A	Right.

Code A .....of everything that happened.

DS Code A Because you weren't on duty on that certain day.

Code A I wasn't on duty on that day.

DS Code A Okay, by making reference to the drugs.....

Code A Yeah, yeah.

DS Code A .....that were used on that day, what can you tell me about, you're off on the 13th.....

Code A Yeah.

DS Code A .....what drug regime.

Code A Um, was given er her normal regular drugs and at ten to nine in the evening er of the 13th er she was given some more Oramorph, that was after the hip had been dislocated so she didn't have any more Oramorph or other pain killers up until the point in which it was discovered that she had a dislocated hip.

DS Code A What time would she have had that fall, do you.....

4.06 Code A The fall took place about one thirty um the nurse who examined her at that time didn't find anything abnormal um and a dislocated hip is fairly obvious so um going on the information I had the hip wasn't dislocated immediately after the fall, um, but once Code A was helped into bed after she'd had her supper which was some time around eight, um, seven thirty, eight o'clock, that evening, um the hip was out of position and was obviously dislocated at that time.

DS Code A So, do you suggest that the dislocation could have

occurred at some other time rather than the fall.

Code A Um, it's obviously occurred sometime during the afternoon. Um, it may have been, I mean the fall may have weakened the, the joint or whatever and then the act of transferring, hoisting her out of the chair back into bed or some other action may have actually made the dislocation happen.

DS Code A I think it would be quite unfair of me to go on about that because.....

Code A Yeah.

DS Code A .....you weren't there, you weren't on duty and can't therefore be.....

Code A No.

DS Code A .....responsible for that. In your experience is it unusual for someone not to be given pain relief over that period.

Code A Um not really because we would give pain relief if someone was in pain and if someone wasn't in pain we wouldn't give it, um, so it really depends and, and people's responses and, and pain does vary from time to time depending on what's happening, what we're doing in the way of transferring them and how they are overall, so um, but she needed analgesia and then once she said that she didn't need it doesn't, doesn't surprise, it's not an unusual pattern.

DS Code A Okay. No I except that. What's your next contact with Code A.

5.49 Code A Er that was on the morning of the 14th when I was

on duty from seven thirty until four fifteen um and then I came on duty to find, um to be, um given all the background to the, about the fall the previous day and the fact that it was suspected that she had a dislocation, um so I went and examined the patient with Doctor Code A who was there about that, about that time um and then arranged for x-ray and talked to daughters, Code A the daughter and discussed what we were going to do um to see if there was a dislocation and what we would then do if um we did find the dislocation which we were fairly certain at that time had occurred.

DS Code A — What does it look like a dislocation.

Code A — Um.

DS Code A — Can you tell.

Code A — Usually the leg um rotates inwards and you can see that the hip doesn't look correct, so if you look at one side and look at the other you can see a very obvious difference and deformity.

DS Code A — Right, so it's a fairly visual diagnosis but with experience you can say well (inaudible).

Code A — Yeah, yeah.

DS Code A — When did you know there was a dislocation.

Code A — We knew for certain once the x-ray had been taken place because then we could see it on x-ray.

DS Code A — Right, and that was done, during the day.

Code A — That was done sometime around mid morning.

7.07 DS Code A — Okay, what drug regime was she on in the

morning.

Code A Um still the same, um, um in fact she'd been given some analgesia at ten to eight the previous night which she hadn't, she hadn't needed any that morning. As I say we gave her some um gave her some Oramorph at eleven fifty and that's after the dislocation had been um discovered, er or x-rayed and, and confirmed.

DS Code A What do the notes reflect that she's in pain then or...

Code A Um well, reason we gave um Oramorph at that point in time is because we knew that a dislocation does cause some degree of pain. We were going to transfer her to Haslar which would involve transfer um to an ambulance and in and out of the ambulance and would cause pain and also that she would need pain relief and sedation for the hip to be relocated so we were starting the sedation process there so if they want, if they were in a position to put the hip back in fairly quickly when she got to Haslar then she would actually already have had analges, some analgesia to cover that process.

DS Code A Right and you did say that earlier, and what dose was, was that the same dose or had we increased the dose.

Code A Um, we gave, no we gave 10 milligrams which is the same dose as she's been having throughout.

DS Code A Okay and then she's off to.....

	Code A	Transferred to Haslar er with one of my health care support workers escorting her and staying with her.
	DS Code A	Was there much of a problem with the family at this time.
	Code A	Um, daughter was obviously anxious and upset but probably no more or no less than I would expect of someone whose mother has come to us and then has suffered a dislocation of a recently operated on hip (inaudible) except that someone in that situation is going to have a degree of anger and upset at the situation.
	DS Code A	Okay. So she's off to Haslar and then you've no contact with her at all for 2, 3 days.
	Code A	I, I saw the daughter later on that afternoon when she came back to collect um some wash gear for her mother, because we did think her mother might come back the same day or might stay a while at Haslar, um so her daughter had come back and collected some wash gear um and spoke to me at that time.
9.28	DS Code A	Okay, so the next contact we have with Code A Code A is on the 17th.
	Code A	On the, yeah.
	DS Code A	Now, this is where the letter from Code A Code A comes in isn't it. The, and we've disclosed that to you the other day. The Flight Lieutenant.
	Code A	I've got it..

	Code A	Yeah.
	Mr Code A	(inaudible).
	Code A	No there would have been two because there would have been initial transfer letter and then another one from.....
	Mr Code A	Tenth August.
	DS Code A	Of Code A and there was a statement of Code A which was put along with it.
	Mr Code A	(inaudible).
	DS Code A	Can I ask you to have a look at Mr Code A statement.
	Code A	Yeah.
	DS Code A	If I summarise it.
	Code A	Yeah.
10.16	DS Code A	Just quickly.
	Code A	Yeah.
	DS Code A	It says that she came to us, she got fixed up , stabilised and then was able to go back.
	Code A	Yeah.
	DS Code A	And she was ready for further rehabilitation. Just take a couple minutes to have a read of that.
	DS Code A	Have you got that accompanying letter.
	Code A	Which one.
	DS Code A	From Code A .....That's the one.
	Code A	Yeah.
	DS Code A	It is in there is it.
	Code A	Yeah it's in here. Yeah.
	DS Code A	Yeah.....(inaudible).
11.53	DS Code A	Can I refer you to the letter.

	Code A	Yeah.
	DS Code A	And I guess that accompanies Code A it's dated the 17th.....
	Code A	Yeah.
12.03	DS Code A	.....so I guess it came back with her.
	Code A	Yeah. Yeah.
	DS Code A	If you have a quick read through that.
	Code A	Yeah.
	DS Code A	Right and what's particularly pertinent perhaps is the very last sentence which was she can however mobilise, fully weight bearing. What, what do you infer by that.
	Code A	Um that she, that she can um stand, we know or already knew she would need assistance with standing, so she would need nurses to help her but she can take her full weight on, that, on the effected leg.
	DS Code A	Right okay so her readmission to Haslar has been an unqualified success then.
	Code A	Well, that, that says that she can transfer um from a, from a medical point of view so if we wish to stand her and take weight on that leg then she can, it doesn't necessarily say that she's going to be able to do that and you would need to assess that with the patient initially and they um, but it would indicate that they felt she was able to transfer and stand.
13.23	DS Code A	So at worse there's a significant improvement in her overall, well certainly in the leg.

Code A The hip is back in place yeah, yeah.

DS Code A The dementia is something with which I've got no idea but.....

Code A Yeah, yeah but that's not going to change that's going um be the same throughout.

DS Code A So although not fully fit she's perhaps improved significantly in the couple of days she's been away.

Code A Yeah.

DS Code A Right were you on duty on the morning of the 17th.

Code A I was on duty from twelve fifteen on the 17th.

DS Code A Right and what can you tell me about the events of the 17th.

Code A Er that I would have arrived a little bit before then, before twelve fifteen and Code A had either just arrived or arrived a little while after I got there um but the nurses actually who had been on duty that morning er would have received her and taken care of putting her into a room which had already been made ready for her. Um that she was in pain and discomfort, very obvious pain and discomfort when she arrived um that actually settled down when she was seen by the doctor but then re, made itself apparent again not long after Doctor Code A had gone um in distress and discomfort and the daughters arrived and could see her in discomfort and they were getting very anxious and uptight, as well, and wanted something done.

14.54 DS Code A Now there are some issues around that transfer which I'm not really fully au fait with, and I don't, something to do with the stretcher, a sheet.....

Code A Yeah.

DS Code A .....what is a street. Can you just explain to the, to the uninitiated.....

Code A Yeah.

DS Code A .....exactly what went on.

Code A Usual, usually if some one comes on a stretcher they'll be on what we call a canvas, which is a er, which literally is a length of canvas with holes up either side and you can slide poles into those holes and it then becomes a stretcher which you can lift from the stretcher, one person either end.....

DS Code A Yeah.

15.26 Code A .....over onto the bed so the patient comes up nice and easily, and over um Code A came to us on a sheet instead of a canvas and I'm given to understand that they couldn't find a canvas and that they'd phoned to say sorry she's not on a canvas um and therefore the ambulance crew when they arrived picked her up on the sheet which doesn't give the same level of support because they're just sort of grabbing the sheet which is going to sag and be uncomfortable and transfer you in that way.

DS Code A So it's a sheet before it has the poles inside.....

Code A Yeah.

DS Code A .....and then it's a canvas.

	Mr Code A	No.
	Code A	No. No it's.....
	DS Code A	I still haven't got.....
	Code A	If it's, if it's a, when someone's on a canvas it's actually a very thick canvas material.....
	DS Code A	Right.
	Code A	.....length of the patient, um and it just curls back on itself either end.
16.14	DS Code A	Yeah.
	Code A	And then you can slip a pole up there and it's very, and then when you lift it it's very firm and rigid and it makes a temporary stretcher.
	DS Code A	Yeah.
	Code A	But she was just on a ordinary bed sheet underneath her and that was just rolled up and lifted and that wouldn't have provided the same sort of support because it would have sagged in the middle and sagged (inaudible).
	DS Code A	Is that an improved way to transfer a patient.
	Code A	Um, I would always try, if I'm transferring a patient on a bed I would transfer them on a canvas, um if a patient arrived, now I wasn't actually involved when the patient arrived and the transfer on the bed but if they arrived and they weren't on the canvas then I would have to decide do I now put a patient, a canvas under the patient's bed mind they've already been moved and that's going to involve quite a disruption to get that under them um or do I transfer them as they are and I would

much rather, I, really patients should always be transferred on a canvas.

17.14 DS Code A It just seems ridiculous that for someone who's had this hip operation is going to be.....

Code A Yeah.

DS Code A .....lifted up.

Code A I think the other difficulty is the ambulance crews are always, always under pressure to get on and do the next job because they've got a backlog and I gather from talking to people that they were in rather a rush and weren't going to wait while we found a canvas but I don't know that anyone specifically stood there and said you must wait um while we get a canvas to do this.

DC Code A If that was the case, you must wait, are they duty bound to remain.

Code A It really depends who's involved, um, if it's one of my more junior staff they may not be enough sort of, you know, may be more difficult I mean they're not there, there a set, a team in their own right and if it was me as the nurse in charge I would have made it, if I'd wanted him to do that I would have made it very clear to them that I wanted to do that but it, I wasn't there so I.....

DS Code A Yeah sure.

Code A .....but if they're transferring the patient it is their responsibility really up until the point when the patient is on the bed, as it is, if they, if they're, if I'm transferring a patient it's my responsibility

to look after that patient up until the moment that the ambulance crew take over so, it's absolutely, it's still their responsibility at that point in time.

DS Code A Okay thanks for that. Was Doctor Code A called out to readmit.

Code A Yeah, um (looking at some papers) I can't, what, what I can't remember, there was so many things going on at that point in time is exactly when Doctor arrived, when Doctor Code A arrived but I think Doctor Code A saw her soon after arrival er and clerked her in but she then became very unsettled and obviously in pain not soon after Doctor Code A had lift.

DS Code A So initially, uncomfortable.

Code A Yeah.

DS Code A Was she given pain relief because of her transfer.

Code A Um, I gave, I gave pain relief at one o'clock er which is when um the daughters came and when she really started to demonstrate the signs of being in pain.

20.02 DS Code A So Doctor Code A had been before that.

Code A Yeah, yeah.

DS Code A Because.....

Code A Yeah.

DS Code A Had she written another prescription at that point.

Code A Um no as we still had the existing prescription so we used, that would have.....

DS Code A How long's a prescription valid for.

Code A Um it needs to be um reviewed, reviewed

regularly um, I'm, what the time limit is I don't know but I mean that would be well within it. If someone's written up for Oramorph that would be, be and remains on the ward or goes off a few days and comes back, be valid for a good number of weeks but needs to be reviewed during that period.

DS Code A Ah ha. Okay she's in pain but she's able to take Oramorph.

Code A Yeah.

DS Code A So her swallow reflex is still there.

Code A Yeah.

DS Code A And up and running.

Code A Yeah. She was refusing to eat lunch at that point in time um but she was swallowing.

DS Code A Right is that significant do you think.

Code A May have been because she was in pain and unsettled or it may have been just her general dementia and overall condition so you know it was just one of the things that we noted at that point in time that some food was prepared for her but she refused to eat it.

DS Code A Okay. Right. How did she progress throughout the rest of the, the 17th.

Code A Arranged an x-ray because the family was worried that the hip was dislocated although it didn't appear to be um and that took place.....

DS Code A Didn't one of your nurses, have I read somewhere that the, the leg looked like it was a figure four.

Code A The, yeah, one of the, Staff Nurse Code A

actually went in with the daughter and actually repositioned the leg because she thought it wasn't in er a very comfortable position but it wasn't in a position that looked like it was dislocated, um, so she made Code A in a comfortable and appropriate position um and with her daughter, um, and generally examined her to check, because if she'd spotted an obvious dislocation at that time again we would have um, it's definitely x-rayed, it definitely needs x-raying.

22.14 DS Code A Yeah.

Code A But it looked in an odd position but not in a dislocated position.

DS Code A Right.

Code A Er. So really (inaudible) that afternoon was to give analgesia to try and make Code A comfortable and to get her x-rayed to try and find out if it had dislocated again, um, or if it hadn't to find out if it was anything else we could do anything particular about.

DS Code A Okay. So what's the drug regime for the rest of the 17th.

Code A Um we carried on, we actually um, because we thought there was a sensitivity to the Oramorph we were giving a slightly lower dose so we were giving 5 milligrams, we gave that at one o'clock, we gave it attain at ten to seven, er sorry, gave it again, I can't read my own writing, looks, I think it was about quarter past three and then but that

wasn't, that obviously wasn't enough, so I gave a higher, a second dose of 5 milligrams at quarter to five and then we went back to giving the 10 milligram dose at eight thirty and then she had some in the early hours of the morning.

DS Code A — Are the family happy at this point that she's in pain as opposed to dementia.

Code A — Yeah, yeah, I had specific discussions with the daughter and Code A in particular was very concerned about how much pain um her mum was in and that we need to get that pain under control so I was working very much in conjunction with the family to um try and provide um what, the sort of care that they wanted for their mum.

DS Code A — So at this particular moment in time on the 17th you're all singing off the same hymn sheet.

Code A — Yeah, yeah.....

DS Code A — Everyone's quite happy with what's happening.

Code A — Yeah, um and that, that's one of the reasons I gave the second dose and I, I distinctly remember looking very carefully at how much can 1 give and when and what, and looking at the option of the syringe driver at that time should I need to proceed to it and saying to um Code A daughter that I wanted her mum to be comfortable before I went off duty that evening.

DS Code A — Was there a consideration to the use of a syringe driver then.

Code A — It would have been one of the options could we

not control the pain with the Oramorph.

DS Code A Right, how, how high, or how far along that ladder were you prepared to go on Oramorph.

Code A Because you're giving, because you're giving quite high doses and it's wearing off um the difficulty is you, you can't just give Oramorph and then say it hasn't worked you need to give it time to build up and I needed to give a second dose so, I think had I, had I gone for that um second dose which topped the Oramorph up to 10 milligrams at quarter to five, had she not been comfortable by the time I went off at eight thirty I would have, at that point been looking whether the use of a syringe driver was the next appropriate step because obviously if I'd gone to the full amount of Oramorph and that hadn't kept Code A comfortable then the next logical step was whether a syringe driver would allow me to give um a more dose and a slightly stronger dose of pain killer.

25.28 DS Code A Right and what's your objective behind that.

Code A In going to a syringe driver.

DS Code A Yeah.

Code A To keep Code A pain free.

DS Code A Purely pain free and that.....

Code A Yeah, yeah. Yeah.

DS Code A Okay thanks for that. And then what happens next.

Code A Um, she was cared for over night. I came, um, I was on duty again the following morning, the 18th

		when she's reviewed by er Doctor Code A
	DS Code A	Had anything significant happened over night.
	Code A	Um she had another dose at, of Oramorph, I gave a dose at eight thirty, she needed another dose at twelve thirty which is, so she's only going 4 hours and another dose at four thirty, so she's going only the 4 hours between doses of Oramorph, um, so that's, we're giving the maximum amount we can, um, if I find the night (inaudible) records that might tell us how she was over night.....haven't got a specific record but I would have got handover from the night staff and obviously they would have told me that um they needed to give the Oramorph um every 4 hours and um that she hadn't been comfort, completely comfortable on that.
27.12	DS Code A	The reasons for those being omitted from, from the record sheet is that an oversight or is.....
	Code A	An over, yeah.
	DS Code A	Yeah, and nothing, nothing else.
	Code A	No.
	DS Code A	Just straight up oversight. What other drugs had she taken....
	Code A	Um.
	DS Code A	.....at the same time.
	Code A	That's on the um on the 18th, she actually hadn't, we've left off the Lactalose um, but she's had, she's having, no she did have Lactalose on the 17th and she had Haloperidol.

DS Code A — Right, what did the Haloperidol do for her.

Code A — Haloperidol is to help with her confusion and agitation.

DS Code A — Right. I think you told me that once.

DC Code A — Is that in an oral form at that time.

Code A — Yes. Yeah.

DS Code A — Okay so up until the 17th.....

Code A — Yep.

DS Code A — .....what's her condition, is she getting better, is she getting worse.

28.35 Code A — She's, she's really overall she's worse, her fluid and her diet intake is poor um she's, we're not really controlling the pain even with the regular dose of Oramorph um and she's quite agitated and uncomfortable and it's making it difficult for us to, to nurse her and look after her overall care.

DS Code A — So generally the scenario is one of, it's becoming increasingly difficult.

Code A — Yeah.

DS Code A — Right, Doctor Code A comes in.

Code A — Yeah.

DS Code A — Then what happens.

Code A — Um, we'd have er reviewed her with myself, we'd have gone and seen the patient and looked at how she was um looked at the x-ray that was done the previous day and then um discussed Code A Code A care and what Doctor Code A felt was this lady's overall condition was deteriorating er quite significantly, that we weren't controlling

the pain and the only way we would control the pain was by a syringe driver er and that she felt the lady's overall condition indicated that she was in, in such poor health that she was actually dying um and that we ought to keep her pain free and make sure we were meeting all her nursing needs but that, that we, that rehabilitation at this point wasn't going to be something that we were going to achieve and that we were likely to be looking at a patient that was going to die fairly shortly.

DS Code A Right and that's a decision that, that's not taken lightly.

Code A No.

DS Code A I would assume.

Code A No.

DS Code A And in conjunction with the family.

Code A I, the family weren't present at that point in time, so what I would then have done is discuss things with the family when they arrived um and try to do that in a sensitive and tactful way um, because you start building up a relationship with a family sometimes it can be just done er by nursing staff, sometimes you'd have to arrange for them to come back and see the doctor if you didn't think that their questions had been answered or you'd um answered all their concerns or they till had worries or whatever. Um but I met with them um sometime around mid morning when they came and discussed their mum's overall condition and

um the fact that we needed to use a syringe driver to control her pain um and that we didn't' think her, or we thought her prognosis was very poor and that she was actually going to die, sometimes.....

DS Code A So it was cards on the table.

Code A Yeah, oh yes, yeah.

DS Code A Right, what was their reaction to that, can you recall.

Code A Upset, as, as you would expect, the, I, I knew from previous discussions with them that they had worries about use of um strong analgesias, I believe Code A actually had experience of, of someone close actually um being in a hospice and having strong analgesia, er so I did in that sort of discussion which you try and make sense, tactful, allow them time to voice their fears and anxieties and to answer any questions they had. Um but overall my impressions was that they understood the situation and they agreed with, the, the kind of care which we were um wanted to proceed with.

DS Code A Did they say at any stage, no we don't agree with this.

Code A No, no, um if they had then I would have taken, I would, I wouldn't have proceeded and I would have taken advice from elsewhere, I would have go to a Nurse Manager or um a consultant to get their advice. So although I knew that was the care

that Code A needed I wouldn't have gone ahead with that sort, that care um if they were in direct opposition.

31.59 DS Code A And what would have been the alternative to the syringe driver.

Code A Er carry on giving Oramorph, um could have given higher doses of Oramorph, so that would have been one alternative.

DS Code A Because she is still capable of taking it.

Code A Yeah. Yeah. Um the problem with that is it wasn't keeping her pain free for um the interval between the doses so it wasn't giving her adequate, it was giving her some level of pain control but it wasn't adequate pain control.

DS Code A But, was there still some way to go before you reached the maximum dose of Oramorph.

Code A Um we could have increased the dose, I think the, it's it's, it's more a matter of the interval inbetwen that, that Oramorph then wears off, um makes it difficult.

DS Code A Do people become immune to it, not immune to it but.....

Code A The effects of it do lessen over time yes.

DS Code A Do they.

Code A Yeah, yeah.

DS Code A (inaudible) with junkies you know they start off and they take more.....

Code A Yeah, yeah. Yeah. They, they, um the effect isn't heightened they get used to it.

DS Code A So it's likely that she becomes less resistant to, have I got that right.

Code A Yeah. She...

DS Code A I don't think I have, it has less of an effect.

Code A Has a less effect yeah, yeah.

DS Code A And for a lesser period of time.

Code A Yeah, yeah.

DS Code A Right.

Code A And the other thing we find when we're trying to control patient's pain it's easier with pain if you can stay on top of it all the time, so if you, if you allow someone to become in pain it's then harder to control, get that pain back under control when if you don't allow someone to get in pain in the first place.

DS Code A Okay.

Code A So if you give a continuous dose that, that never lets that pain come through or if it does come through it just keeps it at a controlled level um then it's much, you don't actually need so much of the medication to keep it under control.

DS Code A Right, where's this pain coming from.

Code A It's obviously from the hip, there's no doubt she was getting pain from the hip but she also gave the impression of someone who was in general discomfort and agitation because anything you tried to do with her was causing her to get upset and distressed. And again that's something that's quite common with people who are very poorly

and dying that, that they have specific pain somewhere but they've also got very generalised pain and discomfort.

DS Code A Yeah okay I'm, I'm with you there. Right, so we, a team decision is referred to .

Code A Yeah.

DS Code A And that team, who's in that team.

Code A Um, that's um Doctor Code A reviewing the patient, myself as one of the nurses looking after the patient and Staff Nurse Code A who's the named nurse er of Code A and was on duty um at morning, um, who, so together we reached that decision and, and the family of course, er so we make that decision and then um at.....

DS Code A That's fairly comprehensive in the, the interested parties.

Code A Yeah, yeah, yeah.

DS Code A And there's no dissent there from anyone.

Code A No.

DS Code A Okay. Who, who fixes up the syringe driver.

Code A That was myself and Staff Nurse Code A um and we started that at eleven forty-five.

DS Code A And what was the contents of that.

35.38 Code A Um that was Diamorphine, 40 milligrams, Haloperidol, 5 milligrams, and Midazolam, 20 milligrams.

DS Code A Right, how does 40 milligrams of Diamorphine compare to the idiot with 10 milligrams of.....

Code A It, it's calculated on the basis of um the amount of um Oramorph that's been needed in the previous 24 hours so what Doctor Code A would have done would have been total up the amount, the total amount of Oramorph we'd given really since um one o'clock the previous day um and then there's a, you can look in the, the formulary book BNF or we've got a booklet produced by the local Hospice which then gives you a conversation for how much Diamorphine to give over 24 hours bearing in mind whether the Oramorph had actually kept someone comfortable or not, so if that Oramorph had kept Code A completely comfortable we would have gone for a lower dose but she wasn't, she was still getting periods of discomfort so we wanted to go slightly higher to make sure that she was pain free.

DS Code A Right just to make absolutely sure.

Code A Yeah.

36.54 DS Code A Okay, and the other drugs, Midazolam that's a new one.

Code A Yeah, the Midazolam's um a, a hypnotic and that basically deals with agitation and relaxes um patient, keeps them calm, um and the Haloperidol she's already on and that's, that has a similar effect and that's kept because it's actually something Code A is on already um and Doctor Code A felt that if that was omitted from the driver we'd, it's something you can give

through a driver um and giving it through a driver would make sure that she didn't get withdrawal symptoms from the Haloperidol.

DS Code A Cos that could have had a knock on detrimental effect.

Code A Yeah.

DS Code A Okay I understand that, and was there one other drug in there.

Code A Um not at that point, we used, we started Hyoscine, but we didn't' start using Hyoscine um, may be we didn't use Hyoscine at all, yes we did, yeah, we didn't start using Hyoscine until the 19th of August which was the um the Wednesday.....

DS Code A (inaudible) and that's, Hyoscine, correct if I'm wrong is for secretions.

Code A Yeah, yeah.

38.05 DS Code A (inaudible).

Code A Yeah, yeah.

DS Code A I've read somewhere there's a potential problem using Midazolam and Haloperidol in respiratory function. Are you aware of that.

Code A Er well, all, all the drugs we are using with the driver can, are known to cause some degree of depression of respiration, so that's a known side effect um and something you'd watch for, when someone's poorly their respiration becomes depressed as they start to pass away anyway so that's one of the difficulties knowing whether the medication you're giving is causing depression of

respiration or whether it's the patient's overall condition.

DS Code A — Right.

Code A — So, but the key thing we're looking at is how comfortable is the patient and comfortable is their breathing.

DS Code A — Okay if they do go into arrest or their respiratory function slows down to a stop, do you have any equipment to use to bring that back.

Code A — We, the doses we're sort, we're using would depress respiration but I've never know it to actually to stop the respiration so in fact and you wouldn't um, so we wouldn't, shouldn't be using doses that actually cause that to happen and if you're, if you're giving Palliative care um you don't, and you help the patient, relatives come to terms with the fact that someone's dying you wouldn't want to put yourself in a position where you're suddenly having to take resusative measures because that would be very confusing and upsetting for the family.

DS Code A — So it's a conscious decision that if, if, if it's a natural by-product of that, that they stop breathing then that's death and...

Code A — Yeah, yeah.

DS Code A — .....that's inevitable.

Code A — Mmm, yeah.

DS Code A — Right, Midazolam used subcutaneously, is it.

Code A — That's, that's very common, we usually use that

in, it's the Haloperidol is the one that we don't usually use but we usually use Midazolam because the relaxes, quite a lot of patients if they're in a lot of pain, they're also, and very well, there's a lot of fear and anxiety going on as well, so it just relaxes them and calms them down, takes away some of the, some of the fear that's associated with their condition.

40.27 DS Code A Right, that's not a product that's licensed for subcutaneous use. Were you aware of that.

Code A Um, I'm, um, the information we work on is produced by um the local hospice and they do say in that, that the doses that are used and the medication that are used are sometimes being used outside of their er normal dosage range and where they'd be used but it's established, well established practices in Palliative care.

DS Code A It's common practice.....

Code A So yeah. Yeah.

DS Code A .....so the although the fact that it isn't licensed.....

Code A That's it.

DS Code A .....for the use is not a bar to using it.

Code A No, no.

DS Code A Because experience tells you.

Code A Because it's being, it is being used in a lot of cancers in that way.

DS Code A Right, so you're, we've reached that point where we're on the syringe driver with the, the

combination of drugs, how long does that continue.

41.29 Code A Given that we're recognising that Code A Code A is in Palliative care we would expect that to continue up until the time she passes away um because if anything sensitivity to the pain killers is going to (inaudible) or, or the pain, level of pain may increase, so you may need to increase the pain killers. If you withdrew um the analgesia then the patient would again be in the level of pain they were before you started it um, so it's expected to continue but it's constantly under review to check the level that you're giving is appropriate to the patient's needs, so really every time you go into the patient and every time you go to change the driver, every 24 hours, um you'll be monitoring how the patient is whether they're comfortable or uncomfortable and how they are over all.

DS Code A What, what steps are taken to insure that she remains hydrated.

Code A Our, our practice um with hydration is, is the patients are conscious and able to take food and fluids then we encourage them and help them, make sure they're not thirsty, um if patients become unconscious and we're delivering Palliative care um we base our work on studies that show that giving patients by alternative means actually doesn't do anything to effect the outcome,

um the fluids aren't likely to absorbed and they become uncomfortable so we don't usually hydrate patients when we're delivering Palliative care, um, unless there was a partic, a specific indication that it was the appropriate thing to do.

DS Code A Right. When did we stop actively treating Code A and move on to Palliative care.

Code A Um, that was on the morning of the 17th.

DS Code A Right, then on the morning of the 17th .....

Code A Sorry, that was on the morning of the 18th. Tuesday the 18th.

DS Code A And at that point, did her death become a matter of time.

Code A Yes.

DS Code A Right were any steps taken in the ensuing 3 days by yourself, Doctor Code A or any of the nursing staff to ensure her level of pain hadn't decreased to enable her to come off of that drug regime.

Code A We would have monitored that when we, every time we looked after her so when you, when you go to wash someone, check there clean and so on that's when you start getting pain if you're going to get any so you could see that if you were, um, cos you have to roll and turn people to get them clean and to change their bedclothes and their night clothes and so on, so if she was showing, showing no signs of pain whatsoever then that would say right you might need slightly less, far

more normal that someone shows some indication of being in pain when you start to move them and you have to judge is that a lot of pain that we're, you know we're, we're putting them through agony and we need to increase things or is it just the normal amount that you would associate with moving someone in which case level of pain killers you're giving is about right.

44.36 DS Code A Right, is it recorded anywhere in the notes that those checks were undertaken on Code A

Code A It's, it's not specific but it's integral with um the nursing care plan so um on the 18th um for her night care but she's comfortable and the daughter stayed. Um on the, on the hygiene that she's had, she's had bed bathes and she's had oral care. Um, on the 19th she's had a night change and wash, repositioned, apparently pain free during care.

DS Code A So if she's pain free during that period, is it not then a proper consideration to reduce.....

(the tape buzzer rings)

DS Code A I think we've got two minutes left, but don't, don't rush your answer because of that.

Code A Right, okay. Right, okay. The difficulty was if you start then reducing the pain, reducing the analgesia and the pain breaks through um you're then right back to square one where you've not got the pain controlled um and you're having to go in with high doses again, so if the patient is, recognising that the patient's condition is deteriorating and

		dying anyway, if they're pain free then you continue at the dose you're at.
	DS Code A	But that doesn't give them the opportunity to recover.
	Code A	But we're all, we're recognising that this lady, we didn't feel this lady was likely to recover anyway at this point in time.
	DS Code A	Right, but she was never given the opportunity to recover was she.
	Code A	(inaudible).
46.36	DS Code A	Had, had someone said hold on she's not in pain let's.....
	Code A	Yeah, right.
	DS Code A	.....reduce this to half the dose.
	Code A	Yeah.
	DS Code A	And see what happens.
	Code A	Yeah.
	DS Code A	Because if she was in pain from a broken hip.....
	Code A	Yeah.
	DS Code A	.....that may have well subsided over the 2 or 3 days. Is there a straight forward answer.
	Code A	We, well, we, we didn't' expect that the pain would have resided, we would have expected if we'd reduced, reduced the analgesia that the pain would have came back at the same level.
	DS Code A	Right and that decision is based on experience.....
	Code A	Yeah.
	DS Code A	.....in.....

DOCUMENT RECORD PRINT

Code A Yeah.

DS Code A Between yourself and Doctor Code A

Code A Yeah, yeah.

DS Code A Right. With hindsight, was it not considered, was it not appropriate that.....

Code A No wouldn't have.....

Tape ends as Code A is talking, at 1541 hours.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21D

Enter type:
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: Fareham Police Station

Date of interview: 24/07/2000

Time commenced: 1552 Time concluded: 1604

Duration of interview: 12 mins Tape reference nos. (◆)

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

Other persons present: Code A (Solicitor)

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(◆)	Person speaking	Text
	DS Code A	This is a continuation of our interview with Code A The same people still present, Code A The time by my watch is three fifty-two p.m. You can leave at any time if you want or speak to Code A get your legal advice. We got to the point at the end of the last tape

where we were speaking about the drug regime over the last three/four days of Code A Code A life and my question was that, having settled on a particular drug regime, why was no consideration given to, to reducing that dose, just to see?

Code A At, I've just erm, come to, there's an entry in the contact record by Staff Nurse Code A at eight o'clock on the 18th, which was the, so that was 24, that's 36 hours after we had started that drug regime, er that she is sleeping in peace, that Code A Code A is peacefully sleeping but she reacted to pain when she was moved and that pain appeared to be in both the legs. So that's 36 hours in and we, we actually know that Code A Code A is in pain when we are moving her.

DS Code A Is, is that right? If that was on the 18th, it only started..

Code A That, we started at er eleven forty-five on the Monday so that was, and that was, this is eight o'clock on ..

DS Code A No, on the Tuesday you started didn't you? She came to you on the 17th.

Code A Sorry, started on a Tuesday, yeah, er sorry eight o'clock on the Tuesday night, yeah, that's right. So that, that's been assessed em..

DS Code A So twelve hours into ..

Code A Twelve, twelve hours in, yeah, yeah.

DC Code A Are you aware at that time how that pain

manifested itself, how..

Code A As Staff Nurse Code A has said its er, it appears to be in both legs when Code A was moved, but she's, she's obviously comfortable when she is not being moved.

DS Code A Right. She is not given any other hydration?

Code A No.

DS Code A So, is it safe to assume that is an inevitability?

Code A Yeah.

DS Code A At one point she's going to die?

Code A Yeah, yeah.

DS Code A On the drug doses, right, is that a particularly high....

Code A No, that, that's er the bottom end of the scale really, erm, we, we sometimes up patient, patients on lower doses but we, we could, on the prescription here we could have gone up to two hundred milligrammes of diamorphine and eight hun...and eighty milligrammes of er midazalam. I've known patients go up to even higher doses than that, so five hundred milligrammes of diamorphine would not be er, an uncommon dose to give to someone who was in that much pain.

DS Code A Right. Was there any other evidence of, of other illness?

Code A Er, it was, it was more a general overview of the patient's condition, a combination of er, the severe pain, the, the er reluctance to eat and

drink, the appearing frail, er and difficulty moving, so it wasn't one specific thing but (inaudible) the overall picture that she presented of being a very poorly lady.

DS Code A — Right. What did she die of?

Code A — Er, Doctor Code A had er, er, stated she died of Bronchopneumonia and certainly on the, on the 19th she was getting a very rattley chest er, which is caused when you have got actual secretions in your chest and we had started er Hyocine at that point.

DS Code A — Right, Did, did the sisters agree with that?

Code A — Er, in the statements that I have seen then they haven't but of course if Code A had developed a chest infection then the, the drugs which we are using to control her pain, keep her comfortable, would have masked a lot of the symptoms of a chest infection. So...

DC Code A — Can I just ask a question? So, I mean the decision is made on the 18th, bearing in mind her condition and that pain, that, that she is dying?

Code A — Yeah.

DC Code A — So, the decision to go down the road of palliative care is taken then?

Code A — Yeah, yeah.

DC Code A — So, but she is dying then

Code A — Yeah.

DC Code A — But she is not dying of..

Code A — A chest infection at that point.

DC Code A at that stage?

Code A At that point, no.

DC Code A But later on, which is, I mean is that caused by the drugs she's on? The, the chest infection?

Code A No, but, but when the, its er really to do with being, being very frail and very susceptible and her respiration not being so good and of course the, the drugs she's on do have an effect on respiration, depressed respiration but her overall condition would have affected the respiration as well.

DC Code A Right. In terms of the 18th at the time, the, the consultation occurs and a decision is taken, what was she dying of then? Or what was you impression of what she was dying of then?

Code A Just a combination of factors. There wasn't one specific factor.

DC Code A Yeah.

Code A Er that she was dying of.

DC Code A Can you, can you just go over those?

Code A Just that she was very frail, that she wasn't eating, she had been very reluctant to eat and drink, she was in pain which wasn't controllable er and that she wasn't able to mobilize or, or doing anything to meet her own needs.

DC Code A Okay.

DS Code A If I went into hospital, as fit and healthy as I hope to be, and were put immediately on a syringe-driver, with that combination of drugs,

would I die?

Code A No. I don't think so. Er but you wouldn't, you wouldn't go on that if you were fit and healthy.

DS Code A (Laughter) I know. But, if I were to put another ninety-one year old woman without any, I mean would that kill her?

Code A No. Patients have been on this, these levels of sort of pain control and sedation er we've upped conditions and have gone on to recover so, no, not necessarily.

DS Code A In your experience, that's, that's happened.

Code A Yeah, yeah.

DS Code A In terms of ..

DC Code A In terms of recovery process for other patients, and this may be a hypothetical question, how do they come out of that? How was that accessed that they could, they can come out of that situation? If in particular they are sedated as a result of what they are on?

Code A Um. You probably wouldn't be (inaudible). If someone was going to er recover you wouldn't see, er and given that levels of sedation um, so its a bit difficult to answer really.

DC Code A Right. So really those four...

Code A Are.....

DC Code A .....taken together....

Code A ... are appropriate to palliative care, they wouldn't, I don't know that, that those, that combination would be appropriate to anyone in

anything other than a palliative situation.

DC Code A — So someone who there, there's a consideration that they may well recover that would not be a combination?

Code A — No, you, you would, may use one or more of those drugs but probably not the entire combination.

DC Code A — But all taken together. So if you were to look at some notes, you've never seen the patient but you've seen they're on a driver and on those sort...

Code A — Yeah.

DC Code A — .....of drugs, would your impression be well this is someone who, who may well be, be dying..

Code A — Yeah.

DC Code A — ..and try and assist in giving her a comfortable, painfree death?

Code A — Yeah, yeah.

DC Code A — Okay.

DS Code A — I was just going through Code A statement at the end of the day. She, she mentions a conversation about euthanasia - do you recall that?

Code A — Does...does she say what day that was on? Was that on the, Monday the 17th?

DS Code A — Yeah.

Code A — Yeah, yeah she, I, I remember. Was that Code A Code A or Code A

DS Code A — My sister, so, Code A

Code A Yeah, I remember Code A um, asking about euthanasia um and of course I advised her that that's not something what we would ever contemplate or consider. Its, its not er something we can do and not something we would do.

DS Code A What's the difference between euthanasia and palliative care?

Code A Palliative care is when we recognize that someone's dying um and the care we are providing is to make that death um a comfortable and dignified experience and meet someone's nursing needs. Um, euthanasia is, euthanasia as I understand it is actually actively um assisting someone in dying.

DS Code A Yeah. One thing we haven't covered. I am drawing to a close now, is a suggestion of a massive haematoma. Do you recall this or..

Code A Dr. Code A who was the G.P. who looked at the xray um said that he felt the cause of the pain was a massive haematoma. Um, as I understand it that's um, bruising as a result of the dislocation and the manipulation to put it back in. Um and, and that could be quite painful. I think Code A level of pain, to me seemed to be much more than just a haematoma, she, she was in a awful lot of uncontrollable pain, and distressed from the pain as well, but, but cos I expect anyone, and we have seen

patients have dislocations put back it and they do have bruising and some discomfort but not on the level that Code A was experiencing yeah.

DS Code A Okay. Just somebody has written down a question here which I am not quite sure is appropriate is why was Code A not given fluids subcutaneously during the period 18th, 19th and 20th?

Well then.. it wasn't...

Code A That's, that's because we, we don't feel that's an appropriate course of action with palliative care and that it doesn't make anyone any, it doesn't change the outcome. Um, it makes them uncomfortable cos the fluids don't get absorbed properly, they, they collect under the skin and don't get absorbed and um, you're just, just adding another intervention which is making a patient uncomfortable um and isn't changing what's actually happening.

DC Code A Am I right in saying that, at that time, the hospital wasn't licensed to, or authorize to, provide fluids through a subcutaneous route?

Code A We, we, no we could give fluids subcutaneously. What we couldn't do is give fluids intravenously and um that's cos we haven't got a doctor on site who could re..re-establish an intravenous line.

DC Code A Right.

Code A Subcutaneously is, is an alternative route at giving fluids and that's, that's what we can ...

DC Code A And you always been, as far as you are aware..

Code A Always been able to give subcutaneous fluids and that doesn't need a doctor to set it up, the nursing staff can actually establish subcutaneous fluids, so we could have, if, if, if it had been appropriate to Code A care we could have established subcutaneous fluids er and run them.

DS Code A Code A what I intend to do in a second is, is to, to kill the tape, run upstairs just to see if there is any other points that I may have missed that they feel need covering, but I am getting to the point now where I think we've had a fairly thorough going over of, of your actions throughout that period, is there anything that, that you wanna, we want to add to your account so far? Is there anything that you feel that either myself or Code A have missed or misunderstood. Just so you can leave here saying well I, I've told them everything that they wanted to know.

Code A Yeah. The only thing really is, is that some of, is that I spent an awful lot of time with, with er Code A and Code A talking to them and answering all sorts of questions and I, I just find it strange that they're now asking questions which they had lots of opportunity to ask at the time and didn't, and I, I find that, that

puzzling.

DS Code A I think, I think that's explained if, if explanation is the right word, with the fact that they perhaps found it difficult to deal with what they termed as the early stages of the loss, dealing with the loss of their mother, and perhaps with the benefit of hindsight, that they felt that some things weren't addressed properly and perhaps there was a case. With hindsight, would Code A have done anything differently at all?

Code A There, there were things that happened with Code A Code A when I wasn't on the ward, um, when she fell, which um it would have been better if Code A had been transferred earlier than she was for the dislocation to look at - I don't know whether that would have changed, I don't believe that would have actually changed anything but it would have um answered one of the big questions that the family had, er more than anything. In terms of Code A care when she returned to us, then no, we, we, we looked at Code A um and examined her thoroughly and made decisions appropriate to her and we discussed things with the, the family and tried to get, keep them involved um in what was happening and make sure that, that they were understanding the care we were giving and in agreement. So um I can't see that um, in terms of the overall care of Code A er

there was anything er that we'd have done differently now if we were in the same situation again.

DS Code A One last thing for me, is, is a point that is raised by Code A in her statement where, and if I read the paragraph out it is on Page 13, she says I told Dr. Code A and the Ward Manager that I'd been to Haslar that morning and explained what happened and told them that Haslar would be prepared to re-admit my mother. I considered that this was essential so that the cause of my mother's pain could be treated and sim..not simply the pain itself. Dr. Code A said that it was inappropriate for a ninety-one year old who had been through two operations to go back to Haslar where she would not survive further surgery.

(inaudible) ... contact this has been at some point on the 17th..

Was it ever a consideration to return?

Code A Yeah, that was after Code A been x-rayed and Dr. Code A had come back in, um Dr. Code A had looked at the xray and Dr. Code A had then come back in so DR. Code A looked at results of the xray on Code A Code A um and discussed it with Code A Code A the daughter, um. I, I can't remember Code A um saying those particular words to Dr. Code A but know, I know it was, that was

in looking at Code A care we consider the options what do we, what do we do here um and Dr. Code A view was the...there was nothing specifically wrong that Haslar would be able to treat um and heal and thought that transfer would be more traumatic. That, that Code A might not even survive the transfer er, cos we know the transfer itself is quite traumatic, and that they wouldn't be able to do anything when she arrived there so the most appropriate thing to do was to keep Code A Code A in our care er and she discussed that with the daughter at that time.

DS Code A — So it would have been to the detriment of her health had she been transferred....

Code A — If we had transferred her back.

DS Code A — ..cos, and there was nothing wrong with her to look at

Code A — (inaudible) cos, when she got there, if there was an obvious, if the hip dislocated again then yeah that would have been an obvious indication or if there was something else that, that Haslar could have er done that we couldn't have done, then it would have been appropriate to transfer.

DS Code A — Great. I am ever so grateful you are taking (inaudible)...no, there's someone with a finger up in the corner (laughter)

DC Code A — Just one .there is more. Just a, just to go over,

back to the 11th and a very quick question on the care plans and the letter in relation to consideration being given to the immobilization. Now it's not docu...there is no care plan for the mobilization. Is there any particular reason for that?

Code A Um, what we, we were working on mobilize...we didn't have a care plan but we were trans ..trying to transfer Code A where we could and, had things not gone in the direction they'd gone in, we would have got a physiotherapist involved in looking at transfers over the, the next few days, er but the fact that she fell and dislocated really overtook the plan to mobilize because obviously once she had re-dislocated we couldn't do anything but we would, at that point in time we were assessing well what sort of level of mobilization er was Code A actually capable of.

DC Code A In terms of instructing the physio, who, who does that fall down to on the ward to, to do that.

Code A Er, nurse in charge of any particular shift, cos the physiotherapist comes on ev...we've got our own physiotherapist and we're saying we've got a patient here that we want you to, to look at please and, and see how they are

DS Code A Great. Anything else that you would like to say at this point? Right, I will run upstairs to make sure there isn't any points but I am sure if we

have missed anything we'd better resolve those quickly, but thanks for taking the time and trouble to answer the questions so fully. All things being equal, the time is eight minutes past four.....

Code A I am quite happy for you to leave those tapes in there while you run upstairs (inaudible)

DS Code A That' very kind of you, you are all heart. (inaudible) etc.....

MG11(T)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of : Code A

Age if under 18 : **Over 18** (if over 18 insert 'over 18')

Occupation : **Staff Nurse**

This statement (consisting of 8 pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature : Code A **Dated the 06 June 2000**

I am employed by Portsmouth Health Care Trust at Gosport War Memorial as a Staff Nurse. I have worked as a Staff Nurse at the War Memorial since 1972.

I work mainly at Daedalus Ward on night duty for about the last three years, covering August 1998.

The ward is mainly occupied by elderly patients. The ward is visited daily by a General Practitioner responsible for the treatment of the patients. The GP will prescribe drugs and treatment which will be administered by the Staff Nurses on the ward.

In August 1998, the GP in question was Doctor Code A A consultant would visit the ward once a week. This was Doctor Code A

Dr Code A is also on call for any emergency cases. On other occasions when Dr Code A was not on duty, a GP would be contacted via a Healthcall system based at Cosham.

The patient capacity at Daedalus is twenty four.

I work a permanent night duty at Daedalus Ward which would consist of 8.15pm to 7.45am. I work mainly Friday and Saturday nights.

In relation to the inquiry regarding Code A, I was at work on Thursday 20th August 1998 and Friday 21st August 1998.

Signed : Code A Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : Code A

On the ward with me on 20th August 1998 was Code A Senior Staff Nurse, Code A Code A Health Care Support Worker Code A Health Care Support Worker. These three were on night duty with me on Friday 21st August 1998.

When I started work at 8.15pm on Thursday 20th August 1998, I was made aware that Code A Code A was on the ward. I do not recall receiving any specific instructions regarding Code A care or treatment. I do not remember who gave me the handover. I was aware at this time that Code A Code A was on a syringe driver. The practice of using a Syringe Driver subcutaneously at the hospital has been in use for about ten to twelve years.

The syringe driver is commonly used at the hospital in order to relieve a lot of pain or discomfort. The driver is able to provide a constant level of pain relief as opposed to oral pain killers which wear off after a period of time causing the patient discomfort prior to the next administration of pain killers.

In relation to the drugs administered by Syringe Driver, in August 1998, Dr Code A as the GP responsible for the ward, would have completed the prescriptions. This was backed up by a weekly ward visit by Dr Code A who would assess the treatment given to the patients.

The syringe drivers are used on all wards at the hospital to the best of my knowledge.

The care and treatment of Code A would have been part of my responsibilities overnight. Code A was in overall charge of the ward and the hospital on the 20th August 1998 and 21st august 1998.

I was made aware, I believe by Code A, another Staff Nurse, that Code A had had a fall. I can not remember if Code A told me anymore about the incident.

Signed : Code A Signature witnessed by : 511

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : Code A

I also remember that Code A had been in the ward previously before returning to Haslar and then returning to Daedalus Ward.

Code A daughter was present with her on Thursday 20th August 1998 to Friday 21st August 1998. I spoke to her and learnt that she had previously worked in a nursing capacity. The daughter had concerns over the transport of Code A from Haslar Hospital to the War Memorial. The daughter also believed that her mother was far healthier mentally than what had been diagnosed.

I do not recall administering any drugs to Code A I would have checked her treatment card to ensure any drugs prescribed were to be administered however it would be unusual to administer drugs overnight.

I have been shown Code A a prescription record for Code A being part of health record Code A. Having looked at this record I can state that I did not administer any drugs through the syringe driver or otherwise to Code A I have looked at the record and noted that the syringe driver was loaded at 11.15am on Thursday 20th August 1998. The driver should last for 24 hours meaning that the night duty would not normally be expected to reload the driver.

I have noted the drugs that were administered to Code A on the health record were as follows. Diamorphin, Haloperidol, Hyoscine and Midazolam. My perception of their effects are as follows Diamorphine is for pain relief. Haloperidol quietens the patient down if they are agitated or jittery. Hyoscine stops fluid building up on the chest. Midazolam also quietens the patient down. Midazolam is not a strong drug.

Code A may have been taken off Oramorph and put on to Diamorphine via syringe driver as the Oramorph was not holding the pain. The syringe driver would ensure the pain relief was constant.

Signed : Code A Signature witnessed by : 512

MG1 1A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : Code A

I do not recall giving Code A any fluids either by mouth or subcutaneously. Code A would not have been given fluids by mouth due to the fact that Code A was not conscious. She therefore would have choked if anyone had tried to force fluids or food into her mouth.

Code A was not given fluids subcutaneously. I recall that there was nothing to alarm me over Code A condition. I did not receive any instruction to administer or not to administer any fluids to Code A

I was not concerned about the drugs Code A was being administered. I could not comment on what effect the drugs were having on Code A as I had not seen her prior to the drugs being administered. I did not speak to a Doctor regarding her drugs dosage nor did I alter the card of drugs given to Code A I checked regularly on Code A and she appeared comfortable. I can not recall the make of syringe driver used. The training received for the driver was on the ward with an instruction booklet in the treatment room. Without having looked at Code A case notes I believe Code A died at about 4am on Friday 21st August 1998. There was no attempt to resuscitate. In Code A case, I was able to pronounce death as her death was expected.

At that time both Code A daughters and a granddaughter were present. I recorded death pronounced on the case notes and the nursing notes..

Code A daughters then prepared her for the mortuary. They laid a rose on her and put a crucifix around her. Part of the preparation included ensuring Code A was clean however the staff carried this out later on.

The procedure from this point is that later in the morning Dr Code A would attend and certify the cause of death. If Code A was to be cremated then two doctors signatures would be required on

Signed : Code A Signature witnessed by : 513

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : Code A

the cause of death. I would add that the other reason why a patient may not be able to take Oramorph is if they are unable to swallow. In this case the patient may be transferred to a syringe driver.

Signed : Code A

Signature witnessed by : 514

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y19

Enter type: ROTI
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: PARK GATE POLICE STATION

Date of interview: 19/06/2000

Time commenced: 1117 Time concluded: 1201

Duration of interview: 44 MINS Tape reference nos. (◆) 44/00/029041

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

Other persons present: Code A - Saulet & Co Solicitors, Portsmouth.

Police Exhibit No: LMC/SRG/4 Number of Pages: 34

Signature of interviewing officer producing exhibit

Tape counter times(◆)	Person speaking	Text
	DC Code A	This interview is being tape recorded, I am DC 1484 Code A the other Police Officer present is....
	DC Code A	DC Code A
0.21	DC Code A	The time is 11.17 on the 19th of June, this interview is being tape recorded at Park Gate

Police Station. Also present is, if you could just introduce yourself, who I'm interviewing, just give your full name and date of birth...

Code A — Code A, Code A

DC Code A — Okay and...

SOLICITOR — Code A, Saulet & Co Solicitors, Portsmouth, legal advisor.

DC Code A — Thank you. You are entitled to legal advice throughout the interview, okay, and you can delay the interview at any time should you want to, okay. Basically the reason you're here is we've undertaken an investigation into the circumstances of the death of Code A Code A on the 21st of August 1998 at Gosport War Memorial Hospital. The investigation centres around an allegation that Code A was unlawfully killed as a result of a course of treatment that was embarked upon between the 17th and the 21st of August whilst admitted to this hospital. We are seeking to interview those members of the nursing staff who had a duty of care to Code A Code A during that time and who in some cases may have provided her with direct nursing care or treatment in order that an account can be obtained to the particular circumstances and issues that existed between those dates. I must emphasise that this is a search for the truth and your account and

answers will be carefully assessed in the light of information arising from other interviews of staff and general correspondence. As a result of this interview and several others further guidance will be sought from professional bodies and ultimately the Crown Prosecution Service on how we should proceed and just to further explain that, it's not going to be a decision solely made by Police Officers who have no experience of how a medical profession works and how a ward like that would work, you know it would be made by someone who is considered an expert in that field, okay. Your solicitor has been provided with relevant material prior to this interview commencing. I must emphasise that you are not under arrest and you're free to leave at any time okay, your right to free legal advice in private extends throughout the period that you're at the police station as I've said before, if at any time you want to stop the interview to speak to Code A Code A then you only have to say and we'll do so. The next bit I'm going to say is the caution, you do not have to say anything but it may harm your defence if you don't mention when questioned something which you later rely on in court, anything you do say may be given in evidence, okay. Do you understand that, you do?

	Code A	Yes
	DC Code A	Okay.
3.14	DC Code A	All sounds a bit heavy but I think it's got to be pointed out that me and Code A have been appointed to interview all the nurses and as Code A said we don't understand what all this, the medical side of things what is right and what is wrong and we're not here to judge or point fingers or anything like that, we're just here to establish what individuals did, what their roles were, who they took their responsibilities from and then we hand all that over to somebody else and they look at it and decide whether there's anything to answer at all, okay. So we're basically a tool to gather the facts about Code A stay at the hospital and that's all we're here for.
	DC Code A	Okay, right obviously you made a statement to us on the 1st of June...
	Code A	...Was it then, the 1st of June
	DC Code A	...at home and I think what we'll do first is perhaps go through the statement...
	Code A	...Okay
	DC Code A	...just to cover the points there. It says you are basically employed as a Staff Nurse at the Gosport War Memorial since, well since 1972 you've been at that hospital, is that correct?
	Code A	It is.
4.27	DC Code A	Okay, now what I'll do is, I'll just ask, you've obviously read this statement...

	Code A	...Yeah.
	DC Code A	...today. Is there anything there you want to clear up, anything that's, that I've put down that you've subsequently looked at and thought well he's not got that quite right, he's not explained that.
	Code A	Well most of it's alright it's just the, that business about Code A, she wasn't actually based on the ward, she was visiting at various times during the night...
	DC Code A	...Right
	Code A	...she doesn't actually stay on the ward...
	DC Code A	...Right, okay.
	Code A	...she's got other things to do...
	DC Code A	She's the Senior...
	Code A	...I mean she's based on Dryad not, not Daedalus.
	DC Code A	..Right, okay.
	Code A	But if I need her I can get her.
	DC Code A	Right, so that's the 20th of August, that would be the Thursday going into the Friday of the 21st that night shift?
	Code A	Yeah.
5.19	DC Code A	So she was in overall charge of the hospital overnight?
	Code A	Yeah.
	DC Code A	Okay, so she would have, would she have popped in from time to time just to make sure everything was okay?

	Code A	Yes, she would come, she would come over, ERM well if I called her and while she went to her break I would have been in charge of the hospital.
	DC Code A	Okay. Can you just explain that again and I appreciate you've told us this already but this is purely for the tape because this is a new, just a new way of us gathering information in relation to Daedalus ward and the hospital, what that wards main responsibilities are and what sort of patients they'll get in.
	Code A	Mmm, well it is elderly care, all we have are eight beds that are allocated for stroke patients that are for rehabilitation if we can manage it and the others are all for long stay, ones that are not expected to recover to any great degree and possibly might go on to a nursing home or rest home when we've got them as good as we can with physio and ...
6.38	DC Code A	...Right, okay. So I mean this word keeps sort of cropping up like palliative care, can you describe for me what that, what that means or what your...?
	Code A	...Palliative care
	DC Code A	...yeah, what your interpretation of it IS?
	Code A	The object is to keep the patient as pain free and as comfortable as possible and trying to avoid that they should injure themselves in any way.
	DC Code A	Right, okay and that would be the treatment for

that, I know would differ from patient to patient...

Code A ...It would

DC Code A ...but would that be mainly drugs being prescribed in order to...would there be other ways of ensuring that, that they didn't injure themselves?

Code A Well most people that we have are to some degree or another erm demented and er well our drugs are helped to control that but everybody doesn't have them it depends, by finding out what they want to do and when they want to do it, as far as possible letting them do their own thing but you've got to understand if they believe that they can stand and walk and we know they can't, then you'd be constantly trying to stop them doing that...

8.12 DC Code A ...Yeah

Code A ...because eventually they are going to fall and erm that causes them some distress and that's what we're trying to avoid.

DC Code A Yeah, okay. You've already stated that you obviously are a Staff nurse, have you got any specific qualifications in treating elderly and patients such as that on the ward or is that part of your...?

Code A ...Qualifications as such, no well only in as much that I've been doing it for what thirty seven (37) years.

DC Code A — Yeah, treating the elderly for that amount of time?

Code A — Yeah.

DC Code A — Okay, right now going over to the Daedalus ward, basically who manages the patients in terms of treatment and plans for treatment. Who would oversee that and actually make decisions based on...?

Code A — ..When, Doctor Code A is the consultant in charge and on a daily basis except at weekends when she's off duty Doctor Code A visits the ward every morning, we check if the nursing staff have any concerns about anyone and she would deal with what comes up then, on a daily basis.

9.36 DC Code A — Yeah.

Code A — And she's been doing that a long time as well.

DC Code A — How long has she been down on the wards?

Code A — Oh I don't know but erm (inaudible) about 10 years or something like that because she was, before we were at Gosport War Memorial we were down at (inaudible) which is in the avenue and she was doing the same job then.

DC Code A — Oh right, okay. So she would come in every morning on a week day?

Code A — Yeah before surgery she would come in round about eight (8.00) o'clock.

DC Code A — And she would be responsible for all patients on that ward including ...

	Code A	...All patients that were Doctor Code A and we didn't have very often anyone that belonged to anyone else.
	DC Code A	No, okay and that would include the stroke patients so that would be the whole ward...?
	Code A	...Yeah, yeah
10.27	DC Code A	...depending on numbers or whatever?
	Code A	Yeah.
	DC Code A	Okay and would she actually visit every patient daily or would it be more of speaking to the staff?
	Code A	No, she would have gone into the office and speak to whoever was in charge at the time and depending what she, what messages were passed on, she would go and see the patients they wanted her to.
	DC Code A	Right so if there was a specific problem with a patient she would visit but if there was no change to a patient, there was no concerns then she wouldn't necessarily do so?
	Code A	It would take her a long time.
	DC Code A	Yeah, okay. In terms of your role on the ward as a Staff nurse now there have been times when you sort of in charge of the ward, is that right? What circumstances would that, would suggest, sorry what circumstances would occur for you to be in overall charge of the ward?
	Code A	Well I'm in charge of the ward on nights.
11.31	DC Code A	Yeah.

Code A The e, because there isn't I mean apart from the person that's in charge of the hospital there isn't anyone senior to me on duty and er I have a responsibility to the ward while I'm there.

DC Code A So, on nights or out of hours you'd have a senior staff nurse overseeing the whole...

Code A ...The whole hospital

DC Code A ...hospital and then each specific ward has its own?

Code A Yeah has its own trained staff.

DC Code A Yeah, okay. So if there was anything that occurred which was unusual overnight or a particular problem with a patient or, where would you refer it to?

Code A I would tell who was in charge of the hospital erm and then I would phone a Doctor.

DC Code A Yeah.

Code A Health call after ten (10) o'clock at night.

DC Code A Yeah, which is sort of like a call out?

Code A Yeah

DC Code A System I understand, okay. We're obviously going over the treatment process and the, Doctor Code A would make decisions obviously on what treatment to provide, would you or any other nurses have any input into that in terms of well you know I....would make suggestions or if you didn't agree with it you would bring it to the doctors attention?

13.02 Code A We are entitled to erm query anything we're,

we're not happy with.

DC Code A

Code A

Right.

Erm and quite often I think Doctor Code A would erm consult with whoever was telling them about a problem as to which drug would be most suitable given the fact that the nurse knows the person personally rather than just as I mean, Doctor Code A couldn't possibly know everybody as well as the nursing staff did.

DC Code A

Code A

Yeah.

So you know and also if that particular drug doesn't seem to be as effective as it might be, you could ask her to change it to a different one because different people react differently to what you would think were the same drug, it's not you know...

DC Code A

Code A

...Yeah.

...it's a chemical thing I'm sure.

14.04 DC Code A

Yeah it would vary on person to person so, for example when Doctor Code A would come on her rounds the next day if there was a problem...

Code A

...Or if you felt that it needed doing but you could always ring her up and she would come in then...

DC Code A

Code A

...Right

...and she would change it on the treatment card if necessary.

DC Code A — Okay, right. Has there ever been times in your career particular at Gosport where a treatment program is one that you don't approve of or you think this isn't right and you've suggested something and you know that's not been taken on, if that was the case is there a process where you would be able to speak to somebody else and say look I'm not happy with this or are you aware of any procedure in the hospital that you could do that?

Code A — Erm, there are supposed to be procedures in place but how effective they are.

DC Code A — Okay and what are those procedures? What would you be expected to do?

Code A — Well initially you would have to see the clinical manager of the ward which would be Code A Code A

15.20 DC Code A — Right, okay, so you'd make representations to him and then what would he do, are you aware what he would do?

Code A — Well presumably he would have to investigate it himself.

DC Code A — Okay. Have you ever had any cause to do that, to speak to the clinical manager?

Code A — Not on Daedalus.

DC Code A — Not on Daedalus. At the hospital? All I'm after is, all I'm trying to ask is, I'm just trying to get the systems sorted out and the policies at the hospital.

Code A No.

DC Code A I mean did it involve anybody who is involved in this case?

Code A No.

DC Code A No, okay and were you satisfied with the outcome of your representation? Did you receive a satisfactory result or an answer about it?

Code A It was a long time ago, no.

DC Code A No, okay. How long ago was it?

Code A Twelve (12), thirteen (13) years.

16.43 DC Code A Okay and in terms of the patient what happened there?

DC Code A I think what we're trying to get at here is the fact that if for you to tell us that if you were unhappy about something, and you thought that maybe the treatment that this person was getting, I don't think its the right sort of treatment...

Code A ...You'd think now that it would be a test.

DC Code A ...then you would go and complain, yeah, you would go and make representations they've made this decision, I don't agree with it, I need somebody else to address it and look?

Code A Yeah.

DC Code A Yeah.

Code A Now it would be addressed and it erm would be erm dealt with properly.

DC Code A Okay but that time twelve (12), thirteen (13)

years ago it was a different issue and you weren't obviously happy about it?

Code A — No.

DC Code A — Okay, okay. Obviously what we're talking about is Code A and although she came in twice into the hospital, the dates we're sort of concentrating on are between the 17th of August and the 21st. Now in relation to your statement you were on nights, on certain days weren't you over that period of time, can you remember what you were working?

18.24 Code A — No, well I worked Thursday, Friday, Saturday.

DC Code A — Okay. I think on your statement you say you started on Thursday, that would be the 20th, what hours do you do on nights?

Code A — It's eight fifteen (8.15) to seven forty five (7.45).

DC Code A — Okay. Perhaps you could just go over...

Code A — ...You get an hour and a half off in the middle.

DC Code A — ...perhaps you could just go over your duties on nights, you know a normal night duty you know what you're expected to do? I know probably each night is different but...

Code A — Basically er well a hand over takes around about quarter of an hour to half an hour depending how much information you've got to pass on and then erm because it's coming up for bedtime, some patients will already be in bed and some will be waiting to go. Basically we

go round, help people into bed, make sure they're comfortable, get their teeth out ecetera.

DC Code A Yeah.

19.30 Code A And erm about something like half past nine (9.30) I would break off from that and leave the health care (inaudible) to do it and I've got ten (10.00) o'clock drug round to do. I come round give everyone their ten (10.00) o'clock drugs and then by the time I've finished going round doing that they've usually finished the rest of the patients, putting them to bed and then its lights out, tidy up and have a cup of tea because we need it by then.

DC Code A Yeah.

Code A Erm then I would, we would call it the silent hours, its a case of checking on the patients roughly half hourly but because there's three of us it doesn't always go that long sometimes its twenty minutes erm of course if theres a noise you have to investigate that erm anybody rings the bell we have to go and do that erm and that goes through until should be six (6.00) o'clock in the morning and then its go round wake everybody up, lets see what nursing care they need, sit them up erm give them a cup of tea, there are some six (6.00) o'clock drugs though not very many because er only the ones that are really essential get given at six because they're too sometimes difficult to rouse enough to take

medicine so a lot of them are given at eight (8) rather than six (6). Erm so we go round and sort everyone out and then half past seven (7.30) is handover time for the day staff.

21.41 DC Code A Okay, just talk me through the hand over then, what sort of things would be discussed at that hand over?

Code A Erm which one?

DC Code A Well both, go for both.

Code A In the evening I would be told erm what sort of day the persons had had, if their medication had been changed erm what sort of investigations were in progress and erm if there were any particular concerns that I need to take notice of erm and what, when its like a Friday night for instance and that's my first night on for five nights, I would be given a sort of rough summary having been off a week since I saw them last.

DC Code A Right.

Code A Erm in the morning erm it depends who was on duty, if the person, people who are on duty were on duty the night before I just need to tell them any of the occurrences overnight.

DC Code A Yeah.

23.02 Code A But if there's some that have been days off or on leave or something I have to give them a more extended.

DC Code A Yeah, okay. Okay, right as I say we're talking

about Code A what's your recollection of Code A doing those period of time?

Code A It's erm I can't honestly remember her, I can remember a figure in the bed but to say I can remember her face or anything specific about her I can't.

DC Code A Okay, now as I understand it the only night you saw her was the Thrusday the 20th going into Friday the 21st.

Code A First thing on the Friday 21st, she died just after, according to the notes, the statements and my notes on the nursing notes, I honestly thought she'd died early morning but I have signed it to say it was early eve..early in my second shift which would have been the Friday night.

DC Code A Right, okay. So it's basically a figure in a bed that you recall?

Code A Mmm.

DC Code A Do you remember her daughters there, do you remember?

Code A I do remember I can't remember her name, the daughter that live, that lives locally, I do remember her being there all the time I had several conversations with her every time I went into check how Code A was and she would have a little chat.

24.56 DC Code A Okay. In relation to your statement as I understand it you weren't involved in

administrative, administering any drugs to..?

Code A — No the syringe driver was already in place.

DC Code A — Okay.

Code A — And I just made sure that it was working properly (inaudible) on duty.

DC Code A — Okay, perhaps you could talk me through the syringe driver, how it operates and who's in charge of it and just a general sort of overview?

Code A — How it operates?

DC Code A — Yeah.

Code A — Er it hasn't got a battery in it, it has a (sighs) adjust the rate that it goes through, pumps it in usually around about 60 to get a 24 hour period, uses a 10 mil syringe, can use a large one but you have to work out a different rate for it then...

DC Code A — ...Right.

26.01 Code A — ...and I've never used it with a 20 mil syringe because its a bit big for the actual driver itself, 10 mils sits in it just right and er the drugs are mixed in the syringe and erm the patient has a needle just subcutaneously just under the skin and er, long piece of tubing that's attached to the end of the syringe.

DC Code A — Okay so its loaded at a particular time of the day?

Code A — Yeah, well erm just whenever its decided that its necessary to use it, it could be night time, it could be any time just when erm its written up

on the chart that there's a possibility that might be necessary and its up to whoevers on duty at the time to make that decision or not as the case may be.

DC Code A So what are the advantages of using a syringe driver over giving drugs by mouth?

Code A It delivers a continous low dose of whatever drugs being used and avoids given injections every 4 or 6 hours erm which have a level of effectiveness and then it tails off so you get peaks and troughs with injections which you don't get with a syringe driver its just a steady, steady flow, its much more effective at controlling pain, discomfort.

27.57 DC Code A How common is the use of the driver on the ward?

Code A Its erm, its used quite consistently these days, not everyone has it.

DC Code A Okay, no. What would, I know you've mentioned the pain side of it but what would be the reasons for putting someone on syringe driver, we've obviously covered the pain aspect is there any other reasons why someone would be?

Code A Some people get extremely agitated (inaudible) can't really always know why and they would be turning themselves round in bed, potentially injuring themselves so you produce something like midazolam that's what's used you know to

quiet them down a bit, save them from hurting themselves.

DC Code A — Okay.

Code A — Also you can use erm hyoscine was used here as well, that dries up the secretions on the chest so they don't get that horrible, noisy, bubbly sound.

DC Code A — Right.

Code A — Without it we'd have to use a sucker which is horrible to use, patients don't like it and er but you're left with having to do that otherwise the patient would drown in their own secretions.

29.29 DC Code A — Right is that because they're laying down all the time when its building up, when the fluid builds up?

Code A — Yes it does. They don't cough when they're under sedation so they can't clear it themselves so it just pulls them eventually.

DC Code A — Eventually, yeah.

Code A — You've got to do something about it so hyoscine sorts that.

DC Code A — Okay, perhaps we'll have a look at the drugs. What I've got here is the file for Code A Code A which you may have seen parts of it before. This part is the, basically the prescribed drugs for Code A, just show you that. Now I believe, if you're aware she was on four drugs, like which were on the syringe driver.

	Code A	(inaudible) this one and these, no, not that one, diamorphine where's the diamorp...that one.
	DC Code A	That's it, it would be diamorphine.
	Code A	Haloperidol. Haloperidol has quite similar to midazolam but the problem is as I said 10 mil syringe you've got to put the diamorphine in which comes in a powder formula, a vial and you have to erm dilute it with something, midazolam, that comes in a 2 mil, it depends on how many of those you have to give, you're filling your syringe up all the time but haloperidol comes in 1 mil, so quite often you would because your syringe was getting too full up you would use haloperidol in place of something like midazolam because it would fit in the syringe, there's nothing sinister about using the two, it's just you know you've got 10 mil, you can't go above that.
31.45	DC Code A	Okay can you just talk us through the four drugs and just sort of describe what they're for and what the effects are?
	Code A	Diamorphine erm is erm pain relief principally although it can be used when somebody is er sometimes they, people who are demented do scream and you're never sure whether it is pain or, or just an agitation of mind and diamorphine does help to address both things at once. (inaudible)
	DC Code A	Yeah, sorry if we go onto the halo...

Code A ...Haloperidol as I said its used for extreme agitation usually, do you know what the only thing that I would say about haloperidol, it does have a build up over time.

DC Code A Does have a...?

32.45 Code A A build up over time, it stays in the system longer than midazolam so that you know if you're giving somebody haloperidol over several weeks it erm it does leave a slight residue each time so that if you would have to cut back on ...

DC Code A ...Monitor (inaudible)

Code A ...at some point, whereas midazolam doesn't, well as far as I'm aware do that and hyoscine like I say erm dries up the secretions.

DC Code A Right, yeah, okay. So midazolam and haloperidol do sort of target...

Code A (inaudible) yeah.

DC Code A What is the reason for giving both, is it...?

Code A Well as I've just explained sometimes you're coming, I must say it's unusual, usually we use either, or but erm though I couldn't tell you why the decision was made to use both at the same time but it could possibly be due to the capacity of the syringe.

DC Code A Right to ensure that she gets...

Code A ...Yeah, yeah.

DC Code A ...the level she needs.

Code A Because the higher, the higher the dose of

midazolam that's used, I can't remember what each vial of midazolam, what it's strength is but it's 2 mils so as you go on you're going to get to your 10 mils before you, you've giving her anything else so if you give, if you sort of use a combination. If you're using a syringe capacity...

DC Code A ...Yeah, yeah.

Code A ...got room for hyoscine comes in 1 mil ones, diamorphine as I say what we usually do is dilute the erm diamorphine with some midazolam to save space, other than that you would have to use sterile water which would increase the amount you're trying to get into one syringe.

DC Code A Are you able to comment on the doses and how much they are?

Code A (inaudible) still at 40.

DC Code A Yeah.

Code A Erm as far as I'm concerned that is a, a low dose given the fact that this woman was given over a 24 hour period.

DC Code A That's the diamorphine and ...

Code A ...Diamorphine and (inaudible), it's not very dramatic at all.

DC Code A Okay.

Code A Er I was on duty and she didn't show any signs of pain at the time when I was on duty so I would have thought that's probably the best

level. Er (inaudible) hyoscine that is about average what most people have and 20 milligrams of midazolam is what I would expect, given that you've got haloperidol as well.

35.52 DC Code A So there all fairly....

Code A ...Yeah, no there's nothing that I would say "Oh crumbs this is too much".

DC Code A Okay, right so this is obviously the prescription record, now as I understand it on the statement you made, you had no input into loading the...

Code A ...No I didn't...

DC Code A .Code A syringe driver and I, also you had no sort of input into discussing her treatment...

Code A ...No

DC Code A ...with Doctor Code A

Code A No, no.

DC Code A Okay in relation to the hand overs, was there any, anything discussed specifically about Code A Code A Do you recall anything you know about her condition or anything to be aware of with her or anything of that nature?

36.43 Code A I can't remember anything specific I mean obviously I would have been told that she was on the syringe driver and what was in it erm and I would have been told that her daughter was present erm but from then on its really TLC.

DC Code A Okay. When you came in I know you, you've

obviously seen some documents now that would refresh your memory but can you recall when you came in on the Thursday and obviously Code A is there, what was your understanding of the treatment she was on? What was your perception of it in relation to her health?

Code A — What am I supposed to say.

DC Code A — Was there anything made to you to feel that she was dying?

Code A — I don't think anybody would have said to me erm she is dying they would probably have said that she's not very well and they would have told me when the syringe driver was first put out and erm it's just continuing care really.

DC Code A — Yeah. I mean obviously do you recall seeing the drugs prescribed on the driver? Would that have indicated to you that she was, she wasn't much, obviously she wasn't well but there was a chance that she would perhaps recover to some extent?

38.52 Code A — No I wouldn't have thought, I would have thought she would recover. I thought she would probably deteriorate slowly but I don't have a crystal ball I don't know...

DC Code A — ...I appreciate that

Code A — ... how long that sort of thing could go on for.

DC Code A — Yeah, okay.

DC Code A — Is it fair to say that the for use of a better word

		cocktail of medicines that she was given, that that cocktail is for...they've prescribed that for somebody in her condition who they believe is going to die and it's just a way of making them comfortable and pain free...
	Code A	...Yes
	DC Code A	...is that what those cocktail of drugs are for?
	Code A	Basically yes.
	DC Code A	If you were like if you went onto a strange ward and you saw these drugs administered to a woman that you didn't know, would it be a fair assumption that there's nothing else we can do for this lady...
	Code A	...Yeah.
	DC Code A	...and she's on her way?
39.42	Code A	Yeah.
	DC Code A	Yeah.
	DC Code A	Okay, you didn't see Code A prior to these drugs being prescribed did you?
	Code A	No.
	DC Code A	No, okay.
	Code A	I just, I just missed her, the week before she came and went before I ...
	DC Code A	...Right
	Code A	...I was on duty and then she was back when I came on the next week so I didn't actually see her prior these (inaudible).
	DC Code A	Okay. Now on nights are you, you've obviously gone over your sort of basic stuff that

you do and obviously things that happen will come on top of that but are you involved in at any time in feeding patients or giving them water or drinks or....?

Code A ...Oh yeah, if there awake and they want a drink we give them a drink and also some people like we need to push fluids and we do that but in Code A case she wasn't conscious enough to drink without possibly choking and I don't want to be responsible for that.

40.56 DC Code A Was there any attempts made whilst you were on the ward to give her water either by mouth or by...?

Code A ...No, definitely not by subcutaneous.

DC Code A Okay.

Code A No, nobody, they, the health care support workers would only do that if I said that it was alright, 9 times out of 10 somebody in this condition it would have to be done by trained staff anyway.

DC Code A Right, being yourself or a staff nurse?

Code A Mmm.

DC Code A Right, okay. Was there any reason you can recall why she wasn't given a....

Code A ...I just said she wasn't conscious enough...

DC Code A ...no, I mean through a needle?

Code A It's one of those erm mute points really isn't it. You, yeah you make a choice to keep somebody hydrated who you're also giving

these particular drugs through a syringe driver and they do come to a stage where they don't absorb however hard and most of what drugs keep account at that point.

42.22 DC Code A Right, okay. So just recapping that then, as we said these combination of drugs in her condition would lead you to think that she was passing on, dying and these drugs are helping her to do that pain free?

Code A Yes.

DC Code A Okay. Was it ever mentioned to you what she was actually dying of?

Code A No, I mean I was, I was told about what had happened with her fall ecetera but not in any great detail, no wasn't, I don't think I was told why this course of treatment was started earlier in the week not specifically.

DC Code A (inaudible) up to day three I think when the treatment was already...

Code A ...Yes.

DC Code A ...in progress so but nobody ever mentioned that she was dying of anything specific?

43.38 Code A No, no.

DC Code A No.

Code A Well I think it's one of those unspoken things that we all, we all accept really you know just (inaudible).

DC Code A Mmm. When you say the unspoken thing is it's a case of there is nothing we can do for her?

DOCUMENT RECORD PRINT

Code A Yeah.

DC Code A Yeah.

Code A That's ...

DC Code A ...And I take it that decision (buzzer sounds) that there is nothing we can do for her would be made by who?

Code A Er well Doctor (inaudible) I presume.

DC Code A Doctor...

Code A Doctor Code A

DC Code A Doctor Code A

Code A Well she being the one that's there every day.

DC Code A Yeah.

Code A And er if she queried that she would have gone to Doctor Code A and spoken to her but I don't know.

DC Code A Right.

DC Code A Okay, we'll leave it there that buzzing noise means we're running out of tape.

Code A Oh right okay then.

DC Code A So we'll take a break. The time by my watch is 12.01. Turn the recorder off.

END OF TAPE

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y19A

Enter type: ROTI
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: PARK GATE POLICE STATION

Date of interview: 19/06/2000

Time commenced: 1207 Time concluded: 1241

Duration of interview: 34 MINS Tape reference nos. (🔊) 44/00/029044

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

Other persons present: Code A - Saulet & Co Solicitors, Portsmouth

Police Exhibit No: LMC/SRG/4 Number of Pages: 28

Signature of interviewing officer producing exhibit

Tape counter times(📼)	Person speaking	Text
0.11	DC Code A	This is commencement the interview of Code A Code A and I'm DC Code A the time is 12.07. The first thing I'll do is remind you that you are still under caution, okay. You do not have to say anything but it may harm your defence if you don't mention when questioned

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something which you later rely on in court, anything you do say may be given in evidence, okay. We've obviously taken a short break, can you just confirm for the tape that I've not asked you any questions regarding this incident with Code A during the time the tape recorders been switched off?

Code A No, (inaudible)

1.01 DC Code A Thanks, right, okay just prior to the tapes finishing we were discussing obviously Code A Code A We discussed the drugs that were loaded into the syringe driver and the fact that the driver was already loaded when you were on duty and you had no input, or you didn't load the drugs for Code A at any time, and your perception of Code A condition and the drugs that she was on as someone who was dying and it was a way of just making her death as pain free and as comfortable as possible, is that right? Is that sort of fair assessment?

Code A Yes

DC Code A Okay. We've discussed the, sort of being given drinks and food and that she wouldn't, you wouldn't feel happy about doing that.

Code A No.

DC Code A a. By mouth because she could probably choke and b. Because of the fact she was dying and the chances are you say she wouldn't be able to

absorb water.

Code A Volumes is greater than the syringe drivers small amounts of volume but the subcutaneous fluid is greater for absorption probably and you want her to absorb the drugs that you've given her, that are keeping her comfortable rather than fluid which is a small perhaps cosmetic thing.

2.46 DC Code A Right, okay so are you saying there that if you were to hydrate with a needle it would affect the, her capacity to absorb the drugs?

Code A Could do not necessarily...

DC Code A ...Not necessarily but could do in individual cases?

Code A Yeah.

DC Code A Okay, right if we go to I'll just refer back to the record of Code A and particularly her care, showing you now her clinical notes. Have you had chance to read these clinical notes?

Code A Well as far as one is able.

DC Code A Right, what do you mean by that?

Code A Interpreting the writing is sometimes...

DC Code A ...Right, okay.

Code A ...a bit difficult.

DC Code A In your role at the hospital would you have ready access to these notes?

Code A Yeah.

DC Code A Whereabouts would these be kept, these clinical notes?

3.57 Code A Kept in the office and on the trolley.

DC Code A — Right, okay. Can you just generally talk us through if you can?

Code A — I don't know if I want to be first. How far do you....

DC Code A — ...Yeah I mean

Code A — ...I mean that just says transfer.

DC Code A — July the 14th, sorry I've gone too far back.

Code A — Re-admitted...

DC Code A — ...This is the 17th.

Code A — ...from Haslar erm the reduction of the what that says, I'm not sure, reduction obviously of the hip, dislocation and under IV sedation, remained unresponsive for some hours now appears peaceful. Erm continue on haloperidol which will keep her from throwing herself about and dislocating hip again.

DC Code A — Right.

Code A — Erm only to have oramorph if in severe pain, then that says see daughter again then the following day it said that she'd been comfortable, says here still in great pain, there appears to be a gap doesn't there erm.

DC Code A — Yeah from the 17th to the 18th.

5.56 Code A — Mmm, but the nurses might fill that in does it not...

DC Code A — Maybe we'll come to those.

Code A — I can't, I can't make that line out erm Doctor Code A erm suggests syringe driver, diamorphine, haloperidol and midazolam, it says

she received on the fifth day, please make comfortable.

DC Code A — And that's on the 18th isn't it?

Code A — Mmm, so that presumably is when the decision was made about...

DC Code A — ...Mmm

Code A — ...and er on the 21st, she was much more peaceful now needs hyoscine for her something chest erm rattly I think that says.

DC Code A — Right that's the medicine to her chest ...

Code A — ...I mean I didn't hear her, any particular chesty that I can report.

DC Code A — ...no.

Code A — Something that I can remember, I mean that's me.

DC Code A — Okay. Can you just sort of go through that then and what that's all about?

Code A — It seems strange (inaudible) very often. Condition very poor that's my perception.

DC Code A — Yeah.

7.32 Code A — Er she was pronounced dead 21.20 hours by me, the relatives were present in brackets (2 daughters), she was for cremation, which is a question I hate to have to ask at this time but I have to ask because they have to have 2 doctors signatures as against one if its for burial.

DC Code A — Right, okay.

Code A — I wish they'd take that, ask that when they're first admitted I really whether they're likely to

die or not it would save us having to ask that at that...

DC Code A — Answer at the time, cremation, yeah.

DC Code A — Question, yeah, okay. Can you remember Code A Code A dying and you pronouncing death?

Code A — Yeah.

DC Code A — Okay. What was the circumstances for it, can you just describe what happened? Just the whole sort of what you recall about it.

Code A — Well, obviously I hadn't been there all day, I was there the previous night but checked on her frequently. Daughter was there all the time and she was reluctant to leave the room so that we could do anything for Code A she seemed to be intent on watching everything erm she was very nice to know but she never complained to me about anything apart from telling me erm about this incident with the ambulance, she never complained about anything or anyone else. She was obviously not happy...

9.13 DC Code A — What's the incident in the ambulance?

Code A — Well there was some query about the method of transferring her in the ambulance which I didn't know anything about, hadn't been mentioned to me specifically but I obviously found out about it since and, but that's all she was saying. She was waiting on that, that first night for her other sister to come from away and she arrived I think

it was possibly that's confused me on time, erm she arrived in the early hours of the morning or whenever it was erm and then we'd get together. Code A did complain about her sister's erm lack of help over the years...

DC Code A Right.

Code A ...I think she felt she'd been left to do it all on her own er then she was fine. She really was, didn't want us to disturb Code A for what we see as the routine things we have to do, check that they're clean and ecetera, or a mouth care which is something we do automatically but she didn't seem to want us to do anything like that she more or less, the implication was that if it was necessary she'd do it herself, she obviously was a nurse.

10.55 DC Code A I think you mention in your statement don't you that Code A wanted to prepare her herself?

Code A Yeah, with two daughters and the, I don't know whether it was a granddaughter or a niece or somebody who works at Haslar erm she arrived just after she'd died, I think they'd found her and they wanted to lay her out and prepare her for the mortuary and er so they did. Did all the usual things, put a nice pretty nightie on, put a crucifix round her neck and there was a particular white rose in the room which I believe had some significance for Code A.

DC Code A ...Right.

Code A ...that they particularly wanted to go down to the mortuary with her and when they said they'd, they'd done their thing the body has to be wrapped up in a sheet to go, for transfer to the mortuary and to health care support workers was waiting to do that and when they rolled her over to put a sheet under, they found that her bottom needed washing which we thought Code A Code A

12.15 DC Code A ...Had done.

Code A ... Code A would have noticed and if she didn't want to do that herself would have told us so we had to do that and then she was wrapped and her daughters both wanted to go down to the mortuary with her which they did, but they didn't actually go into the mortuary itself but just waited at the door, removed the crucifix before she went in.

DC Code A Okay, right can you just go over the procedure then, you've obviously gone in there and she's died, can you recall who brought that to your attention or was she just found or discovered?

Code A Well in the last hour or so I was in there frequently but given the fact that the daughter was there I didn't stay in the room all the time, we do stay with them if there's no relatives there but erm I got...the daughter called me in several times to check before the last time when, when she had died.

DC Code A — Right, okay so it was just a, at first she slipped away?

Code A — Yeah, basically stopped breathing.

13.41 DC Code A — Okay so what procedure, now you've obviously described the preparing for the mortuary and what would normally happen, in terms of notifying people and paperwork to fill out what are your responsibilities there?

Code A — Erm notifying people, well Doctor Code A I hold a certificate that says I can pronounce somebody is dead but this doesn't mean I'm saying why...

DC Code A — ...No it just (inaudible)

Code A — ...it just means I can say whether somebody's alive or dead erm so I do this, write up my notes and I would inform whoever was in charge of the hospital erm because there was relatives present they would let the rest of the family know, normally I would have to ring and erm Doctor Code A would be informed when she visited the ward in the morning, she would go down to the mortuary if she wanted to see her and I would have to get somebody else, another doctor because of it being for cremation.

DC Code A — Yes, as I understand for cremation it's two doctors.

Code A — Two doctors.

DC Code A — Where you aware of the criteria required for the second doctor?

15.07	Code A	No, I don't have anything to do with it basically it's only where the patients affairs of us and Doctor Code A will ask somebody else to...
	DC Code A	...But you in this case you had to establish that she was being cremated so Doctor Code A was aware in order to comply with...?
	Code A	...Yeah because erm if somebody's for cremation, well all the erm undertakers know anyway and they won't release the death certificate until they've got two because it's the law.
	DC Code A	Yeah, okay, alright so that's endorsed on her clinical notes, now there are some other notes aren't there?
	Code A	Nursing notes.
	DC Code A	Which I just want to go through generally really, which I think relate to her sort of general hygeine?
	Code A	Yeah.
	DC Code A	Right we have the contact records?
	Code A	Yeah that's nursing.
	DC Code A	And what is this actually used for, the contact record?
	Code A	Oh sometimes it feels like your doing things in triplicate but this one is kept in the office, as against at the end of the bed, which is a care plan.
16.33	DC Code A	Right.
	Code A	This one is for, it isn't filled in everyday it's

filled in for specific incidents that come up.

DC Code A — So if anything is worth noting it should be recorded?

Code A — Yeah, perhaps specifically...

DC Code A — ...but its not like a....

Code A — ...out of the ordinary

DC Code A — ...you don't do like a half hourly visit and say no change, no change, you know all the way down, you know every half hour or anything like that, it's only written in if there's something to say.

Code A — No, no that's erm that's on the care plan which is probably just the recent care plans, these are kept at the end of the bed...

DC Code A — Yeah.

Code A — ..and for each erm thing you need to do like you have to have one for the bowels, one for hygeine, one for whatever you know (laughs) one for night, we have one for nights, if there's any spe...dressings or sort of you know things like that...

DC Code A — ..Yeah.

17.40 Code A — And they're supposed to be done every time anythings done to the patient. I have to say they don't always get filled in erm due to a time thing you know, you're rushing from one to another...

DC Code A — ...Yeah

Code A — ...erm and you don't always stop and fill it in, we know we should but it's...it's a bit chaotic

you know you always try and go back and check that they have all been done before I leave the ward but sods law that I'll forget one.

DC Code A — There are occasions then that they're missed?

Code A — Yeah.

DC Code A — So the care plan relates to sort of a...

Code A — ...General every day care.

DC Code A — ...being washed and fed and...

Code A — ...You know TLC bit (laughs).

DC Code A — Yeah basically and the contract record is in relation to a...

Code A — ...Specific incident.

DC Code A — ...specific incident so I'll draw your attention to the final entry on the contract record, which is on the 21st of August again.

18.43 Code A — Mmm, that's me again.

DC Code A — That's you again and you've timed it at twenty one twenty (21.20)

Code A — Yeah

DC Code A — On the twenty first (21st) that you pronounced death....

Code A — ...Yeah.

DC Code A — ...of Code A Okay. Would you ordinarily be completing the care plan?

Code A — Erm, mmm, most of them we just do the night one but if there's...if asked they had to renew a dressing because it's come detached or something specifically needs doing I might do one of those but...and sometimes the urinary

one, if the blood is...if the erm if they've got a catheter and the catheter was blocked and I had to do a wash out and I'd have to record it.

DC Code A Okay. So again on the final page of this nursing care plan, so should there be a separate one for nights, is there like a...?

Code A Should be it's usually the last one, not always, usually. but it doesn't appear to be there, no.

DC Code A Okay so this one here obviously the nineteenth (19th) is the last entry and obviously another two days but that would basically...this would basically cover things like being washed, being fed, teeth cleaned, dressings changed?

20.27 Code A Mmm, er yeah er well, on specific sheets...

DC Code A ...Right.

Code A ...possibly what we would say was all nursing care which means that we've done all the things that were necessary.

DC Code A Right, okay so you'd summarise it in a....

Code A ...Mmm

DC Code A ...right this one here is....that obviously relates to the eleventh (11th)?

Code A Yeah when she first came in.

DC Code A This evaluation, can you describe...explain what this refers to?

Code A Well it just says no food taken so obviously she, but the twenty first (21st) she was on the driver wasn't she it was an issue, that she would, would or wouldn't have done somebody's just.

	DC Code A	Okay. Do you know whose signatures these are in relation to thriteenth (13th)?
	Code A	I think, oh know I really can't be sure but I think it looks very much like it might be Code A Code A I don't know.
21.36	DC Code A	Okay what's the middle one there on the fourteenth (14th)?
	Code A	Right, Code A she's a health care support.
	DC Code A	And the final one on the twenty first (21st)?
	Code A	That look's like the same one.
	DC Code A	Yeah so possibly Code A
	Code A	Possibly.
	DC Code A	Okay so in relation to the care plan, ideally they should be completed but there are occasions when they're not?
	Code A	This particular night we had two.
	DC Code A	Two...
	Code A	Two deaths.
	DC Code A	Two deaths, right, okay. Can you remember at the time how....the capacity of the ward? How many patients you had in the ward?
	Code A	No.
	DC Code A	Okay, what is the size of it? You've got eight...
	Code A	...Twenty four (24).
	DC Code A	...you've got twenty four (24) beds, okay.
22.22	Code A	There not all full up very often, we, we average around about eighteen (18) or nineteen (19).
	DC Code A	Okay.
	Code A	But I can't remember.

DC Code A — Right so and on that night you had Code A Code A overseeing it, would she have been notified about the deaths?

Code A — Yeah.

DC Code A — Would that be soemthing just to make her aware?

Code A — Yeah, yeah she also erm held the key to the safe if there's any valuable to put away.

DC Code A — Right, okay...

Code A — ...she records it in the book down in the office.

DC Code A — Would she ordinarily come down to the ward just to oversee everything?

Code A — Not normally, no erm only if I wanted her to, if I asked her to 'cause well she just happened to be there at the time, you know.

DC Code A — But the responsibility on that side of it would tend to fall to yourself?

Code A — Mmm.

23.24 DC Code A — Okay, right. So just..I'll just sort of recap then and summarise what we've discussed so far so it was in the middle of the second night the twenty first (21st) that Code A died, so you'd seen her a night and a half effectively.

Code A — Nine twenty (9.20).

DC Code A — Okay. You didn't have any discussions with Doctor Code A

Code A — No.

DC Code A — Or Code A ? Did you have any discussion with Code A regarding Code A

	Code A	No.
	DC Code A	Or any problems?
	Code A	No, I don't think so.
	DC Code A	Okay.
	Code A	I don't think that..it or depends on what duty he's on, I don't always see him every week.
	DC Code A	Okay. Your first contact with Code A she was already on the syringe driver?
	Code A	Yeah.
	DC Code A	And had been for a couple of days previously?
	Code A	Yeah.
24.21	DC Code A	Excuse me and your perception of the drugs she was on in her..her general level of health gave you the impression that she was dying and this was a path to take to assist her, not to assist her but to make it pain free as possible and as comfortable as possible. What you said you didn't recall the sisters making any representations to you about...
	Code A	...Nothing specific, no.
	DC Code A	...about the treatment she was receiving at that time?
	Code A	No.
	DC Code A	But you are aware which you've learnt since about the, a problem with the transfer from Haslar?
	Code A	Yes. I knew it, I..it was something that was spoken about erm by the daughter, I can't, who the nursing staff had mentioned it.

DC Code A — Okay. Now we've described your sort of role on the ward and basically you were responsible overnight, and I think it's fair to say that you had no concerns over what Code A was being prescribed?

Code A — No.

25.40 DC Code A — There was no concerns at all over the level of drugs or her reaction to them?

Code A — No.

DC Code A — Okay. I think you've mentioned this before in your statement, you're not able to comment on the actual effects of the drugs because you didn't see her...

Code A — ...No, I didn't see her before she had them.

DC Code A — ...beforehand so you can't say, okay. We've described the drugs and what they're intended to do and the levels we're talking about you say that's sort of ...

Code A — ...Reasonable.

DC Code A — ...perfectly reasonable amounts. No concerns over the level of drugs. We've discussed the scenario if you had a problem with the treatment, what procedure you'd follow in order to do that and we've obviously discussed the syringe driver operation. There's one thing, do you know the make of the syringe driver?

Code A — Golly, I've no idea.

DC Code A — Okay.

Code A — You wouldn't believe it would you (laughs).

	DC Code A	What training do you receive in using it?
26.51	Code A	(laughs) I think we did this before.
	DC Code A	Yeah, yeah.
	Code A	Erm we're just instructed the first time we use it and then there's er a leaflet up on the wall in the erm treatment room that we can refer to if we've got any queries.
	DC Code A	Right, okay. If, is it, do you recall there being a change of model or a change of make on the ward?
	Code A	No.
	DC Code A	No, so it's...do you recall using the same one, for how long? How long had that been on the ward?
	Code A	It must be, well I mean I've only been on the ward, that ward for about three weeks but in the hospital overall it must be ten, twleve years, must be.
	DC Code A	Okay. Just another point, just going back to the previous notes about, there was a comment made on the twenty first (21st) about her chest, Code A chest, it didn't look very clear and a mention of hyoscine on here, from your recollection you stated that you had no concerns over....
28.07	Code A	...I don't recall her being chesty...
	DC Code A	No.
	Code A	...but then
	DC Code A	I think you'll find that she had hyoscine from

		the seventeenth (17th) anyhow, although its...
	Code A	...No she'd had that
	DC Code A	...was it, where's the...have a look at the drug thing, I think Doctor Code A prescribed it if required and it was administered straightaway.
	Code A	Well no it was actually put...first put up on the nineteenth (19th).
	DC Code A	On the nineteenth (19th) did it sorry.
	Code A	Yeah, nineteenth (19th), twentieth (20th) and the twenty first (21st).
	DC Code A	So by the time you actually came on duty she may have not had to...
	Code A	...No.
	DC Code A	...the rattle so to speak because she's already on the hyoscine.
	Code A	On the nineteenth (19th) at eleven twenty (11.20) she would have had it all day...
	DC Code A	...So that
	Code A	...prior to me coming on duty at eight.
28.47	DC Code A	So you wouldn't have heard it anyhow?
	Code A	No.
	DC Code A	Okay.
	DC Code A	Just...can I ask a question for a sec?
	DC Code A	Yeah, yeah go on.
	DC Code A	In relation to the medicines that she received the four medicines that we've already been through, are you aware of any possible adverse effects which may have affected Code A health because of the combination of drugs?

	Code A	No.
	DC Code A	There's nothing adv...like a and b don't really go so she shouldn't have them?
	Code A	No, this is a combination we use regularly.
	DC Code A	Yeah and also is there any equipment on the ward, like to assist people's breathing or used in emergencies to resuscitate people or anything like that?
	Code A	We do have a trained resuscitation erm...
	DC Code A	...Equipment on
	Code A	...equipment on it and we do have oxygen on the ward.
29.48	DC Code A	But somebody in...sorry
	Code A	Well, a lot of the patients and not for resuscitation.
	DC Code A	Yeah.
	Code A	It's not like the younger, you know so mostly on patients we wouldn't use it but we have got it on the ward and we can use it if necessary.
	DC Code A	Yeah but somebody like in Code A situation may have, she's ninety one (91), she's poorly, hip replacement, deaf, can't see very well, can't look after herself that's the sort of patient that would be put under the no resus?
	Code A	Yeah, they would be given a combination of the drugs as well.
	DC Code A	Yeah.
	Code A	Erm.
	DC Code A	The combination of the drugs as well, I mean...

	Code A	...It's a very strange exercise to erm, er and all shouting all (laughs) resuscitation because it just...
	DC Code A	There's no point.
	Code A	...wouldn't be relevant. Unfortunately this is all overtime by us even if we know all the circumstances it's not...
30.59	DC Code A	...I'm sure it does.
	Code A	...it's not easy. It's all life.
	DC Code A	Okay, just looking through your statement on page three.
	Code A	Oh dear.
	DC Code A	No it's just a point...
	Code A	Not the right account.
	DC Code A	...you mention the daughter also believed that her mother was far healthier mentally than what had been diagnosed?
	Code A	Mmm
	DC Code A	Can, obviously you only saw Code A when she was...
	Code A	Right, yeah.
	DC Code A	...you know obviously sedated or whatever. What's drew your attent...
	Code A	What makes you say that?
	DC Code A	...Yeah what makes you say that basically?
	Code A	It, this must have been part of the handover that erm because obviously I was giving out a resume of what had happened in the week before and erm I, it's so long ago but I think I

remember being told that despite being asked to stay in her chair she wouldn't do that. Her belief in herself that she could get up and do whatever she thought she wanted to do outside the room which we get all the time and erm on this particularly occasion she did get up and she did fall which is very sad but Mrs, what Mrs..the way Code A was talking her mother was talking to them perfectly normally, well again it's a case of perception erm and for Code A Code A it might well have been normal, what she'd gotten used to...

DC Code A ...Yeah.

Code A ...because she'd been with her mother on a continuous basis. They very often don't realise the degree to which the dementia is there whereas the people outside would query it quicker, does that help, is that okay?

DC Code A Yeah that's fine, yeah. Were you aware that she had senile dementia?

Code A Yes.

DC Code A And you're aware of her other ailments at the time? Would that have been part of the handover you received?

Code A Yeah.

DC Code A Can you recall what they were?

Code A No.

(laughing)

DC Code A Fair enough.

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Code A For the most part we, erm bits that stick are the relevant bits at that, that time, things that are gone before I found, wanted to query something I could look it up.

DC Code A Okay, right is there anything else you wish to add?

DC Code A Can I go home, you can go home (laughing)

Code A (laughs)

DC Code A Is there anything you want to clarify? Anything you've said that you feel we haven't understood or warrants further explaination?

Code A I don't think so.

DC Code A Okay. Hand you a notice explaining the tape recorder procedure which is just there. Time by my watch is twelve forty one (12.41) (coughs) excuse me, turning the recorder off.

END OF INTERVIEW

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20

Enter type: ROTI
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 25/07/2000

Time commenced: 1110 Time concluded: 1136

Duration of interview: 26 MINS Tape reference nos. (📼)

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

Other persons present: Code A - Hempsons Solicitors

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(📼)	Person speaking	Text
	DS Code A	this interview is being tape recorded, I am Detective Sergeant Code A the other police officer present is....
	DC Code A	DC Code A
	DS Code A	Right I'm interviewing Doctor Code A Doctor could you give me your full name please and date of birth?

DOCUMENT RECORD PRINT

Code A — I am Doctor Code A date of birth Code A

DS Code A — Right, also present today is.....

SOLICITOR Code A of Hempsons Solicitors.

DS Code A — Today's date is Tuesday the 25th of July the year 2000, and the time by my watch is ten past eleven (11.10) in the morning. This interview is being conducted in an interview room at Fareham Police Station and at it's conclusion I'll give you a notice explaining what will happen to the tapes. I must remind you Doctor Code A that at any time during this interview you have the right to legal advice, if you want to talk to Mr Code A without us being present then please ask and we will leave the room. Your presence here is voluntary, you are not under arrest, you can leave at any time. Right, I also ought to say that you don't have to say anything but it may harm your defence if you do not mention when questioned something that you later rely on in court, anything you say may be given in evidence. If I can just point out this notice where it says that this interview room is capable of being monitored when the tape recorder is on the record mode only and with the tape running, a warning light will indicate when monitoring is taking place which is this red light here and at no other time can your conversation be overheard. Right that's my introduction.

We the police are investigating a complaint made by

Code A and her sister Code A Code A into treatment afforded to their mother, Code A who was a patient in the Gosport War Memorial Hospital particularly between the 17th and the 21st of August in 1998 and I understand that you were one of the doctors who were providing care for Code A and I understand that you have a prepared statement that covers your dealings with Code A and I'd invite you perhaps in your own time just to work through that statement and give me as much detail as you can about the dealings you had with Code A Code A

2.23	Code A	Reads statement as attached.
26.46	DS Code A	Thanks ever so much for that, what I'll do is we'll take a break there. Would you like a drink?
	Code A	Yes, please.
	DS Code A	What would you like?
	Code A	Lot's of water please.
	DS Code A	Yes of course we'll arrange that for you. By my watch the time is 11.36 and I'll turn the tape recorder off.
		STOPPED FOR BREAK

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y20A

Enter type:
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 25/07/2000

Time commenced: 1159 Time concluded: 1205

Duration of interview: 6 MINS Tape reference nos. (📼)

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

Other persons present: Code A - Hempsons Solicitors

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(📼)	Person speaking	Text
	DS Code A	This is a continuation of our interview with Doctor Code A. Doctor we've had a short break now after your long and full explanation of your dealings with Code A Code A I'd like to just explore one area if I can and that was the relationship that you had throughout her stay with the family, particularly

the two daughters. Are you able to expand upon that at all?

SOLICITOR Code A I'm afraid as I've already mentioned before we started unfortunately Doctor Code A does feel very upset and uptight by er the allegations and er would find it very difficult I think to deal with, with questions hence obviously (inaudible) statement so erm given that concern that she wouldn't do herself justice er I've advised her not to make any further comment er so she will be NO COMMENT.

1.03 DS Code A Okay, what I'll do is I have just a very few questions that I'd like to run through and I understand that the answer will probably be No Comment but if you do feel that you'd like to answer any of them at any point then please feel free. I think one of the main thrusts of the complaint known by Code A and Code A was a lack of clarity in the explanation as to the use of a syringe driver. Do you consider that you explained and got there acceptance of the use of a syringe driver?

Code A NO COMMENT

DS Code A Would you be happy to explain exactly what the term I'm happy for nursing staff to confirm death meant on the 11th of August?

Code A NO COMMENT

DS Code A Was Code A death inevitable on the

		11th of August?
	Code A	NO COMMENT
	DS Code A	Once we'd gone down the route of using a syringe driver, at any point from the 18th to her eventual death on the 21st, was there any consideration given to reducing the levels of diamorphine being used to assess if there was any recovery or any improvement in her general overall condition?
2.57	Code A	NO COMMENT
	DS Code A	Was there a consultant available in the War Memorial Hospital during that week?
	Code A	NO COMMENT. NO COMMENT
	DS Code A	No I think I'm happy there. Right (inaudible).
	DC Code A	(Inaudible)
	DS Code A	One of the other complaints by the family was the question of re-admission to Haslar for a third time was discussed and the family indicated to yourself and Code A that they'd had a conversation with the consultant at Haslar who was willing to re-admit her but were you aware of that conversation?
	Code A	NO COMMENT
	DS Code A	And if you were aware that that conversation had taken place why wasn't her re-admission arranged?
	Code A	NO COMMENT
	DS Code A	Okay, I think that's the points that we needed to cover straight away. Thanks ever so much. Is

there at this point anything else about this incident or matter at all that you'd like to add or to clarify? This is your opportunity by way of closure to say anything else that you'd like.

Code A No thank you.

DS Code A Okay by my watch the time is five past twelve (12.05) and I'll turn the tape recorder off.

END OF INTERVIEW

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y17

Enter type: ROTI
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: PARK GATE POLICE STATION

Date of interview: 20/06/2000

Time commenced: 1414 Time concluded: 1459

Duration of interview: 45 MINS Tape reference nos. (◆) 44/00/289213

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

Other persons present: Code A Saulet & Co Solicitors, Portsmouth

Police Exhibit No: LMC/CM/10 Number of Pages: 46

Signature of interviewing officer producing exhibit

Tape counter times(◆)	Person speaking	Text
	DC Code A	This interview is being tape recorded, I am DC Code A the other police officer present is....
	DC Code A	DC Code A
	DC Code A	Okay it is Tuesday the 20th of June, 2000. The time by my watch is 14.14. I'm interviewing

Code A please can you give your full name and date of birth?

Code A Code A Code A Code A

DC Code A Thank you and also present is....

SOLICITOR Code A of Saulet and Co Solicitors, Portsmouth, Legal Advisor.

DC Code A Okay. The interview is being conducted at Park Gate Police Station. At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes. I must remind you that throughout the interview you are entitled to legal advice and we can delay the interview at any time for you to receive that advice so if your in any doubts about that just say so at any time. Okay I'm now going to explain why we've asked you to come down here today and just basically a summary of what we're trying to achieve. The Hampshire Police have undertaken an investigation into the circumstances of the death of Code A Code A on the 21st of August 1998 at Gosport War Memorial Hospital. The investigation centers around an allegation that Code A was unlawfully killed as a result of a course of treatment that was embarked upon between the 17th and the 21st of August whilst admitted to this hospital. We are seeking to interview those members of the

nursing staff who had a duty of care to Code A Code A during that time and who in some cases may have provided her with direct nursing care or treatment in order that an account can be obtained to the particular circumstances and issues that existed between those dates. I emphasise that this is a search for the truth and your account and answers will be carefully assessed in the light of information arising from other interviews with the staff and general correspondence. As a result of this interview and several others further guidance will be sought from professional bodies and ultimately the Crown Prosecution Service on how we should proceed. Your solicitor has been provided with relevant material prior to this interview commencing. I must emphasise that you are not under arrest and you are free to leave at any time, your right to free legal advice in private extends throughout the period you are at the police station, okay. Now the next part is the caution, you do not have to say anything but it may harm your defence if you do not mention something which you later rely on in court, anything you do say may be given in evidence, okay. That's the caution, do you understand that?

Code A Yes, I do.

DC Code A Okay. As I 've said to I think everybody who

we've spoken to so far, there's quite a lot there, what I would try and emphasise is that there's no judgements going to be made by myself or DC Code A or anybody within the police force or CPS without having spoken to people who have got experience in the medical profession and also experience in the treatment of elderly patients, you know it's not a judgement we're able to make so it's not a case of us asking questions and getting answers we don't necessarily understand and making a rash judgement on that. It's going to be a carefully considered results at the end of the day.

3.44 DC Code A Mine and Code A role in this sort of enquiry is to establish fact...

Code A ...Yes.

DC Code A ...like as Code A said we're not in a position to query what drugs are issued, when they're issued, what for and who by or anything, that's not our department. We're just here to establish what people know and their roles and responsibilities during the course of Code A Code A time at Gosport War Memorial.

Code A Yeah.

DC Code A Okay, what I'd like to do first is just get some background about yourself in relation to the hospital and I just wondered if you could outline your experience and qualifications and how long you've worked at Gosport hospital.

Code A Just within Gosport hospitals?

4.30 DC Code A Well and generally if it's relevant, if you feel it is.

Code A Well I trained as a nurse, I started in sixty seven as a staff nurse in the trauma unit, I got married by about nineteen seventy two I was a staff nurse in a mental hospital, I followed that by a stint on the medical ward and then I went into industries as a nurse for first of all Pye Telecom and then Sainbury's. Then we moved, I joined Gosport War Memorial on an elderly care ward as a staff nurse, I became sister of that ward, I left and had my son, I went back on night duty and I stayed on night duty for the astonishing amount of twenty years...

DC Code A ...Good grief.

Code A ...plus and I have just, I left night duty last October and took a post on days on the same ward as I've been on nights for the two previous years, so I've a wide experience throughout the War Memorial and worked in every department,(laughs) and that's it really.

DC Code A (laughs) Okay, no that's great.

DC Code A (laughs) That's it, that's a lot.

DC Code A Yeah, right so in August ninety eight what were your duties?

5.40 Code A As the night duty staff nurse as an E grade, I was, I took charge of the ward, I also had a remit that er when the duty sister was absent to

take charge of the hospital which involved doing minor injuries and overseeing the other wards.

DC Code A — Right.

Code A — And that was...but on that particular night I wasn't stationed on the ward as far I remember.

DC Code A — Right, yeah I mean the dates obviously for this, we're discussing at the moment are the seventeenth and the twenty first....

Code A — ...Yes, yes I believe I was on the night of the sixteenth which ran into the seventeenth after midnight I think if you look at the duty rota.

DC Code A — Right.

Code A — So I wasn't actually there on the night of the seventeenth but I worked into the seventeenth.

DC Code A — So you worked there when she arrived back from Haslar midday on the seventeenth?

Code A — No.

DC Code A — No.

6.27 Code A — No, I must have been, I can't remember what night I was on. Do you have my duty rota somewhere?

DC Code A — It's the only one we haven't got.

Code A — You're kidding.

SOLICITOR — The night rota.

DC Code A — We have got access to it I mean...

Code A — ...She came back on the Tuesday, I'm trying to think of the previous week when she's admitted, I think I was there on the six...yes I do

remember her being there because I remember she was in room three when she was initially admitted for the first night I ever, one and only night I ever saw her there...

DC Code A — Is that when she initially came back from her hip operation?

Code A — No, that was when, well that's when the hip operation had happened.

DC Code A — Yeah.

Code A — Then I had a..my pattern of working was I worked Sunday, Monday on one week and Sunday, Monday, Tuesday on the following week rolling round all the time...

DC Code A — Yeah, right.

Code A — ...so I believe I was there on the night she came back from Haslar.

7.22 DC Code A — Right.

Code A — I believe.

SOLICITOR — Which night are you talking about?

Code A — Which is, I'm try...it's difficult isn't it.

DC Code A — Well I think the first night she came back was the eleventh wasn't it?

Code A — Yes, I was there the day she was admitted and then the following week that was the Tuesday, what night did she, I must have been there on the night she came back from Haslar.

DC Code A — Yeah, as I understand it...

Code A — ...I think so.

DC Code A — ...the seventeenth was a Monday.

	Code A	So I would have, yes it's a bit confusing, so I must have worked the seventeenth, eighteenth that particular...
	SOLICITOR	That was nights?
	Code A	That was at night, yes.
	DC Code A	And what is your night duty, what's the times?
	Code A	Oh quarter past eight 'til quarter to eight in the morning.
7.57	DC Code A	Okay.
	DC Code A	A full night.
	Code A	A full night
	DC Code A	Do you remember Code A
	Code A	No, not really I'm sorry.
	DC Code A	No.
	Code A	I've not got a clear, I can't see her face at all.
	DC Code A	No, okay. We are aware that her daughters were there from time to time throughout....
	Code A	...Yes
	DC Code A	...excuse me, throughout that week. Do you remember them being in the hospital?
	Code A	I don't really remember her daughters at all, most of what I remember is the things that were said on handover about each patient and really it's, it was just an ordinary old night really, it was...I don't remember the daughters staying, she may have stayed 'til late but I'm almost certain she didn't stay all night on that occasion.
	DC Code A	On that occasion. You say about the handover do you remember anything being said

specifically about Code A on the handovers?

8.53 Code A Not really I'm sorry you know it's a long time ago and obviously they tell you the background but they're telling you the background about twenty other people at the same time and it doesn't stand out particularly as anything abnormal.

DC Code A Who would generally conduct the handover?

Code A It's done between the senior nurse on duty from the day shift and the staff nurse and the two health care support workers who worked through the night so there are four of you in the room and the handover starts.

DC Code A And is that how many you would have on nights ordinarily sort of three?

Code A Yes, there were three of us usually unless there was a disaster or somebody went off sick and couldn't replace them but only three of us.

DC Code A Generally so you supervise two?

Code A Two health care support workers on the ward, yeah.

DC Code A Okay and as I understand it the health care or perhaps you can describe what the support workers, what their role is?

9.49 Code A Well their role is to do basic nursing care under your instruction which do you want me to...

DC Code A ...Yeah please do.

Code A ...(inaudible), erm change patients beds, make

them comfortable erm do pillows erm bedpans, toileting, undressing anyone and putting them to bed who needed to go to bed erm that kind of thing and that's really their job.

DC Code A — Okay, so you mention your sort of general role but in terms of on nights...

Code A — ...Yeah

DC Code A — ...in terms of the patients you're looking after, what are your, sort of things you're expected to do on nights?

Code A — Well you're really expected to continue in, continue their care and their care is obviously different at night to it is at day because during the night they're in bed whereas during they're not usually so that you really have lots of things to do like, make sure that you know their pressure areas are relieved, that they're positioned properly, that they're comfortable and this kind of thing that is you know different thing from sitting in a chair to lying in bed so in fact they really nurse quite differently at night erm I think what else do you do, well you have to oversee the treat..any treatment they have, you do the drug round obviously and you're responsible for the, for the drugs given to patients.

11.16 DC Code A — Yeah, okay.

Code A — Which you do.

DC Code A — Who's responsible for prescribing the drugs and

		the treatment?
	Code A	Well the drugs are prescribed either by a GP, by Doctor Code A clinical assistant or by Doctor Code A the consultant and a GP would be called in if we had erm if a patient suddenly fell ill or yeah, and we couldn't you know Doctor Code A wasn't there and call the consultants and you know at night kind of thing but, but that's how you sometimes it's health call and sometimes it's the Gosport practice.
	DC Code A	Yeah, as I understand health calls like a duty...?
	Code A	...It's in Havant somewhere, its the health call.
	DC Code A	I think it's Havant Road, Drayton.
	Code A	Yeah and you get them in and they'll come and see everybody who's experiencing difficulties in any way.
12.05	DC Code A	Yeah, okay and you would refer to the notes in order to ensure that the treatment...
	Code A	...Yes.
	DC Code A	...prescribed...
	Code A	...Yes
	DC Code A	... you're complying with?
	Code A	Yes, yes.
	DC Code A	Okay. You are aware that Code A was ultimately put on a syringe driver which I think occurred on the eighteenth. I wonder if you could just talk us through the syringe driver process, what benefits it has, how it works you know just a general overview?

Code A

It's a, it's a good and erm it's a good method of giving analgesia to a patient erm it, it, you put it under the skin with a needle and it's strapped down er otherwise the patients will probably be having intromuscular injections every four hours which is distressing them, and painful for them that's the way it used to be done, it works basically as a pump, you have erm, you can have lots of different drugs in it that work in different ways erm because the patients on a syringe driver it does not necessarily mean that their deaths imminent. I believe syringe drivers came from (inaudible) called ambulatory syringe drivers and cancer patients use them for pain relief and actually walk round with them on their body and that's really where I believe that they came from, so it's a good method of giving certain drugs to people to control symptoms, to relieve distress and also to relieve erm patients tend to fill up in the chest as the heart fails, they can't clear the water from their body and they get bubbly and because they're bubbly I don't necessarily think it means they've got a chest infection, it means that their heart doesn't work terribly well and it relieves that distressing symptom and you know the drugs of choice are really dependant on what symptoms the patients showing, the main drug is diamorphine...

	DC Code A	...Right.
	Code A	...which is given erm in varying doses depending on you know you start with a, there's a whole pain regime that's laid down really erm which is a bit simplistic I think if it depends where you're coming into the pain regime, you know how severe the patients suffering is.
14.53	DC Code A	Okay well perhaps we'll move onto that then. We've got here Code A health record.
	Code A	Yes.
	DC Code A	And I'm just going to show you the prescription...
	Code A	...Yes, drug record.
	DC Code A	...the drug record and we've got obviously various drugs here not all given at the same time..
	Code A	...Yeah.
	DC Code A	...I just wonder if you could talk me through whi..as we understand it there were four drugs loaded onto the driver on the...
	Code A	...Yes.
	DC Code A	...I think it was the eighteenth it started and diamorphine, haloperidol, midazolam and hyoscine, I'm getting good at this now aren't I?
	DC Code A	Yeah you are because originally we couldn't get out heads around (inaudible) our tongue around that one.
	Code A	Haloperidol...
	DC Code A	Laughs

DC Code A — Haloperidol

Code A — Several names it's known as a ...

DC Code A — ...Oh don't confuse us

Code A — ...no but you find that people have it in (inaudible) all drugs have erm a chemical name and also manufacturers brand name...

DC Code A — ...Yeah.

Code A — ...so you find that haloperidol could be manufactured at several names

DC Code A — Okay, I just wonder if you could us through the, these four drugs and what they do?

Code A — What they do firstly, diamorphine is a major or the major player in what's called analgesia or pain relief erm it's street name is heroin erm and it's a, it's an artificial derivative of the poppy, pain killer, excellent drug of choice has side effects which are respiratory, depression works on that area of the brainwave, depresses your explorations unfortunately (inaudible) otherwise it's excellent. Haloperidol is used for patients who are demented and it's a sort of er calming drug almost but it's used mostly for them you know we don't, it's not used in general medicine, I think it's used for people who are erm what can I say, how can I say, er mentally distressed I think really would be the word I can...

17.27 DC Code A — ...Having read some of the statements I think people have referred to them being noisy?

Code A Yes.

DC Code A Does that make them, is that...?

Code A If somebody's noisy, or they're mentally distressed or it can be quite noisy without being so but erm somebody who is severely demented can scream and cry and be inconsolable even...

DC Code A ...Right.

Code A ...and sometimes the drugs used you know for that, to make them calm again and that's the drug. Hyoscine erm it's used a lot in surgery, it dries secretions erm as I say it, it stops the erm the bubbling erm and it's really given almost as a comfort to people who find it very distressing to have the pain relief, they've to have their respirations depressed because the respirations want something else put in to, so that we can breathe better without distress. Midazolam it's related to valium and that's another calm me down drug really.

18.48 DC Code A Okay. Those four together then...

Code A ...Yes.

DC Code A ...loaded onto the driver at the same time...

Code A ...Yes.

DC Code A ...is that a combination that's usual?

Code A Yes, yes it's usual, yes it could be, there could be other drugs but in like erm cycloscine which is an anti nausea if somebody's feeling very sick and use lots of drugs in combinations but that's fairly, probably if you weren't mental you

didn't have haloperidol, if you were sick you might have the cycloscine you know it's taken as a, it's a judgement made on a patients medical condition.

DC Code A — Yeah, okay. Obviously we've got the various amounts here of drugs prescribed...

Code A — ...Yes, yes.

DC Code A — ...diamorphine is between...

Code A — ...Yes

DC Code A — ...forty and two hundred is it milligrams...

Code A — ...Milligrams, yes.

DC Code A — ...and if I can draw your attention to the amounts actually administered which...

Code A — Yes.

DC Code A — ...if you agree with me they all remain at forty?

Code A — Yes so she wasn't being increased the pain was controlled obviously by what was being given to her.

DC Code A — Okay so the amounts there on the four, on a scale you know of...

Code A — I see the hyoscine was increased but yes that's fine, it's nothing.

DC Code A — ...okay are they particular high, what I'm saying are they high doses or particularly low doses or somewhere in the middle?

Code A — They're very low doses really, you know to be fair, they're not, they're not huge doses, I mean we get people with them with a hundred and twenty in them and of diamorphine over twenty

		four hours but that's minimal to be fair...
	DC Code A	Mmm, okay.
	DC Code A	Mmm
	Code A	...it's not erm...
	DC Code A	And as I understand it in relation to diamorphine the forty to two hundred means it's a...
20.40	Code A	..Yeah.
	DC Code A	...gives the nurse discretion to...
	Code A	Yes.
	DC Code A	...to up the dose if...
	Code A	Yes, mmm, mm.
	DC Code A	...if it's apparent that (inaudible)
	Code A	Yes, if the patients are not being erm if the pain's not being controlled you can increase it, you can also stop the driver take it all down and start it all up again with increased doses of drugs in it.
	DC Code A	Oh you can.
	Code A	Yeah.
	DC Code A	Right, okay, because I understand it's on a twenty four hour..?
	Code A	It's on a twenty four hour cycle.
	DC Code A	But you can actually...
	Code A	...Yeah, yeah.
	DC Code A	...take it off and start again?
	Code A	Yes, yes you know supposed they haven't put hyoscine in it, you could stop it all and add it.
21.16	DC Code A	Okay.

	Code A	But you'd start again, you'd just stop it all and start again, you don't put things in a syringe that things have been in the syringe before, do you understand me.
	DC Code A	Yeah.
	Code A	You don't top it up, you just take it all away and start it up again.
	DC Code A	Okay, obviously these drugs are related to oral as well?
	Code A	Yes.
	DC Code A	Can you just have a quick look through and see if there's any that you've administered throughout...?
	Code A	...I obviously gave this lady oromorph.
	DC Code A	Okay
	Code A	And I was (inaudible) on the eighteenth because that's my signature.
	DC Code A	Right, I just for the purpose of the tape I'll describe, it's the eighteenth of the eighth at...what's that...?
	Code A	..oh twelve thirty
	DC Code A	...oh twelve thirty...
21.58	Code A	Twelve thirty am I mean (laughs)
	DC Code A	Oh right, twelve thirty am.
	DC Code A	Half past midnight?
	Code A	That's it.
	DC Code A	Half past midnight.
	DC Code A	Half past midnight that's got it, got five mils?
	Code A	Yes.

DC Code A And that's your si...?

Code A ...That's right

DC Code A Squiggle.

DC Code A Yeah, squiggle there?

Code A That's my signature, yeah.

DC Code A Okay, and I take it at the time that's what Code A Code A was...?

Code A ...Prescribed as here.

DC Code A ..prescribed, which is the oromorph?

Code A Yes.

DC Code A And that's some doses there?

Code A Ten milligrams in five mils.

22.26 DC Code A Okay, I know you've said already that you can't remember a great deal about anything about Code A but I'm still going to have to ask various questions about it.

Code A Yeah, yeah.

DC Code A Can you remember the effects that had on her at the time? Whether that dose was sufficient?

Code A I think erm that at the time presumably that er she'd had it earl..why had she had it, where had she bee...she'd been in Haslar that I can remember erm I don't like to really say but I rather think that it was difficult to administer it orally, I think that's where erm people spit it back at you and that kind of thing erm and I'd like to point out that it was given at an unusual time so she was obviously in pain because it was, it wasn't given at a time when I would

		have been doing...
	DC Code A	...Pretty bad.
	Code A	...the drug round you see...
	DC Code A	...Yes, that's
	Code A	...so I've given it at half, in the middle of the night kind of thing and the drug rounds done about ten o'clock.
23.39	DC Code A	So it's fair to say that, so that's an unusual time...
	Code A	..Yeah
	DC Code A	...generally to ?
	Code A	Well it's not unusual but it obviously means to me that the woman was in pain and I was giving her something for it, it wasn't done at a..it was something that had cropped up during the course of the shift, she was obviously making some kind of (inaudible).
	DC Code A	Okay.
	DC Code A	Would that have been there I appreciate it's recorded there and the fact that she's been given pain relief, would the fact that your attention was drawn to her because she wasn't plainly recorded anywhere?
	Code A	Yes erm
	DC Code A	Could there be written down Mrs, you know Code A in pain?
	Code A	No I think actually I put something like in the notes oromorph ten milligrams in five mils at present and that was about as far as I got with it

other to say that I did record it on the nursing notes that I'd given her.

DC Code A — Okay, can you just have a look through the others just to see if there's any there?

24.36 Code A — (inaudible) that's just because she was constipated.

DC Code A — That's the lactulose?

Code A — Lactulose it's just a, it bulks it up and this is obviously a regular drug that, that she...

DC Code A — That's er haloperidol

DC Code A — Haloperidol

Code A — ...haloperidol that was something that she was on anyway I believe, this was the oral morphine really which they, you know it's written in it's obviously four hourly and then sometimes they write like they have here, at ten o'clock at night that she obviously she didn't need it then so it wasn't given but it was given here, you have to write it in two differ..it was given here at half past twelve in the morning so she was obviously not in pain when I went round with the drugs at ten...

DC Code A — ...Right

Code A — ...but she obviously was later.

DC Code A — Yeah.

25.28 Code A — And in fact it had really been given in a sort of a out of hours type way really.

DC Code A — Okay.

Code A — And that's all I (inaudible)

DC Code A — In relation to the four drugs which were administered by the syringe driver, are you aware of any potential adverse side effects it could have had on Code A health just purely the drugs together as a combination of two, or three or four of them at all?

Code A — No, not adverse, no.

DC Code A — No. What about regarding the drugs licences, are you aware of whether they're licenced or unlicenced for subcutaneous use?

Code A — Well they're obviously licenced because to get an unlicenced drug is a, is a procedure...

DC Code A — No, I think..sorry..as far as I'm aware certain drugs are licenced to be administered in certain, used in certain routes either orally...

Code A — ...Oh I see

DC Code A — ...yeah

Code A — I see you mean you, you wouldn't give lactulose into a muscle is that what you're trying to tell me (laughs).

DC Code A — I'm hoping you'll tell me.

26.38 Code A — No you wouldn't, you'd have a nurse, yes there's as far as I am aware and...

DC Code A — ...They are licenced for subcutaneous use?

Code A — ...they can be given subcutaneously.

DC Code A — Right.

DC Code A — Okay. In relation to the four of them and I appreciate you weren't on duty in the final...

Code A — ...No.

DC Code A ...couple of days but taking them as they are are you able to say whether that's, those combination of drugs indicate that the person they're being administered to is someone who's dying or you know very ill and close to death or is there other scenarios where that wouldn't be the case?

Code A Well there are but in this case I believe that they were administered to Code A to make her less distressed and more comfortable.

DC Code A Okay. On the night she did, you were on duty when Code A was there did you, can you recall any signs of her dementia or any times when she was calling out?

27.51 Code A As far as I recall I think that on her initial admission she seemed to call constantly and was distressed and mentally distressed and obviously erm where she'd had the hip done it's very painful, it's very brutal what's done to them in theatre, to see it done is pretty awful really, these frail old ladies and it's, you need to be a big strong chap to get the hip back in.

DC Code A On the date that you had...I think was it the last time she had the oromorph, was that the...

DC Code A No, that's the second to last.

DC Code A ...the second to last time, you obviously gave it to her because you believed she was suffering some kind of pain?

Code A Yes.

DC Code A — Would, did anybody come and try and find the source of the pain or was it..

Code A — ...Well yes

DC Code A — ... assumed it was the hip operation?

Code A — Well we always try..

DC Code A — Yeah

Code A — ..and really before you, you know try to make somebody comfortable before you raced in with a lot drugs to be honest...

28.55 DC Code A — ...Yeah.

Code A — ...and I think she was in pain.

DC Code A — Right so that would have been the course of act...you'd have tried to re, re-position her first?

Code A — Well, we'd re-position her, we'd try and give her a drink and other things you know, perhaps a cup of tea you know you sort of you know when you talking about giving major analgesia you do look at the whole situation each time.

DC Code A — Do you recall trying to re-position Code A Code A

Code A — Not really, I can remember the room she's in on her initial admission and I can remember the room she was in on her second admission but Code A I can't see her face at all, it's, I just can't I'm sorry.

DC Code A — Yeah, no.

DC Code A — You say she was in room three the first time?

Code A — Yes, I can.

DC Code A — And what was the room in second time she was

there?

29.40 Code A I think she was in room four.

DC Code A Room four.

DC Code A Okay.

Code A Opposite the nurses station so she could observed, well she could be observed anyway but...

DC Code A ...But is that the sort of policy that the ward may have, that the more....

Code A ...Well yes if it's somebody...

DC Code A ...not risky patients but the more ....

Code A ...Yeah

DC Code A ...what's the word I'm looking for.

Code A Poorly

DC Code A Yeah, the sicker people get put nearer the nurses office so you can keep, be easier to keep an eye on them?

Code A Yes, although we are mostly on our feet erm if you stop to write notes and things you stop at the nurses station and its eas you know you can sort of keep an eye on the two rooms opposite the nurses station which is usually...

DC Code A ...Are they isolated from the rest of the ward then are they?

Code A No, no it's all in the ward, have you not been to the ward?

30.26 DC Code A No.

Code A No, it's divided into four beds, I think we've got three four beds, one six bed and the rest are

		single rooms.
	DC Code A	Oh right, so the three and four are they multi occupancy?
	Code A	Yeah.
	DC Code A	Yeah
	Code A	Yeah you know they (inaudible - laughing)
	DC Code A	Sounds like bedsit land don't it
	Code A	They're divided into men and women as well it's not mixed but yes you do put the poorly ones nearer your post because you're there answering the telephone that kind of thing.
	DC Code A	Okay, right so we've covered the drugs and we've covered the fact that they would be prescribed either by the GP Doctor Code A or...?
	Code A	Yeah, well she's the clinical assistant actually to Doctor Code A although she's the Gosport GP.
	DC Code A	Right, okay.
	SOLICITOR	Can I just ask a question on the drugs?
	DC Code A	Yeah.
31.26	SOLICITOR	It's a question they've asked you about, the hyoscine...
	Code A	Yes
	SOLICITOR	You said was giving the gurgling sound?
	Code A	The secretions
	SOLICITOR	The secretion, if you look at the record not the syringe driver you see it was increased from two hundred to four hundred?
	Code A	Yes.

	SOLICITOR	What would that indicate?
	Code A	It would indicate that her heart was failing and that the secretions were probably building up.
	SOLICITOR	So the noises were getting louder?
	Code A	Yeah she could maybe developing a chest infection, in fact it's put in really erm before people do start this awful gurgling.
	DC Code A	Mmm,mm, and as we've been explained before that the, that one of the reasons isn't solely for the patients benefit which it is...
	Code A	...Yeah.
	DC Code A	...it's for the relatives as well so they don't get distressed over the noises the patient makes.
32.10	Code A	Yes, although...
	SOLICITOR	...The nurses would have heard, probably heard the gurgling sound doing this course of treatment?
	Code A	They could well have done, yes.
	SOLICITOR	Mmm, that's it thanks
	DC Code A	Okay and how are the...obviously so whoever prescribes this course of treatment...
	Code A	Yes
	DC Code A	...how do they review it? How regularly do they review the treatment to see it's effects and ...?
	Code A	Well it would be reviewed daily and at any other time that you felt it may have caused concern.
	DC Code A	Right.

	Code A	So...
	DC Code A	...So on an, as been explained to me previously on a night shift...
	Code A	...Yeah
	DC Code A	...if something happened which caused you concern you'd contact health care, health call?
	Code A	Whoever, you would actually ring the number of Doctor Code A surgery...
	DC Code A	...Oh right.
	Code A	...and they'd get one of her partners if they were doing the call or you may be referred to health care.
33.02	DC Code A	Right and during the day time obviously Doctor Code A
	Code A	Came in every day.
	DC Code A	Okay
	Code A	To see them and review them.
	DC Code A	And review them, okay. I'm aware this didn't happen in this particular case but this is just a general question over hospital procedure I'm after. If there was a time when you were concerned about treatment prescribed by a particular doctor, and you'd made representations to that doctor and you know they'd fell on deaf ears basically...
	Code A	...Yeah.
	DC Code A	...and the treatment persisted, are you aware of any procedure in place that you would be able to go and register your concerns with?

	Code A	Yeah, well yes you could either go, which I would do in the first place, I would go to the ward manager and say that I wasn't happy with what was happening and you could take it up with your college of nursing who have representation for you.
34.07	DC Code A	Right
	Code A	You know so if you really felt very strongly about something that was happening you know there are people that you can talk to about it.
	DC Code A	Yeah, okay.
	Code A	But not in this case (inaudible)
	DC Code A	No, have you ever had a problem?
	Code A	No I haven't.
	DC Code A	Never had a concern in the hospital I presume?
	Code A	Not, no, no, no, not to ...
	DC Code A	Okay.
	Code A	...I'm trying to think.
	DC Code A	Okay. On the, as I sa..I appreciate your as I mean I'm asking questions when your, you've already told me that your memory of Code A Code A isn't great but in relation to the treatment she was on when you were present not the syringe driver later on but when you were present, what were your, what did you understand about the appropriate treatment? What did you think it was set to achieve for her?
35.05	Code A	I think it was set to erm principally to make

sure that she had no pain and that she suffered the minimal distress in her illness.

DC Code A Were there any times from the seventeenth that you recall where she got out of bed, you know she was helped out of bed or got out of bed?

Code A Not during the night shift as I recall, no.

DC Code A No, okay. Was there any times you saw her being supported to walk or going to the toilet or to the commode or..?

Code A No.

DC Code A No.

Code A No.

DC Code A Okay.

DC Code A You mentioned there that they (inaudible) to ease her pain, distress through her illness. Are you aware of anything particular that Code A Code A was suffering from, I appreciate she's ninety two, she's had major surgery, she's deaf, she can't help herself anything like that but is there any particular illness that you're aware of that she was suffering from?

36.02 Code A Dementia.

DC Code A Dementia.

Code A Mmm.

DC Code A Okay. What problems may, would her dementia have caused to the staff in terms of diagnosis and in dealing with her?

Code A If it's possibly erm it's sometimes very difficult to tell the difference between you know if

somebody's making a noise why are they crying so loud erm she did cry a great deal I believe but it does make it difficult because they can't answer questions that you're asking them, you know they can say anything really, you know and cause it is difficult but there are signs that people are in pain that outweigh signs that they're in dementia you know. I mean if something hurts you'd probably find that they're holding it if it's their head, or their arm or people tend to guard the part they've hurt erm so really I suppose that she was obviously I think there is a difference between the sort of cry of someone who's dement, you know who's really demented and somebody in pain, people don't cry a great deal in pain I don't think but you'd probably find that they were holding, it's a difference, it's not a wailing, it's a sobbing if you've hurt yourself dementia they wail and you know it's different really, it's difficult to sort of describe but I mean I don't you know, I don't really recall her wailing so much.

37.58 DC Code A On those, going back to the course of treatment that she was put on, the combination of the four medicines would that have sedated her sufficient enough that she wouldn't be conscious at all throughout that time?

Code A Uhh, well it depends. She wouldn't have been, shouldn't have been or wasn't rendered deeply

unconscious, she should have beenrendered pain free.

DC Code A — Sorry deeply sedated so she's not able to sit up and try and converse with anybody or ...?

Code A — I don't believe this, I don't (inaudible) on this but...

DC Code A — ...If you don't know, you don't know.

Code A — ...well I do but I don't recall her having a conversation and the purpose of it is to ease her pain not to render her unconscious erm she may well have been very drowsy erm the whole idea of it was to keep her on a plane so that she was comfortable it wasn't to, to you know it's not cause to...

39.03 DC Code A — ...Knock her out?

Code A — ..No, though it may well have done but it, it, it's not why it's put up, it's not put up to, to sort of knock people unconscious and render them you know incapable or anything.

DC Code A — Okay. Just want to go through the various notes that we have here. First one I'll show you which is still forms part of the Code A Code A notes are the contact records. If we take it from the seventeenth, I wonder if you wouldn't mind having a quick look through see if there's any...

Code A — ...This is when she returns.

DC Code A — ...yeah, relating to you from the seventeenth of August.

	Code A	Right (looking through documents). That's all quite normal nothing in there that's untoward.
	DC Code A	Is there any that's (coughs) excuse me, that you've completed?
	Code A	No I didn't obviously nothing happened to her overnight to warrant that I wrote in there.
40.31	DC Code A	No, okay.
	Code A	I just must have made a note on her nursing notes.
	DC Code A	In relation to the nursing notes are they kept with her medical record or are they kept...?
	Code A	They're kept separately on the ward.
	DC Code A	Are they?
	DC Code A	I think they're at the front actually
	Code A	These are the nursing notes and those the back ones these ones are the medical records.
	DC Code A	So have we got a copy of the nursing notes?
	Code A	There the nursing notes.
	DC Code A	Oh sorry.
	Code A	They also, well they divide into two, you have the nursing notes kept in the office and these the care plan that you devise individually for each person.
	DC Code A	Person.
	DC Code A	Okay. Would you mind having a look through those as well just to see if there's anything relating to you? Take your time on it there's no...
41.16	Code A	...Re-admitted, that's me, forgot to sign it.

	DC Code A	Right so that's just for the purpose of the tape...
	Code A	...Yeah
	DC Code A	...seventeenth of August ninety eight re-admitted seventeenth of August ninety eight, oromorph ten milligrams...
	Code A	...five mils
	DC Code A	...five mils at...
	Code A	...present
	DC Code A	...at present. So that means that that's what she's...
	Code A	...That was the analgesia that I gave her on that night.
	DC Code A	Okay, right.
	DC Code A	Sorry I got the impression that she came in at half twelve on the seventeenth?
	Code A	She must have come in at lunchti...usually came at...
	DC Code A	...Lunchtime
	Code A	...they're mostly admitted by about lunchtime, we tend to admit in the morning and discharge in the afternoons.
	DC Code A	So the first entry you got to put on the nursing notes then was when you came on duty which would have been after...
	Code A	No, this is the night nursing plan.
42.09	DC Code A	Oh sorry.
	SOLICITOR	(inaudible)
	Code A	Yeah these are the night nursing notes, the day nursing notes are different...

DC Code A	(inaudible)
Code A	...because of the, sorry...
DC Code A	...No that's alright. (laughs)
Code A	...because you have an individual it's difficult, each patient this is because of the, it should be poor dietary intake and it's to try and make some record of what people have eaten, that's just one of the samples and you'll find there's lots of constipation (inaudible) but the night nursing is literally how they, how you deal with them during the night.
DC Code A	Okay, can I summarise this so I understand it.
Code A	Yes, yes.
DC Code A	So for nights you have a nurse care, a nursing care plan form...
Code A	...Yes.
DC Code A	...which you detail what you've done...
Code A	...yes.
DC Code A	...at various times but during the day time they have specific....
Code A	...For each indivi
DC Code A	...headings to work under.
Code A	Yes that's right, although you're following these as well at the same time...
DC Code A	...But you would record it on here?
Code A	...it should really be called a sleep plan I think...
DC Code A	...Right.
Code A	...would be better.
DC Code A	Yeah.

Code A You know, think.

DC Code A Right, okay no that's fine, I understand that, okay. So when you would have done that which would have, which was at half twelve?

Code A Yeah.

DC Code A I take it that you endorsed it and just put on for the purpose of the record that she was...

Code A ...Having oromorph at that time, yeah.

43.28 DC Code A And in Daedalus as well she actually come back.

Code A She was re-admitted, yeah.

DC Code A Okay.

DC Code A On these notes here if they for getting Code A if somebody who'd come back from Haslar with a hip operation came back onto the ward and she was reasonably okay even if she'd had a major operation, would there be a form in here, I mean this one here's got nutrition, it's got constipation and I think there's for hygeine as well isn't there or something...?

Code A Yes.

DC Code A Personal hygeine, would there be a record of physio or anything like that?

Code A What you..

DC Code A ..For any...

Code A ...yes you should record that in the nursing notes (buzzer sounds), if somebody was going to have physio erm we are allowed to ask the

physio to see them without a doctor, you don't need a doctor to get a patient to be seen by a physio, this is the ruling at the moment whether it was in place then I wasn't on days.

DC Code A Right so if somebody came back after a hip operation would it be general that the physio would be arranged for for their exercise and ...?

Code A Well not, depending on the patient...

DC Code A ...On the patient, yeah.

Code A ...but erm you'd, I myself if I had somebody admitted tomorrow who'd had a hip done I would ask our physio to just look at them.

DC Code A Right.

Code A to just make sure that you know and then you would have to go on depending on how well you were going to mobilise them obviously some people come back and they're already you know on their crutches and on their way and other people come back and they're just never going to do anything at all and you know and all stages in between.

SOLICITOR In your experie

DC Code A We're coming to the end of the tape here so I think we better...

DC Code A Yeah, we'll halt, we'll stop it there I think. We going to take a short break to change tapes, the time is 14.59. I'm turning off the recorder off.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y17A

Enter type:
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: Park Gate Police Station

Date of interview: 01/06/2000

Time commenced: 1502 Time concluded: 1519

Duration of interview: 17 mins Tape reference nos.
(🎞) 44/00/02913

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

Other persons present: Code A Saulet & Co Solicitors, Portsmouth.

Police Exhibit No: LMC/CM/10 Number of Pages: 17

Signature of interviewing officer producing exhibit

Tape counter times(📼)	Person speaking	Text
	DC Code A	Okay, this interview is being tape recorded, this is the re-commencement of the interview of Code A and I am DC Code A Code A the time by my watch is 15.02. Just remind you that you are still under caution, okay and I'll just remind you what the caution

is. You do not have to say anything however it may harm your defence if you do not mention when questioned something which you later rely on in court, anything you do say may be given in evidence, okay. Can you just confirm that you've not been asked any questions during the break while we've been changing the tapes.

Code A No, no questions asked.

0.55 DC Code A Okay, thank you. Right we were dicsussing the notes and how they work and what's filled in. Now as I understand it and forgive me if I've gone over something that I've already asked but the contact record notes which one's here...

Code A ...Yeah

DC Code A ...the buff coloured ones, there purely for unusual incidences for times when health is deteriorating....

Code A ...Or change of treatment when they've been seen by a consultant or by Doctor Code A and the treatments been changed, they're really a erm record for that kind of thing, not a care plan, a care plan is care given by nurses.

DC Code A Okay.

Code A To patients.

DC Code A In your role would you ordinarily be completing the care plan in terms of personal hygeine and...?

Code A If I'd done, if I'd done that, if I'd washed

		someone I would record that I had washed them.
	DC Code A	Yeah.
	Code A	Who actually does the care to them records what they've done and signs it.
2.08	DC Code A	Okay and where is that care plan kept?
	Code A	At the foot of the patients bed.
	DC Code A	Okay, alright, can we just have another look just to see if there's any...I think this is the night (inaudible) one isn't it and the only one...
	Code A	...Yes
	DC Code A	...I'm sorry let me just go over this again...
	Code A	...Yes, yes.
	DC Code A	...because of that break.
	Code A	Mmm,mmm
	DC Code A	I've completely forgotten, lost me train of thought for a minute, so the 17th that is the entry completed by....
	Code A	...Yeah
	DC Code A	...in relation to the oromorph...
	Code A	...Yeah.
	DC Code A	...so there's medication given so you've completed the care plan, okay. Right so just to recap so far then, in relation to Code A Code A you sort of remember her presence as such but nothing...
2.59	Code A	...Yeah.
	DC Code A	...specific about her appearance or...
	Code A	...No.

DC Code A or her daughters....

Code A ...No.

DC Code A Right, okay.

Code A No I don't remember her daughters at all.

DC Code A Okay, now this is the first night she came back from Haslar?

Code A Yeah.

DC Code A Now you obviously as you say you prescribed or you administered oromorph to her...

Code A ...Yes.

DC Code A ...on that evening. Can you remember what she was like at that time or are you, you were compelled to give her that oromorph, what was her...if you can?

Code A I can't remember the specific...

DC Code A ...No

Code A ...instance why I gave her oromorph. I know why I would give someone oromorph...

DC Code A ...Yeah.

Code A ...but I can't remember why (inaudible)

DC Code A ...In this particular case?

Code A No.

DC Code A No, okay.

Code A I can't see her face or anything like that at all.

DC Code A No, but you have explained already I believe the circumstances why you would give it but in this case you can't remember exactly why?

Code A I can't remember specifically no, sorry.

DC Code A Okay, Just going to..want to go onto a couple of

more questions, general questions about treatment. To start off with hydration, what would be the circumstances where hydration would not be given to a patient?

Code A If they were unconscious, unable to swallow, if they'd lost a swallow reflex say a brain problem erm oral hydration (inaudible)...

DC Code A ...Yeah.

Code A ...erm there could be other ways of hydrating people but depending on the circumstances.

4.45 DC Code A What would be the other (inaudible)?

Code A Well you could either, you could either, we don't actually have IV's in the War Memorial you know cannular for a intravenous...

DC Code A ...Right.

Code A ...drip it's not a thing that we practice because it needs sort of 24 hour care by a doctor and we don't have that...

DC Code A ...You don't have that, no.

Code A ...in the Gosport War Memorial erm there are other ways of giving fluid which weren't practiced at this time which should become common now and its given in the same way as the syringe driver except its attached to a giving set in a bag and its put in under the skin erm which can be satisfactory or not really, depending it tends to go into the tissues quite a lot and you end up changing the site quite a lot and erm but patients are given now...

	DC Code A	...Okay
	Code A	...it wasn't I have to say nobody was having that sort of erm treatment at this time it's obviously something thats you know become what shall I say...
	SOLICITOR	...Policy.
	Code A	...yeah (inaudible).
	DC Code A	Was it available at that time?
	Code A	Not to my knowledge.
	DC Code A	No, so it's a new concept that's come into being?
	Code A	It's a new concept that's come in, it's obviously to keep people out of acute beds I think you know instead of sending them back, you can give them a litre in 24 hours through a subcutaneous infusion as its called.
	DC Code A	I'll write that one down as well.
	Code A	Yeah.
	DC Code A	Are there occasions when obviously we've mentioned orally that they would be able to take it, are there occasions when that new system wouldn't be appropriate either?
	Code A	Oh yes obvi, I mean obviously every patient is, is treated to some, they're treated as individuals and you don't have a great role in plan for everybody, you know you don't just do this because, you do what you have to do for each individual so each individual people are...
6.53	DC Code A	...Everyone's different yeah.

Code A ...Yeah.

DC Code A I wonder if you could give us some examples (inaudible)?

Code A Sorry.

DC Code A Examples of when an intravenous infusion would not be appropriate you know?

Code A I think if somebody was patently dying you wouldn't try to rehydrate them, it wouldn't be in their best interests nor would it be kind so...

DC Code A ...Right.

Code A ...you know you wouldn't if they were patently dying.

DC Code A Yeah, yeah so that would form part of their palliative care?

Code A Yes, yes palliative care, and a lot of research into you know given fluids, withholding fluids erm the other latest thinking on it is people who are in the process of dying don't suffer for not having fluids it's, it seems that it's gone from them that they're thirsty and not, that's just some of the research that we've...

DC Code A Right, okay. What decisions are taken in that course of... I mean obviously we've got the drugs that are dealt with by...

Code A ...Yeah.

DC Code A ...the clinical assistant or the consultant...

Code A ...Yeah.

DC Code A ...In relation to the hydration and this new system...?

Code A ...Well you would, you would report that you felt that the patient needed hydrating, they weren't taking it sufficient orally most people who are hydrated that way are people who are not making a litre a day...

DC Code A ...Right.

Code A ...in the fact they're drinking something but it's coming well under what they should really be having to maintain their body systems so really you would say, I would say to Doctor Code A so and so is not drinking really very much and Doctor Code A would probably say well put up some sodium chloride as a, a subcutaneous infusion...

DC Code A ..Okay.

Code A ...and run it you know for 12 or 24 hours and that's really how that would work.

DC Code A So the authorities down to the clinical assistant or the consultant to do that...

Code A ...Oh yes you ...

DC Code A ...it's not a nursing staff...?

Code A No you can't prescribe drugs for patients.

DC Code A Right.

Code A Not even paracetamol, you can actually but you know all drugs that are given to patients are prescribed by a doctor.

DC Code A By a doctor, okay, right. Now in relation to Code A well aware of the answers you've given already...

	Code A	...Yeah.
	DC Code A	...on the nights you recall and we're talking about the 17th, 18th, were there times where any attempt was made to give her a drink, do you recall?
	Code A	Well I don't recall, all I can say is that if she'd been in any way able to receive a drink she would have been offered a drink...
	DC Code A	...Yeah.
	Code A	...because that is the policy and the health care support workers know quite well that you know people are to be given drinks so if there's any way that she could have taken a drink she would have been offered one...
9.47	DC Code A	...Yeah.
	Code A	...or helped with one or fed with one or you know, so...
	DC Code A	Okay, now I've mentioned her daughters and you can't actually...do you remember them being there or is just you don't remember them at all?
	Code A	I can't remember them at all, I'm sor, I just don't think they were in the ward when I was there at all at that time.
	DC Code A	Okay because the question I was going to ask is are you aware of any complaints they had about the treatment of their mother, during the time there?
	Code A	Well early in the..was handed over to us you

know they were there and they had got several complaints but we weren't deal...I wasn't dealing with them so I haven't really taken it on board you know.

DC Code A — Do you know who was sort of in charge of her care? I know we've got the GP who comes in daily but was there someone sort of overseeing her?

10.48 Code A — Each patient has a named nurse.

DC Code A — Yeah.

Code A — Erm which is a system that works and it doesn't work in that if you've got a day off they haven't got a named nurse have they, you know it's one of those things...

DC Code A — ...Yeah, yeah.

Code A — ...but we do all have our own named patients (inaudible)

DC Code A — Well I've got...

SOLICITOR — ..Code A

DC Code A — ...Yeah.

Code A — Oh right, there's Code A yeah, yeah so that's the normal system it really...

DC Code A — ...Yeah.

Code A — ...means that erm what shall I say, yes she decides some of their care and deals with their social workers and that kind of thing, you know sort out the discharge from hospital, it's usually, usually doing that the system is a team nurse, team nursing with male nurses...

DOCUMENT RECORD PRINT

	DC Code A	...Okay.
	Code A	...so that's the sort of thing they'd be doing.
11.44	DC Code A	Yeah so from your recollection you don't recall having spoken to the daughters directly?
	Code A	No, not at all, no.
	DC Code A	But you were aware at the time of some...?
	Code A	...That they weren't happy.
	DC Code A	Can you remember what they, did you get any messages what they were, weren't happy about?
	Code A	I just think they were just not happy with the standard of care they felt we should be providing in the ward, possibly they misinterpreted what, you what was going to happen to their mother in the ward erm I don't really sorry.
	DC Code A	No, okay.
	Code A	You know it's...
	DC Code A	There was something else I was going to ask but it's gone. Okay, obviously you weren't around the last few days when Code A Code A (inaudible) hospital?
	Code A	No I was off duty.
	DC Code A	But what was you final, can you recall your final impression of her, can you?
12.48	Code A	No, sorry not really, I don't.
	DC Code A	Okay
	Code A	I mean that's nearly two years ago, no not really, I suppose really if I had any impression

of her I just probably hoped you know that she'd be kept peaceful and pain free, it's you know the best you can hope for them...

DC Code A ...But you have no specific recollection of...

Code A ...No.

DC Code A ...condition or ...?

Code A ...No, no not you know she's obviously a poorly lady but you know.

DC Code A Another general question, patients transferred from one hospital to another like Code A Code A was from Haslar to Gosport War Memorial, are you in your position privy to the like the handover notes from the people that discharged her from Haslar to the care of the Gosport War Memorial?

Code A Usually their medical notes are sent with them erm there was a time when Haslar didn't send notes because it was a military thing...

DC Code A ...Yeah.

Code A ...establishment, we got photocopies but usually what happens is whoever's in charge of the ward writes a letter...

DC Code A ...Yeah.

Code A ...detailing what's happened and what, what sort of treatment they're having and how they've been in there and ...

DC Code A ...Yeah.

Code A ...that sort of thing and that's a nurse to nurse thing.

DC Code A — Yeah and who would get that at the Gosport War Memorial?

Code A — Well whoever was either admitting her or whoever the ambulance man gave the notes to, you'd open the letter, read it and then anybody could read the letter it was no you know sort of secret thing it's just...

DC Code A — ...So if somebody was to come in like at midday as it was with Code A who...I know you probably don't know who actually got the notes and referred to them for the course of treatment from then on in but would they generally hand them to the ward manager like Code A Code A is it or could it be the staff nurse or..?

14.49 Code A — If he was on duty or...

DC Code A — ...Yeah, the staff nurse say there's nobody in particular that the notes...

Code A — ...No.

DC Code A — ...Do they go to the most senior person on the ward at that time?

Code A — Well usually yes, they...

DC Code A — ...Yeah

Code A — ...usually you know they usually send us a, they're also given to the person who's admitting the patient you know it just depends on you know what you're doing at the time, it's not erm you're not sitting there waiting to admit someone by any means you know you're

doing lots of other things but you know the note would be read by the staff, if there ever was a note I don't know.

DC Code A — Mmm

DC Code A — Okay.

Code A — But that's what happens normally.

DC Code A — But you, did you see any notes in relation to any letters or ...?

Code A — Not that I can recall, usually on night duty if we'd had someone admitted when we'd stop work, I'd pick these up and read them for every patient that was admitted you read them you know...

15.46 DC Code A — ...A lot of the times I take it you just rely on the handover you get from the staff nurse on duty before you?

Code A — You do at the time but then it's...

DC Code A — ...This is Code A, she's in from so and so, this is the treatment she's on...

Code A — ...Yes.

DC Code A — ...the course of medication is to keep her comfortable or this is what we've been required to do...

Code A — ...Yes, yeah and then there's an initial period when you're actually working quite hard, when you actually stop that kind of work...

DC Code A — ...Yeah.

Code A — ...you'd find that most nurses will go and pick the notes up and read them.

DOCUMENT RECORD PRINT

DC Code A	Mmm
Code A	And see what's you know happening.
DC Code A	Okay, I think...
DC Code A	Yeah, yeah
DC Code A	Is there anything you would like to add, anything you feel you'd like to say?
Code A	(inaudible) I feel that the ward keeps a good standard of care and a lot better than a lot of wards and a lot better than some wards I've worked in and you know we try and work as a team and we try very much to put the patients first and the relatives as well and a lot of time is devoted to patients families.
DC Code A	Okay, is there anything you'd like to clarify, anything you've said you feel warrants further explaination?
Code A	No, I don't think so.
DC Code A	Okay. I'll hand you a notice explaining the tape recorder procedure, which Code A will persist in filling out. The time by my watch is 15.19 and I'm turning the recorder off.
	END OF INTERVIEW

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y18

Enter type:
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: Park Gate Police Station

Date of interview: 29/06/2000

Time commenced: 1026 Time concluded: 1104

Duration of interview: 38 mins Tape reference nos. (◆) 44/00/03848

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

Other persons present: Code A (Sauley & Co Solicitors) Legal Advisor

Police Exhibit No: LMC/MRC/18 Number of Pages: 47

Signature of interviewing officer producing exhibit

Tape counter times(◆)	Person speaking	Text
0.51	DC Code A	At the conclusion of the interview I'll be giving you a note explaining what will happen to the tapes. Okay? I'm now going to go through - we have a set sort of screed that we read out to explain why we've asked you to come in and what we are trying to achieve by it really. The Hampshire Police have undertaken an

investigation into the circumstances of the death of Code A on the 21st August 1998 at Gosport War Memorial Hospital. The investigation centres around an allegation that Code A was unlawfully killed as a result of a course of treatment that was embarked upon between the 17th and 21st of August, whilst admitted to this hospital. We are seeking to interview those members of the nursing staff who had a duty of care to Code A during that time and who, in some cases, may have provided her with direct medicine care or treatment in order that an account can be obtained to the particular circumstances and issues that existed between those dates. I emphasise that this is a search for fact and your account and answers will be carefully assessed in the light of information arising from other interviews with staff and general correspondence. As a result of this interview and several others, further guidance will be sought from professional bodies and ultimately the Crown Prosecution Service on how we should proceed. Your solicitor has been provided with relevant material prior to this interview commencing. I must emphasise that you are not under arrest and you are free to leave at any time. Your right to legal advice with Code A in private, extends

throughout the period you are at the Police Station, so that basically means any time during the interview you want to have a chat with Code A Code A then we'll stop the interview. We will leave and obviously you can discuss whatever point you want to discuss.

The next bit is the caution. You do not have to say anything, but it may harm your defence if you do not mention when questioned something which you later rely on in court. Anything you do say may be given in evidence. Okay, do you understand the Caution?

Code A

I do.

DC Code A

Okay and just one more point I'd like to make about this, because it's quite harshly worded or it may seem harshly worded, myself and Code A here are just get an account of what's happened on those few days, what people's roles are, what the set up to the hospital is and you know, we'll look through the notes on the way through and you can explain various bits that are relevant that you can explain. We're not here to make any judgements and certainly we're not in any position to make any judgements. Any decision that's taken regarding this will be made with full consultation with someone who's an expert in this sort of area, who's got a medical background and is medically qualified, so it's

not going to be taken by some hard nosed copper somewhere who hasn't got a clue how these things work. Okay, what I'd like to do to start the ball rolling is if you could go over your role within the hospital and your qualifications and experience.

Code A I work on Daedulus Ward and I'm an E grade Staff Nurse, which means mostly I take charge of the ward. Um, what else do you want to know?

DC Code A Um, your experience, how long . . .

Code A Oh yeah, oh well I trained the seventies and I worked at the Royal Hospital, Portsmouth until it closed, where I had general experience in surgical, medical, children's nursing, private nursing, orthopaedic nursing. When the Royal Mem. . um when the Royal closed, then I moved to QA and I worked on the orthopaedic wards. Then I left QA and for two years I worked with autistic adolescents and quite enjoyed that. That was very near where I live in Alverstoke. Er . . I then left Anglesey Lodge and moved to Gosport War Memorial, I worked on the Children's Ward originally, where we did minor operations on children, ENT and Orthopaedic.

When the NHS closed the Children's Ward then I moved to the ward I'm on at present. We have eight stroke rehab beds and sixteen

continuing care beds, which is where I was working when Code A . . came..

DC Code A — Okay, how long have you been on Daedulus Ward?

Code A — And I've been on Daedulus Ward um. . twelve years I think it is.

DC Code A — Okay. So can you sort of describe the continuing care and what sort of patients you tend to get in to the . . . .

Code A — In continuing care we have basically . . we have patients very frail, elderly patients, with multiple medical problems, normally problems like Parkinsons and Alzheimer's, um Multiple Sclerosis, old. . um patients that have had many strokes um patients that are highly dependant normally needing two nurses probably to have a wash and get up and mostly we have to feed our patients. . .

DC Code A — Right. . yeah. .

Code A — . . . mealtimes, and they are fed.

DC Code A — So they tend to be very dependant on . . .

Code A — They are highly dependant patients mostly.

6.26 DC Code A — Okay, alright. Thank you for that. Um I mean if we can move on to Code A . .

Code A — Yeah.

DC Code A — . . . which is the whole crux of this, what are your memories of . . her?

Code A — My memories of Code A was that I was her main nurse, but I wasn't actually on the

ward when she was admitted. She was admitted under my name by a D grade nurse, who worked with me. I was on leave. When I came back from leave was the day Code A Code A came . . was re-admitted from Haslar, so that morning we worked as normal. I went for my coffee break about 11 o'clock and as I came back, Code A had been admitted, so I was met by um two health care support workers, who had acutally not assisted her into bed, but was actually there when she was put on the bed. One of them, support worker, Code A came to tell me that she was quite worried really because this patient had been transferred on a sheet, where she should have been on the canvas on a tall base. .

DC Code A Right.

Code A . . . and she wasn't happy with the way she was lying. Also she felt the patient was in pain. So I went into the room and introduced myself to the sisters and the patient, I pulled back the covers and had a look and found she wasn't lying properly. One sister said, because I was on my own at the time, told me she was a nursing officer - an ex nursing officer - and offered to assist me. I accepted this explanation of a nursing officer and she did help me put her mother in the correct position

and she did seem more comfortable. Then I remember lunch came and this sister was trying to . . . daughter I should say, was trying to feed her mother and her mother couldn't take the food, so I did ask one. . . another health care support worker to go and mince the food, which she did. She took it to the kitchen, had it minced, bought it back and she carried on attempting to feed her Mum.

Somewhat later, we heard her Mum in pain and distress again and um I went into the room and had a look at the patient and she appeared to be in pain, she was crying out in distress and I spoke to the daughters as is normal. We . . on our ward we try to involve the relatives as much as possible in the patient's care. . .

DC Code A

Mmmm.

Code A

. . and I said to her daughter, um I'd like to give your Mum something to relieve the pain, is it okay if I do it and she said yes please. So I went to find the Manager, Code A and said this patient, Code A is in pain, um I'd like to give her some Oromorph, which is a liquid, which is morphine based. We gave her a very small dose er, two qualified staff check these drugs, so nobody ever gives them on their own, so they are in a locked cupboard within a locked cupboard, so we went in and measured the drug, checked that we had the right amount

left. We have a book, I expect you've seen it, a CD book. . .

DC Code A — Er. . . .

Code A — . . . where we enter these drugs.

DC Code A — . . .yes I think I've got a copy here actually. . .

Code A — . . and in the book we put the patient's name, the date, the dosage um and then we check the amount that's left that we're going to replace in the cupboard and we both sign and we also sign a treatment card - prescription card. .

DC Code A — Right.

Code A — . . with again, the date, the name of the person, the amount of the drug and we sign that when the patient's taken it, 'cos sometimes they may not want to have it when we've actually drawn it up. Er so we gave this um Moromol to the patient and she did appear more comfortable and at half past one that day I went off duty.

DC Code A — Do you want to put the notes. . . .

DC Code A — Yes sure, yeah, yeah. . .

Code A — Sorry, I've changed. . . .

DC Code A — If there's anything at all you want to refer to. . .

Code A — . . I've changed the times of my um . .

DC Code A — Obviously, yeah, this is a duty rota . . .

Code A — Yeah.

DC Code A — Yeah, anything you want to refer to to. . . .

Code A — Yeah.

DC Code A — . . refresh your memory. . just er . . .

Code A — Sorry, half past three I went off duty.

11.27	DC Code A	Okay. So that was on the . . .
	Code A	That was on the . . .
	DC Code A	On that, on that er . . .
	Code A	17th.
	DC Code A	On the day of the 17th you said that Code A Code A was in an awkward position. . .
	Code A	Mmmm.
	DC Code A	Can you describe the position that she was in.
	Code A	Yes, she wasn't lying flat on the bed, she was . . one leg was curled . . .
	DC Code A	Yeah
	Code A	. . um, bent . .
	DC Code A	Right.
	Code A	. . and really she was supposed to have a pillow - her position was abduction, she should have had a pillow between both legs, so that she's lying with her legs stretched out and the pillow between.
	DC Code A	Right.
	Code A	. . to keep the hip in the right position.
	DC Code A	Right and whose responsibility would it have been on the transfer er whose responsibility to put her to bed initially?
	Code A	Whoever's on the ward.
	DC Code A	Would it have been . . I mean could it have been the . . .
	Code A	There were two trained staff on the ward that morning. .
	DC Code A	Yeah.

Code A I was on my coffee break, so I wasn't on the ward. The other trained staff was giving an enema or suppositories, something like that and . . so she would be gowned and gloved and doing what she had to do. . .

DC Code A Mmm not really in a position to . . .

Code A Not in a position to oversee the transfer of the patient.

DC Code A Yeah, but would it be, I mean er, I mean obviously we want . . and you weren't there. . .

Code A No.

DC Code A . . but I think we all agree that she didn't come in on a stretcher, she came in on . . .

Code A She came in on a sheet.

DC Code A Yeah, can you describe what that means.

Code A Which means that it's not taut, therefore as she's been . . . as the poles have been moved over um her body would stretch the sheet . . .

DC Code A I take it this sheet business is some form of stretcher.

Code A It's a stretcher. It's a canvas which goes on a stretcher is a um an oblong piece of material which is taut material . .

DC Code A Yeah.

Code A . . both poles go - there's room both sides for the poles to go down. . .

DC Code A Yeah.

Code A Okay, so four or two people, two strong people could hold the stretcher, both ends . .

DC Code A	Yeah
Code A	. . and the patient would be lying on a taut surface.
DC Code A	So in that. . . .
Code A	For a dislocated hip, this is what is required.
DC Code A	Yeah so in these circumstances then, if er for arguments sake, I know you wasn't there . . .
Code A	No.
DC Code A	. . . two ambulance crew, two of the. . . .
Code A	I wasn't there, but . . .
DC Code A	. .. transport crew from Haslar to Daedulus Ward . . .
Code A	Yeah
DC Code A	I take it they wouldn't hang around in the ward
Code A	I have to say, can I say they had expressed to Haslar that they didn't wish to bring the patient without a canvas.
DC Code A	Yeah, but I take its the case they are not going to stand around in the ward holding a stretcher waiting for somebody to transfer from stretcher to the bed.
Code A	Well no, they obviously did it.
DC Code A	Yeah.
Code A	Yeah.
DC Code A	Yeah, so that more than likely in the hospital, the transfer crew would have put her into the bed?
Code A	Mmm.
DC Code A	Yeah.

Code A It was.

DC Code A Just in relation to her positioning; it's been described by another colleague that she was sort of in like a figure 4, her legs.

Code A Yes, I could describe it as that, I did say one leg was bent . .

DC Code A Yeah. . .

Code A . . so that could look like a . . .

DC Code A . . tucked under the other and looked a bit like a figure 4.

Code A Yeah it could have been like it.

DC Code A Can we just go over the next few days, what your memories are and then obviously we'll go into the specific bits and pieces and obviously we've got the notes here for that, but in relation to any more dealings you had with Code A Code A er anything significant that you remember and including obviously any conversations with her daughters, anything that came up during those few days.

15.00 Code A We actually knew, or we were told, that her daughters were suing the nursing home where she did originally break her hip.

DC Code A Right.

Code A Therefore we bent over backwards to try and prevent a complaint, which we would do anyway and not that they had, not that the patient had any different treatment, she didn't, but we wanted to make sure there were no

complaints.

DC Code A — So it would be fair to say you sort of conscious that er . . .

Code A — We were conscious that this could occur.

DC Code A — That something could come up from it.

Code A — Yes.

DC Code A — Okay and other than the complaint that you were aware was being made, was there any other reason that led you to feel that. . . was anything else said or . . .

Code A — In hindsight yes.. . yes.

DC Code A — Okay, can you tell me what . . .

Code A — Well, one support worker became quite friendly with one daughter. She did her astrology charts. . her astrology chart and her sister's, um chatting to them in a friendly way. One sister who rang her many many times . .

DC Code A — Can you remember which she was . . .

Code A — Code A First of all she was a lawyer, then she was a TV producer. She'd written books, this is what she told the support worker. Um she um expressed an interest in spiritual healing and all sorts of astrology and etc. Things in that vein and she instigated three members of staff, myself included, going to Chichester to a meeting, some medical technical society, which was full of doctors, psychiatrists, medical people.

DC Code A — Mmm.

Code A — The speaker was the President of the National Federation of Spiritual Healers, he's a GP in West Sussex - very nice man. We quite enjoyed this, however when everybody introduced theirselves, as we did, at the beginning of this meeting, Code A introduced herself as a interested person, so we knew then that she wasn't a lawyer etc whatever, also, reading . . I'm diverting I know. . but reading the other sister's statement, I don't believe she was a nursing officer, I think she worked in nursing homes.

DC Code A — Right.

Code A — But, anyway, so we were at this meeting and she actually did um she was very derogatory about her Mother's death there in front of us, which is probably why she wanted us there and we did actually enjoy the meeting, we left and went home and that was it, you know.

DC Code A — When you say derogatory, what did she say?

Code A — Oh she said she was unhappy with the way her mother died and she didn't feel that the nursing care was adequate, etc.

DC Code A — Okay, who was actually . . what other members of staff . .?

Code A — Present?

DC Code A — Yeah went to the meeting.

Code A — Health Care Support Worker, Code A Code A and Health Care Support

Worker, Code A and myself.

DC Code A: So three of you?

Code A: Three of us were there. .

DC Code A: Okay.

Code A: They also sent letters to various members of staff - this is Code A - and presents of books, books on healing, after life, after death experiences.

DC Code A: Okay, do you know who received those?

Code A: Um the Manager Code A Support Worker, Code A one of the night staff, I think that was it, I'm not sure. She also presented us with her Mother's chair from the nursing home, a rather nice easy chair . . .

DC Code A: For the ward?

Code A: For the ward, to thank us for looking after her Mother.

DC Code A: How long after. . .how long after her Mother's death was that then?

Code A: Within the first month or two.

DC Code A: So six to eight weeks go by . . .

Code A: Yeah.

DC Code A: . . and there's been no representation made by Code A to . . . .

Code A: I believe there was a complaint, I don't know the date of the complaint. .

DC Code A: But up until that day when . . the meeting that you went to, you weren't aware that Code A Code A had any representations about her

Mother's treatment at all?

Code A No.

DC Code A No?

Code A No, in fact we were quite shocked to sit there and listen to the complaints at the meeting. .

DC Code A Right.

Code A . . therefore we just. . we didn't even say goodbye, obviously, we just got up and left at the end.

DC Code A Right.

Code A . . although we enjoyed the meeting itself.

MR Code A She orchestrated that meeting?

Code A Yes she did.

DC Code A I'm sorry Code A

Code A It would appear that she orchestrated that meeting to make a complaint in front of other people.

DC Code A Oh right.

Code A That's the (inaudible) from what's been said.

Code A Totally ignored her I must say.

DC Code A If we can go back to on the ward then. We've got obviously the first day and what you remember of that, the fact she was moved, she obviously came back from Haslar and you're the main nurse.

Code A Yeah.

DC Code A What does actually that mean?

Code A That means I am the patient's advocate. It's my duty to look after the patient and their

relatives, to keep them informed of her progress, any medications that we give her. To include them in her treatment, particularly since this lady had Alzheimer's, but this is for every patient anyway.

DC Code A — On that point can you remember er Code A Code A problems she had a the time when she came to the War Memorial? What was wrong with her?

Code A — Yes. She was deaf in both ears. She'd had a cataract operation on both eyes. She'd had a six month history of falls. She had Altzheimers, which had worsened over the last six months. She'd had a hysterectomy in 1955 and then she'd fell at the nursing home, Glen Heathers, fractured her right neck of femur on the 30th July '98, where she was subsequently admitted to E6 at Haslar for a right hemi arthraplasti.

DC Code A — Which is a hip replacement, is it?

Code A — Yeah, similar.

DC Code A — Okay.

DC Code A — On top of that are you aware of any other ailments that she had. I mean we've been made aware that she had Alzheimer's, were you aware?

Code A — I did say Alzheimer's.

DC Code A — Oh did you, sorry.

Code A — . . . it worsened over the last six months.

DC Code A — Sorry, I meant Dimentia, or is that the same.

Code A — Well Dimentia and Alzheimer's are . . .

DC Code A — One and the same are they?

Code A — . . . very similar.

DC Code A — Right.

DC Code A — What sort of form did that take do you recall with Code A ? What . . . how. . ?

Code A — The Dimentia?

DC Code A — Yeah, how did that affect her?

Code A — It affected her speech and her memory.

DC Code A — Okay, so . . .

Code A — She did need . . she needed her daughters to look after her.

DC Code A — Yeah, was she able to talk or was it . . .

Code A — Very little.

DC Code A — Very little.

Code A — She cried out frequently.

DC Code A — Right, okay and that was down to the Dimentia or the Alzheimer's. .

Code A — Yes.

DC Code A — . . that she would cry out like that?

Code A — Yeah.

DC Code A — Okay. So was she a woman that was er you said that she needed her daughters constantly. Was she the sort of patient that needed constant and total care? Was there anything that Code A Code A could do for herself?

Code A — Nothing.

DC Code A — Nothing?

DC Code A — Right okay. Obviously we're looking from the 17th when Code A came back in, but did you have any dealings with her on the first occasion that she came into the ward, which was from the 11th.

Code A — On the first occasion she came in I was on leave.

DC Code A — So you . . .

Code A — I met her on the 17th.

DC Code A — You met her on the 17th, oh right, okay. If we go over. . you've mentioned, I think you called it the CDR, which is the Controlled Drug Register?

Code A — Yes.

DC Code A — I've got a copy of it here and um highlighted is the entries relating to Code A If you'd just care to have a look through that for a moment. . . . . and I believe there's some entries where obviously you've. . your signature is. Um I think it starts off on the 18th.

Code A — Yeah.

DC Code A — Um can you confirm that that's your signature there?

Code A — That's me, yes.

DC Code A — Um and that's the time it's booked at is it, 11.45

Code A — 11.45, yeah.

DC Code A — I can't see another one there for you.

Code A — There, 10.45 on the 20th.

DC Code A — Oh yes. . . on the 20th.

Code A — Mmmm.

DC Code A — And that's countersigned on each occasion?

Code A — Each occasion, yes.

DC Code A — On the 20th it's . . .

Code A — It's Code A She, at the time she was a sister on Sultan Ward, she's since retired.

DC Code A — Oh right, okay.

Code A — And this is Code A my manager.

DC Code A — That's the 18th, yeah.

Code A — Mmm.

DC Code A — And we go to the next page, sorry that one is for 30 milligrams Diamorphine injection, the one I've just showed you.

Code A — We we, yes that was in a drug.

DC Code A — And er, there's another there on the 20th at 10.45.

Code A — That is also countersigned by Sister Code A

DC Code A — Now I think what we've learned from speaking to other people is the reason two, there's two entries is because you can't get 40 milligrams in one . . .

Code A — Oh yes. Because we'd use a phial of 30 milligrams of Diamorphine and one of 10.

DC Code A — One of 10?

Code A — To make 40.

DC Code A — To make 40?

Code A — Rather than use 10. . four 10s.

DC Code A — Yeah, okay.

Code A	Yeah.
DC Code A	Right, um and then obviously this form says it's countersigned because it's a controlled drug.
Code A	Quite.
DC Code A	Um and that's your sort of running total down . .
Code A	That's our total which we keep in a locked cupboard in a locked cupboard.
DC Code A	Oh right. Now I don't understand it. Can you remember when she was put on the syringe driver?
Code A	Um, I honestly didn't remember that day, but but, Code A the Manager said yes it was me and him that did it.
DC Code A	That actually . . .
Code A	That actually . . .
DC Code A	. . started the . .
Code A	. . . initiated it.
DC Code A	. . initiated it.
Code A	However Code A had already spoke to the relatives and the Doctor.
DC Code A	Right.
Code A	Which is standard procedure.
DC Code A	Okay. There's just. . if we can go over that and just cover the procedure with that then, so who's decision would it be in order to. . .
Code A	It would be everybody's decision.
DC Code A	Right.

Code A the whole team.

DC Code A The whole team would . . .

Code A Right, plus the relatives.

DC Code A Right, so there'd be a consultation about it?

Code A Yeah, yeah.

DC Code A Were you present during that consultation or any discussions?

Code A Not on the initial, the initial would be between . . formal one would be between Doctor Code A and the relatives.

DC Code A Right okay.

Code A Yeah, but however Code A would have said to me what he was going to do. . .

DC Code A Yeah.

Code A . . do you agree.

DC Code A Okay and obviously, I take it nursing staff would have to because obviously they are going to do it.

Code A We would agree if the patient was in distress and pain.

DC Code A Okay, so ultimately then who . . .

Code A Nobody is left in that condition.

DC Code A . . .whose decision is it to do it, I mean if.

Code A It would be mine if it were me there . . .

DC Code A Yeah, yeah.

Code A Okay? If I was there with Code A he's the Manager, so it's the . . .

DC Code A Yeah.

Code A . . it would be his, but I would make that

	decision if he weren't there.
DC Code A	What to actually put her on a syringe?
Code A	Yeah, to operate it, yeah.
DC Code A	Oh right, okay, so . . .
Code A	I'm . . .
DC Code A	No, no, I think you might be confusing, I think this needs clarification . .
DC Code A	Let me, let me get this, let me get this right.
DC Code A	'Cos you can't, you can't authorise controlled drugs, can you?
Code A	Cause I can.
DC Code A	What the administration of them?
Code A	Yeah.
DC Code A	I'm.sorry, we didn't appreciate that, I didn't.
DC Code A	Right, if I tell you what I understand previously . .
Code A	Yeah.
DC Code A	. . because it's different to um what, what. . Basically as I understand it, Dr Code A is a . . . . .
Code A	Dr Code A. .sorry, Dr Code A would have to write the actual . .
DC Code A	Prescription?
Code A	The actual amount and the actual prescription, sorry yeah. .
DC Code A	Right
Code A	This is what you mean, isn't it, sorry.
DC Code A	Yeah. So ultimately . . .
Code A	I can't write it, no.

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DC Code A	I mean I know you have to agree with it. . cos obviously . ..
Code A	Yeah. . I don't have to agree with it. . .
DC Code A	No. . right. . we'll cover that point . .
Code A	Yeah.
DC Code A	Let's just take one at a time. So Dr Code A is the one who says well I'm going to prescribe this particular drug. . .?
Code A	Yes.
DC Code A	er and this amount . . .
Code A	Yes
DC Code A	And then there is a consultation . . .
Code A	Yes
DC Code A	. . and basically I take it she'll listen to every .
Code A	Quite, yes.
DC Code A	. . Other peoples' views . .
Code A	Yes.
DC Code A	. . 'Cos as I understand it, she comes in on a daily basis . .
Code A	She does.
DC Code A	Um and obviously she's going to listen to members of staff who are there permanently . .
Code A	Quite, yes.
DC Code A	. . . who can see what is happening.
Code A	Yes, 24 hours.
DC Code A	Am I right in saying ultimately, the decision to prescribe controlled drugs falls on Dr Code A as the GP?
Code A	She prescribes it, yes.

DC Code A — Yeah, okay.

Code A — She does. . she writes it.

DC Code A — And to clarify that, you're not in a position to say that lady's in pain . . .

Code A — To clarify it . .

DC Code A — . . . I'm going to give her 40 milligrams of Diamorphine off your own back.

Code A — Oh. . . off my own back no. . .no.

DC Code A — Right, okay.

Code A — I do beg your pardon.

MR Code A — Just something else I want to clear up. Who's ultimate decision is it to put somebody on the syringe driver?

Code A — The team.

MR Code A — You can't make it on your own?

Code A — The team. Everybody.

DC Code A — I know, but do you need a . . . who's . .

Code A — I have said that though, didn't I? I said that.

Code A — Yeah, but it was slightly confusing.

DC Code A — Can you, if you say Dr Code A and Mr Code A your first line manager, weren't there, would you be able . . .

Code A — If I were there on duty . . .

DC Code A — . . Can I, oh can I just finish. . .

Code A — Yeah.

DC Code A — If Dr Code A and Code A weren't there . . .

Code A — Yeah.

DC Code A — . . are you qualified and authorised to make a

decision on the ward to say I want that lady on a syringe driver?

Code A Do you mean if Dr Code A had already written the . . .

DC Code A No. No if that wasn't the . . .

Code A No, I would have to contact Dr Code A wouldn't I and say . .

DC Code A Saying this lady I believe she's in pain when you give an injection, can I suggest that we put in a syringe driver and then it would be under her authority . . .

Code A That's it.

DC Code A . . that the syringe driver . .

Code A I couldn't do it on the telephone conversation authority, I couldn't take a telephone . . .

DC Code A Oh right.

Code A . . um I couldn't take it over the telephone..

DC Code A No.

Code A She would have to come and write it.

DC Code A Yeah. Right.

DC Code A Then obviously from there then Dr Code A has said prescribes this course of treatment, syringe driver and these drugs . . .

Code A Yeah.

DC Code A In your role you are obviously authorised then to administer that.

Code A Yeah.

DC Code A But in terms of actually prescribing it, making the ultimate decision to follow that course of

treatment and to prescribe those drugs, that is down to Dr Code A

Code A Yes.

31.03 DC Code A Okay.

Code A Yes, I'm not allowed to prescribe controlled drugs.

DC Code A Yeah, but you are allowed to administer?

Code A Yes.

DC Code A Right, okay.

DC Code A Got there.

Code A With another qualified member of staff.

DC Code A Yeah, there's two of you there all the time.

DC Code A Two of you there. Yeah, I probably didn't phrase the question quite well . . .

Code A Sorry, no, no, it's probably me sir.

DC Code A Now this is , , obvioulsy that's why we need to get these things sorted out, so. .

Code A Yeah, yeah.

DC Code A Okay. If we just go over that then, so let's start again. So we've got this sort of consultatin process erm and I think we were talking about whether you remembered being involved in that. Whether you recall any any conversations with Code A or Dr Code A or the family, the two sisters, in relation to the syringe driver and what drugs were being proposed.

Code A I can't actually recall their conversation, but I do know our procedure which we follow regularly.

DC Code A Right, okay.

Code A We always adhere to the same procedure.

DC Code A Are you aware of any concerns that the sisters had about this treatment as being . . .

Code A No.

DC Code A Okay, did they make any representations to you. . . .

Code A No.

DC Code A . . . .personally? They didn't, okay. Did you become or are you aware of any representations they made to any other member of staff?

Code A No.

DC Code A Right, okay.

Code A As far as I was concerned they agreed . . .

DC Code A Right thankyou.

Code A . . . that their Mother would not suffer.

DC Code A All right. Let's just clear up Dr Code A role, um which maybe I should have done at the beginning to make this a bit clearer. What is her sort of responsibilities with the ward?

Code A Her responsibility is to the ward and to the Consultant. She visits, she is the clinical assistant. The Consultant does her rounds regularly and she will give her views on the treatment of the patient and on a day to day basis Dr Code A will carry out that treatment.

DC Code A Okay, now Dr Code A s the Consultant for the . .

Code A She is the Consultant Geriatrician for our ward.

DC Code A — Okay and Dr Code A who's a GP will come in on a . . .

Code A — She was the Clinical Assistant.

DC Code A — And will talk with staff on a daily basis . .

Code A — Yeah, yeah.

DC Code A — . . about the patients.

Code A — Yes.

DC Code A — Now I understand she wouldn't necessarily deal with every patient on the ward?

Code A — She will do all the the patients that require her.

DC Code A — That would be sort of brought to her attention or . .

Code A — That would be brought to her attention, yes.

DC Code A — Right, okay. What would . . .

Code A — We can also ring her or bleep her if we have an emergency.

DC Code A — Right. Okay and if she's not available, if it's out of hours, is there any other doctors. .

Code A — Then her partners deputise for her. . .

DC Code A — Right, so . . .

Code A — . . in the, in the Practice.

DC Code A — Okay, is there always a sort of a Doctor available?

Code A — There's always a Doctor available.

DC Code A — In one form or another?

Code A — In one form or another.

DC Code A — Okay and what's Mr Code A role, Clinical Manager, something?

Code A — He's in charge of the ward. He would have

		been the old sister or a charge nurse, but now you are called a Clinical Manager.
	DC Code A	Right, so he's a registered . . .
	Code A	You actually have more responsibilities.
	DC Code A	Right, so he's a registered nurse?
	Code A	Yes.
	DC Code A	Does he have more qualifications than you . .
	Code A	Yes.
	DC Code A	. . or is he just more experienced? He's got more qualifications?
	Code A	Yeah.
	DC Code A	Okay. So, um, do you know what his sort of role is or . . .
	Code A	I know what his role is.
	DC Code A	Okay, can you just go over that for us?
	Code A	Um, he's in charge of the ward, he's in charge of all the staff and um his role is to um monitor that the ward is run correctly and that the staff are all motivated and um etc. and now he has a budget as well . .
	DC Code A	Yeah . .
	Code A	. . which he has to adhere to. Therefore his responsibilties probably greater than they used to be as a sister.
34.59	DC Code A	Right, okay. All right, so we've covered the consultation process with . . and that's a general one as well, that applies to any patient . .in relation to . . . .
	Code A	Yeah

DC Code A . . this sort of treatment that we're talking about with the syringe driver. There would be consultations with the family, with members of staff who had an interest. . .

Code A Yes.

DC Code A . . and people could offer their opinions, basically. . .

Code A Right.

DC Code A . . but ultimately Dr Code A is the one who says yes or no.

Code A Yes.

DC Code A . . we're going to do this or not?

Code A Yeah.

DC Code A Okay. This is another general question. If a decision was made by any Doctor about a type of treatment they were proposing to prescribe and you . . you had strong reservations about it . . .

Code A Then we don't do it, basically.

DC Code A You don't do it?

Code A No.

DC Code A Okay. If there came a scenario where the Doctor insisted it was done, and I'm not for one minute saying this was the case in this case, but this is just a . . .what I'm trying to get at is the procedures in place if there are procedures in place.

Code A The procedures in place would be . . yes, that we have another manager above Code A

DC Code A — Right.

Code A — First of all we go to Code A then we would go to the other manager. We also have our ICN representative, our Union body who would instigate an investigation.

DC Code A — So its, basically, it's fair to say that you'd be aware of . people with . .

Code A — Basically we wouldn't give a drug if we didn't feel it . . necessary.

DC Code A — And you certainly wouldn't feel on your own or isolated because - you know -

Code A — No. Not at all.

DC Code A — You know of people you could go to if there was a problem.

Code A — You know you have a very good support system, yeah.

DC Code A — Yeah. During your time at the hospital, have you ever had sort of . . . situations

Code A — This has never happened . . . . no. . .

DC Code A — Situations where you've had a disagreement with a Doctor over a level of treatment or . . .

Code A — No, no.

DC Code A — . . .you've never had a problem?

Code A — No we'd always talk if we felt . . actually I've never had to, but I would.

DC Code A — No, okay. But you're aware of what you would do . . .

Code A — And I wouldn't give a drug if I didn't feel it necessary.

DC Code A Yeah. Okay. All right. Has there ever been anything in the ward where someone's had a particular er problem with what's been prescribed to a patient, that you're aware of?

Code A No. . no.

DC Code A No? Okay. All right. If we go over to the syringe driver now. .

Code A Yeah.

DC Code A What I would like to do is talk about the syringe driver and the drugs and what they do. If you could just explain to me what the syringe driver is and what it's there for. What it's job is.

Code A Yeah. The syringe driver is just a means of administering the drug over a 24 hour period. Prev . .well before we had syringe drivers we would give injections every four hours, of morphine or strong drugs for pain. Quite often it didn't last four hours we'd have to go back to the Doctor and say that patient's writhing in pain, falling out of bed, it's three hours, can we give another one and quite often they would say no. Now we can give the drug over 24 hours and it delivers a regular dose. This doesn't happen these troughs and lows, they don't happen any more. People walk around with drivers, it's just. . it's any drug.

DC Code A Yeah.

Code A It's a means of delivering it.

DC Code A — Okay. So it's not just something that's set up for palliative care?

Code A — No.

DC Code A — Okay. Now the next question would be can you just, if you can, sum up what palliative care is in a . . .?

Code A — Palliative care is a means of easing a patient who perhaps is a terminal patient and needs . . difficult to explain . . . I would say it eased the last few months or whatever of their life so that it improved their . . enhanced their standards of care.

DC Code A — Right, okay. In relation to Code A when she was obviously put on the driver, what impression did you have of her health and what was going to happen to her.

Code A — She was very distressed and in a great deal of pain.

DC Code A — Did you feel that she was dying?

Code A — Not at that time, no.

DC Code A — When did you or did you ever come to a conclusion that she was dying?

Code A — Probably a couple of days before she died um we realised that it was probably imminent, as nursing staff.

DC Code A — Yeah, okay, but are you aware of what she was dying of?

Code A — We knew she had multiple problems. We knew at that time she had a haematoma which is a

blister on her affected hip, the hip that she'd broken.

DC Code A — Right, a haematoma's like a bruise isn't it?

Code A — It's a blister, it's blood, it's a collection . . haema's blood and it's a collection of blood.

DC Code A — Oh, I see, okay, yeah.

Code A — So we knew that caused a lot of pain. . .

DC Code A — Right.

Code A — . . and with all her other medical problems. .

DC Code A — So it was in. . .

Code A — And we also thought she probably had a chest infection.

DC Code A — Okay, what made you think that?

Code A — Because her chest was rattling.

DC Code A — Right. Okay. Now in relation to the haematoma, when did, can you remember when that came about, I'll put the notes there if you want to look at them.

Code A — Well on this particular day, on this particular day when she arrived back from Haslar on the 17th, one of the daughter's mentioned that a Doctor at Haslar said that her Mum should go back if this hip came out again, her Mum, rather than if she was in pain she should go back to Haslar.

DC Code A — Mmm.

Code A — And um I rang Dr Code A and said . . mentioned the way the lady was transferred, I mean it was possible that that hip could have

slipped out again and she arranged for an x-ray at our hospital, we have an x-ray department and Code A was x-rayed and it wasn't out, so she didn't return to Haslar.

DC Code A Right, okay.

Code A However, it was discovered later I believe that she had a haematoma.

DC Code A Right, what would cause that then? I know it's . . .

Code A Well it's possible I feel the ambulance crew said she was in pain and distress as soon as she got in the ambulance and it's possible that the way she was transferred, both in Haslar and in our hospital.

DC Code A Sort of could cause.

Code A What would cause a collection . . . does that mean that she'd ruptured some blood vessles or something that had collected there or. . .?

Code A Or two pieces rubbing together could cause a collection of blood or maybe from the operation.

DC Code A Right so yeah, I mean obviously you're not in a position to say exactly, but those are some of the examples it could be.

Code A Yeah.

DC Code A Okay. And so I've got the contact notes here and there's a few relevant to you, you may have already seen them and we've. . a lot of them you've covered anyway, to be honest.

Um, but I think what we'll do actually saying that we'll take a short break 'cos the tapes are running out.

DC Code A — Tapes run out after 45 minutes and we're on 43.. so..

Code A — (inaudible)

DC Code A — Time by my watch is 1104. Turning the recorder off.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y18A

Enter type: ROTI
(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: Code A

Place of interview: PARK GATE POLICE STATION

Date of interview: 29/06/2000

Time commenced: 1117 Time concluded: 1156

Duration of interview: 39 MINS Tape reference nos. (🔊) 44/00/030848

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

Other persons present: Code A Saulet & CO Solicitors - Legal advisor

Police Exhibit No: LMC/MRC/18 Number of Pages: 44

Signature of interviewing officer producing exhibit

Tape counter times(💻)	Person speaking	Text
	DC Code A	Okay, this is the commencement of the interview of Code A Okay it's time by my watch is 11.17 on 29th June, taken a short break. I will remind you that you are still under caution and I'll just go through the caution again.

You do not have to say anything, but it may harm your defence if you do not mention something when questioned which you later rely on in court. Anything you do say may be given in evidence.

Code A Yes.

DC Code A Okay, do you understand that?

Code A I do.

DC Code A Okay. That's not anything additional to what we've said already, it's just reminding you that this interview is being conducted under those headings and it's the caution.

Code A Right.

DC Code A All right and can we also . . can you also confirm for me that during the break um we've not discussed the case, I've not asked you any questions in relation to anything with regard to Code A

Code A No you haven't.

DC Code A Thank you. Okay, right, we were talking about the syringe driver and um you explained, you've explained the advantages of the syringe driver and that it gives a constant level of pain relief for whatever relief is, you know the drug in it is designed to give and it prevents these troughs in in pain relief . . .

Code A Yeah.

DC Code A . . .and stops patients waking up or in pain or whatever, towards the end of the treatment.

We've discussed that. We've also discussed that it's not purely for palliative care, it is for other forms of treatment as well . .

Code A Yes

DC Code A . . . and it's I believe it's quite a small machine . . .

Code A It is.

DC Code A So people can walk around with it . . .

Code A You can put it in your pocket.

DC Code A Yeah . . and whatever, so that it gives them that constant . constant care.

Code A Care.

1.52 DC Code A Okay, we've discussed Code A condition and the fact that it was probably, I think you said and correct me if I'm wrong, a couple of days before she died that you got the impression that she was actually starting to die . . .

Code A Yeah.

DC Code A . . she was starting to die. She had a chest infection, or you felt she was, she was . .

Code A Did.

DC Code A Did have a chest infection or had a chest infection and I take it it would be fair to sum up and say she was very ill or very poorly.

Code A Very poorly, yes.

DC Code A Okay. Now there are times, what I'd like to do now is go over the drugs that were administered and I've got here, which might be

a bit clearer, cos this is the original copy, the health record. You've actually got your own notes there. I take it this is the, this is the prescription record, is it called?

Code A It is the prescription chart, yes.

DC Code A Okay. Now I think there's sort of several entries or a few entries relevant to yourself. I'm not sure, I wonder if you could just point out for me which ones are, you're involved in.

Code A This one's mine, the 20th of the eighth, I can see my signature here.

DC Code A Okay that's for hyoscine.

Code A Yeah.

DC Code A And that's . . is that 400?

Code A It's 400 micrograms at quarter to eleven and the Midazolam, 20th of the eighth, 10.45, 20 milligrams and my signature, Code A Obviously on that day we didn't put any Diamorphine . .

DC Code A I see.

Code A . . or did we? Yes we did, we put 40 milligrams of Diamorphine, 20th of the eighth, 10.45, that's my signature.

DC Code A Okay, and I believe you've got the haloperidols?

Code A Haloperidol - 20th of the eighth, 10.45, 5 milligrams, my signature.

DC Code A Okay, so looking at those four . . .

Code A Yeah, so I put the driver up that day. .

DC Code A Yeah to ask you a fairly obvious question, it

looks . . you've loaded the driver on that day?

Code A I must have put it up. . . yes I must.

DC Code A Okay. Can you just go through for me what each of the drugs do, what they are designed to do?

Code A Right, Diamorphine Hydrochloride is a powder in ampules, five, ten, thirty, one hundred and a five hundred ampule. .

DC Code A Right

Code A . . and I believe it's heroin. . .

DC Code A Oh right, okay.

Code A And it's a very strong painkiller, indicated in severe pain and the initial dose is five to ten milligrams, four hourly. . .

DC Code A Right

Code A . . for an adult.

DC Code A Okay. What about the others there?

Code A . . .and Haloperidol is for severe anxiety and the management of anxiety, dosage 1.5 to 5 milligrams, 10 milligrams, 20 ampules and we actually gave 5 milligrams, which is a very. . as you can see is a very small dose. You can go up to 20 over 24 hours.

DC Code A Oh right. Okay.

Code A Midazolam, 20 milligrams over 24 hours, again an anti anxiety drug with 20 milligrams being a very low dose.

DC Code A Right and the Hyoscine?

Code A Oh and Hyoscine is a drug to dry up secretions

in the patient's bronchal tubes, which occasionally can cause quite a lot of distress to the patient.

DC Code A — Right, okay.

Code A — And that is only added if it's required.

DC Code A — Oh right. As I understand it . . .

Code A — And 200 micrograms, sorry 400 micrograms isn't a large dose, she could have had 800.

DC Code A — Right, I mean that was my next question, in relation to the level of dosage, your saying that they're quite . . .

Code A — They're quite low, they're a normal, a normal dose.

DC Code A — Obviously when, it's got here the drug . . .

Code A — Yeah.

DC Code A — . . Diamorphine, for example, it's got 400 to 200 . .

Code A — We could've . .

DC Code A — 40 to 200

DC Code A — Sorry 40 to 200

Code A — 40, yeah, we could have given 200.

DC Code A — So, am I right in saying that when the Doctor, Dr Code A in this case . . .

Code A — Yes.

DC Code A — . . has prescribed these, she's given the nurses who have got the authority to do so, discretion to increase the dosage . . .

Code A — Quite, if the patient required it.

DC Code A — If the patient required it, yeah. Would that

involve any further consultation with Dr Code A before . . .

Code A Not necessarily.

DC Code A Wouldn't necessarily. She's given you that sort of . . . .

Code A Yes.

DC Code A . . . those guidelines to fit in, so . . .

Code A Yeah.

DC Code A . . I mean I take it if you had to go over that . .

Code A Well she knows that two of us would have decided.

DC Code A Right.

Code A If we decided that this patient was in distress and pain we could have upped her pain . . .

DC Code A Right.

Code A . or if we felt she was terribly anxious we could have upped her. .

DC Code A Okay

Code A . anti anxiety drugs.

DC Code A Right, so yeah, if the level was not working then . . .

Code A Yes.

DC Code A . . . and it's within the parameters that are set, you can increase it within those.

Code A We can, yes.

DC Code A Okay, you mentioned that the Haloperidol and the Midazolam were both for anxiety?

Code A Yes.

DC Code A Um. . .

Code A I believe she prescribed them because of the patient's condition and her high level of anxiety.

DC Code A Right.

Code A Um, however the Haloperidol was 5 milligrams over 24 hours, which is very low, if you're asking why she had both.

DC Code A Yeah, yeah. What would the reason in all the thinking be behind that, would you be able to . . .

Code A The thinking would be that . . of the high level of anxiety of the patient.

DC Code A Okay, and the other question, I mean is there any reason why there's two and not like they just increased the Midazolam for example.

Code A Well I didn't actually - this is a question you would have to ask Dr Code A because she actually prescribed it.

DC Code A Right, okay okay. In terms of of what's been loaded onto the driver, are you able to comment on whether that's a normal . . .

Code A I would say it's a perfectly normal dose . . .

DC Code A . . sort of in relation . .

Code A . . and quite normal.

DC Code A Yeah, what about the combination of the four medicines.

Code A What about it?

DC Code A Is tha . . have you seen that sort of combination before?

DOCUMENT RECORD PRINT

Code A	Oh yes.. . yes.
DC Code A	Is it the sort of thing they've given to somebody in Code A condition?
Code A	Yeah
DC Code A	It is?
DC Code A	Okay.
DC Code A	Are you aware of any er adverse side effects that a combination of one or two or the mix of all four . . .
Code A	No because we wouldn't use it if we were aware there were any adverse side effects.
DC Code A	That was the question, are you aware that there would be any adverse side effects?
Code A	No.
DC Code A	No?
DC Code A	Okay. What I'd like to do now, is I've got a . .
DC Code A	Can I just check one thing. On one of the drugs, one has been increased.
Code A	Which one?
DC Code A	You can tell me.
Code A	Oh I can't see now. They're all 400, they're all 400 micrograms.
DC Code A	Wasn't one increased?
Code A	They're all 20s. The Diamorphine is all 40s and the Haloperidol is all 5 milligrams.
DC Code A	No, one of them's increased.
Code A	Where?
DC Code A	(Inaudible) just (inaudible) from 200 - oh no it

	is 400 isn't it?
DC Code A	That's 400 there, that's all 20s . .
Code A	That's all 40s. . .
DC Code A	I thought there was one increased.
Code A	That's all 5s. Possibly we . . .
DC Code A	I think you're looking at the Oromorph.
Code A	This, this was changed . .
DC Code A	Yeah.
Code A	She started off on an extremely low dose, which is . . .
DC Code A	And that was raised. It started off, what was it, 200 . . .
Code A	That's micrograms and then . . .
DC Code A	Is that 200 or 400?
Code A	400
DC Code A	To me it looks like a 4, but . .
Code A	It is a 400. . and the actual dosage is within 200 micrograms to 800 micrograms, so it's still only half.
DC Code A	Yeah.
DC Code A	Yeah, it's still within the . . .
Code A	Yeah.
DC Code A	. . the parameters.
DC Code A	Do you know, I don't know whether you're qualified to tell us or not, but do you know whether all of these drugs are licensed by the drug company?
Code A	Of course they are, yes.
DC Code A	For use in a syringe driver for subcutaneous

use.

Code A — Of course ..

DC Code A — They are?

Code A — They are, yeah. We can bring you literature . . .

DC Code A — Yeah.

Code A — . . if you'd like to see it, on the drugs.

DC Code A — Right.

DC Code A — Is that available on the ward?

Code A — Its available on the ward, yes. If you came on the ward you'd be able to see it.

DC Code A — Yeah. So all the drugs that you have in stock, is there something you can refer to for the prescription.

Code A — Oh yes, we're, we're controlled on the trust by the pharmacy at QA as to what we can order and what we can give. . .

DC Code A — I take it . . .

Code A — . . and they're all checked and . .

DC Code A — If by mistake or for whatever reason, if a Doctor prescribed drugs for the patient and the Pharmacist gets it first and he looks at it and says hold on mate, hold on a minute, you can't do that. .

Code A — Mmm, can I just tell you that the Pharmacist comes from QA every Thursday on our ward. She checks every prescription . .

DC Code A — Right

Code A — . . for any problems or any drugs that are given . . it's her . . she's the expert.

DOCUMENT RECORD PRINT

	DC Code A	Right, so if . . . .
	Code A	So any drugs that interact, she'll tell us.. .
	DC Code A	That's right, she'll say . . .
	Code A	She'll pass it onto the Doctor and they'll change it.
	DC Code A	So there is something in force that if somebody wasn't aware that a combination of drugs . . .
	Code A	Oh yeah. . . . . yeah.
	DC Code A	. . could cause a potential problem to a patient by administering the two drugs together, or (inaudible) together . .
	Code A	It would be very quickly picked up.
	DC Code A	. . the Pharmacist is the person to say Whee, what you doing here, you can't do that.
	Code A	That's right, mmmm.
11.49	DC Code A	Try this one instead.
	Code A	Yes, she, she visits every week.
	DC Code A	Oh right.
	DC Code A	Do you know, is it a particular day that she visits?
	Code A	Normally it's Thursday, I did notice she was there Monday this week, but sometimes she changes.
	DC Code A	But it's a weekly basis?
	Code A	It's a weekly basis and I can tell you her name if you want to know it, Code A
	DC Code A	Right.
	Code A	She's been a Pharmacist for many years.
	DC Code A	Okay. Just going back to the syringe driver, I

mean obviously we've been talking about literature for this, what training do you get to use the syringe driver.

Code A Um, we get in house training I should say, on the ward. We get training, we used to have a school of nursing at QA, it's now moved to Southampton. We get trained, we used to get trained in there. We do study days on the ward for all staff, cos I was talking about trained staff. Obviously because we work as a team on the ward, the untrained need to know about the drugs and why we use them and etc.

DC Code A Right, so they've done . . .

Code A So we have days on the ward when we will all get together and sit and talk about it.

DC Code A Right, okay and is there any instructions for the driver?

Code A Yes.

DC Code A To hand?

Code A Yes it's actually on the door, if you come into our controlled, into our drug room, it's on the door . .

DC Code A Oh right.

Code A . . as you go in.

DC Code A Okay.

DC Code A Do you know. . do you know the . . .

Code A Oh the drivers are taken regularly over to QA to the technical department to be checked.

DC Code A Oh for maintenance . . to make sure that they . .

Code A For maintenance and they are dated on the drivers.

DC Code A Yeah.

DC Code A Oh what they all get sticky labels, do they?

Code A Yes, yeah.

DC Code A Do you know the make of the driver?

Code A Yes. Grazeby.

DC Code A Grazeby. You're the first one who knew that, well done.

Code A I was told to look it up.

General laughter.

Code A I wouldn't have remembered.

DC Code A Are they. . . we have got an instruction we've got to find out what the make of the driver is and hopefully we'll try and get hold of one, I think.

Code A We, we've got all the stuff for you. .

DC Code A Yeah.

Code A We came on the board (inaudible)

DC Code A Right.

DC Code A Okay. Now I'd like to move onto the . . now what I've got here is the nursing care plan? I think this particular one is for nights. Now if I think what I'll do as well, because you've got some. .

Code A . . . yes it is nights.

DC Code A . . I've been made aware obviously . . we've got the internal, it's called a statement, but I'm

aware that it's not actually a signed statement, it's more a . . somebody's summary of your conversation really, I think that's the best way .

.

Code A Code A , Manager.

DC Code A Do you want to have a quick, have you . .

Code A I have looked at it.

DC Code A . . had chance to read it? Now you've got some issues with this haven't you, I've been made aware about.

Code A Well I just felt that the interview that she and I had together. .

DC Code A Yeah.

Code A . . it's like your written statements isn't it and if I'd have seen it I would have said to her well it's not really, you know it's not really what we talked about.

DC Code A Did you get a chance to look at this . . . .

Code A No, no.

DC Code A . . after it was typed? You didn't, so when was the first time you've actually seen this?

Code A When this compl. . well when you initiated this enquiry.

DC Code A On this occasion, so what . . .

Code A Couple of weeks ago.

DC Code A . . couple of weeks ago, right. Okay. What are your sort of problems with it? What are . . . . .

Code A I don't have any problems with it, I just feel that um . . .

DC Code A Is it a case of the way it's worded, is. . . .

Code A Yes, yes.

DC Code A . . you're not happy with?

Code A It's just not. . . . .

Code A I think for safety reasons, that should not be put to my client, and you shouldn't ask her any comments on that.

Code A And I feel also, I'll tell you something else I feel, that Code A got my name from here and she's included me in her complaint to you.

DC Code A Right okay.

Code A Mmm, 'cos she mentions my name . . .

DC Code A Right.

Code A . . quite a bit.

DC Code A Okay, you you. . . I'll tell you this straight away, I don't think you as an individual has been complained about.

Code A No, but what she said about. . . .

DC Code A About you . . .

Code A . . naming me . . .

DC Code A She's moaned about you to the . . .

Code A The things she said about me are untrue.

DC Code A Right, okay, but can we just make sure that we're quite clear about this. . .

Code A I think she got my name from there.

DC Code A Yeah. Let's make it quite clear that we're not talking to you today because she's said to us that you want to go and speak to Code A

DOCUMENT RECORD PRINT

Code A she's got something to say. We are talking to every member of staff . . .

Code A Yes I know.

DC Code A . . . that was on duty during the time Code A Code A was in hospital.

Code A . . I'm just saying that what she said about me wasn't true.

DC Code A Okay.

DC Code A Okay. I only brought that up because I thought there was an issue with it, but we've cleared that now.

Code A There's no real issue, no.

DC Code A Yeah, okay.

Code A I could have written it better.

DC Code A Yeah, yeah and you've made it clear that actually you've not . . .

Code A I've lost my job now, but still.

DC Code A You didn't have the opportunity to read it?

Code A No.

DC Code A Okay. Let's move onto the care plan then. Now as I understand on her admission, or any patient's admission, there are certain forms that need to be completed.

Code A Yes, lots of paperwork.

DC Code A Yeah, okay. Can you go through what generally would be required for a patient?

Code A Yes, um there's all this, all general information, there's . . we like to put past history, sometimes we put social history, so that we can

look at that and we've got a resume of the patient.

DC Code A — Huh huh.

Code A — Then what happens when they (inaudible), their understanding, communication, are they continent of urine, are their bowels continent, how they eat, what type of diet, what's their appetite like, pain, teeth, vital signs, blood pressure, weight, etc. Mental study - the reason this wasn't done on Code A was because it would have been nought because we couldn't initiate any answers. .

DC Code A — Right.

Code A — So I suppose you could say we should have had nought there . .

DC Code A — Right.

Code A — . . with some, a lay person looking at it.

DC Code A — Yeah.

DC Code A — But to be honest, I'll tell you now, we've looked at that and not seen anything untoward about it at all, we don't know what's . .

Code A — No.

DC Code A — Again, me and Code A are policemen, we don't know what forms have got to be filled in, what haven't got to be filled in, so (inaudible)

Code A — Yeah. . that's an indication of the patient's mental . . .

DC Code A — Yeah.

Code A — . . . condition, out of ten . . .

DC Code A yeah.

Code A So if you's had say 2 out of 10 you would have had. . .

DC Code A . . some form of conversation . . . .

Code A Yes, some form, but none of it would probably be relevant. Bartel, this is important for us . . . .

DC Code A Right.

Code A This is three, which is fairly normal for our ward. Now this is an indication of what happens with her bowels, what happens with her bladder, do we need to wash and dress her, yes we do. Do we need to take her to the toilet? Definitely and how many, how dependant she is.

DC Code A Oh right, yes.

Code A Okay? So she is . . because she scores nought, she is totally dependent. And feeding: can she feed herself, do we need to cut up the food? Yes we do, everything, so that's another nought. Transfer: now we've got major help which is right, so it's one to two people to transfer. Mobility: she can't so she got a nought.

DC Code A Mmm.

Code A Dressing: highly dependant, so we have to wash and dress her. Stairs: no way, nought. Bathing: highly dependant, nought, so she's scores three, which tells us that she needs two people to look after her, she's highly

dependant.

DC Code A — And as you said, I think, some time ago, that she was totally dependant.

Code A — Totally dependant, yeah. This is a water low pressure score prevention, now this is you're probably aware that people who can't move, be it because they're elderly or because they're depressed and won't move, develop pressure sores extremely quickly.

DC Code A — Oh right, yeah.

Code A — . . and in their first 24 hours of admission, we are supposed to do this um and initiate the appropriate treatment, so we go through and her build is average and she gets a nought. Her skin type, someone said is healthy, I would question that, and she got a nought. Sex and age: she gets 2 for being female and 5 because she's 80 plus. They haven't done anything with the special risk. Continent: they've put down occasional incontinence - I don't think that's right, she got one for that. Mobility: chairbound - 5, Appetite: average, I would have said it was extremely poor, but she got a nought anyway. Because she'd had surgery and a CVA she's got 4 there and because she's been on the table, surgical table . . .

DC Code A — Right, yes.

Code A — . . which is notorious for getting sores and things, she actually comes out with very high

risk, 27, so she was nursed on an air mattress which are pretty expensive, but they proves to having an air mattress, we would have turned her two hourly which would have been most uncomfortable wouldn't it for her? Also you can't turn a patient with a fractured hip, on her side. . .

DC Code A Mmm.

Code A . . . you've got to really tilt them.

Code A so the mattress she was on was probably the most comfortable . .

Code A Of course.

Code A . . that she could've had.

Code A Yeah, yeah and we wouldn't . . lifting and handling we have to have a . . . that's the medicine she's on, she was . . she came in on lactalose and haloperidol, the one you questioned in the driver. She was having one milligram twice a day . . .

DC Code A Right.

Code A . . she actually came in on two milligrams of haloperidol. Then the contact record where we write every day: that's somebody said the (inaudible) found on the floor and normally it's signed - you see . .

DC Code A By the relevant nurse, yeah. There's an entry for you at the bottom there.

Code A There's an entry for me at the bottom. In hindsight, I wish I'd have written that over the

other side of the page, 'cos she said I added that afterwards . .

DC Code A — But you didn't, can we clear that up then?

Code A — Yeah, I did not write that afterwards. I told you how I discovered Code A

DC Code A — Yeah, it was brought to your attention . . .

Code A — Yes.

DC Code A — . . by er I think it was Code A .

Code A — Yes.

DC Code A — . . and you've included . . . let me just summarise what you've.

Code A — I've put, I've written what they, which we would normally do. I looked at her notes when she came from Haslar and they said to remain in a straight knee splint for four weeks, which is 4/52 . .

DC Code A — Mmm mmm.

Code A — . . . and pillow between her legs, that's to abduct her hips, but at night. No follow up unless complications and I signed it and then I, the same morning, as Code A told me there was no canvas, I thought well that's very important, I'd better add that and I put it here.

DC Code A — But that was added on the same day?

Code A — On the same day.

DC Code A — On the same morning?

Code A — On the same morning.

DC Code A — Okay.

Code A — We checked her for (inaudible) I don't know

whether you know about MRSA, do you?

DC Code A That's the flesh eating bug is it?

Code A No it isn't the flesh eating . . .

DC Code A No?

Code A That's another one.

DC Code A That's another one, is it?

Code A This is a staphylococcus aurius that's become resistant .

DC Code A (inaudible)

Code A . . that's a bug. We all carry this bug on our bodies. .

DC Code A Oh all right.

Code A You've got some . . .

DC Code A I'm sure I have.

Code A It's become resistant to the normal anti-biotics and um is's very prevalent . . I must watch what I'm saying. . for people that come out of surgery, where she'd come, so therefore we tested her for it.

Code A Careful 'cos I'm going in for surgery soon, don't frighten me.

Code A I know. Oh, sorry, sorry. It's particularly a problem for the elderly and very young, you're all right.

DC Code A In fact, I've noticed that, there's a . . . .

Code A There's a negative result . . yes.

DC Code A Pathology service.

Code A That's right. She was negative.

DC Code A Is it like swabs they take?

Code A They're swabs, mmm.

DC Code A Swabs, yeah and they're all negative, so . . .

Code A So she didn't have it. And then these are all the . . we've got different nursing care plans now, cos this is two years ago, we've got better ones. We'd have one for the nights . .

DC Code A Which is that one.

Code A One for nutrition. One for constipation. Then we also have a bowel chart there.

DC Code A Yeah.

Code A Personal hygiene. That's her prescription sheet. Investigations and that's it basically.

DC Code A Yeah. Just going back to the care plans, now although you're the named nurse . .

Code A Yeah.

DC Code A I mean it's obviously quite clear that you're not the sole person who's going to attend to Code A Code A I mean clearly, obviously when you're off duty it falls down to other people and from what you've described it as, really you're sort of like a point of contact almost between . . .

Code A I was um . .

DC Code A Other members of staff . . .

Code A . . . team leader I think at the time.

DC Code A Right.

Code A We work in teams.

DC Code A Yeah, so, but what I'm saying is not solely your responsibility to look after Code A

Code A in terms of her care plan. It would fall down to the team basically.

DC Code A Yeah.

DC Code A But when you and your team aren't there and the . . .

Code A It would fall down to another team.

DC Code A That's right, but although your name's on the top of the sheet, when you're not there, obviously you can't be responsible for . . .

Code A Quite, yeah.

DC Code A They don't phone you up at home and say you'd better come in 'cos she needs a wash.

Code A No, no.

DC Code A I take it as you're there during the day, you'd be the person more than likely to interact with the sisters and the family. . .

Code A I would probably be the person to . . . yes, make all the contacts.

DC Code A 'Cos obviously you become a familiar face with the patient and the family and they can relate to you.

Code A Yeah.

DC Code A And that's why you're named as a named nurse.

Code A Mmm.

DC Code A Yeah.

DC Code A Okay. So we'll just go through this, we've got the nutrition and obviously there's various points here, um refused breakfast and lunch and

porridge eaten and no food taken. We've got her bowel movements and her personal hygiene. Um now I'd say there should be a mobility one as well, generally.

Code A There could have been.

DC Code A There could have been.

Code A However, she had no mobility did she, so. . .

DC Code A Right, so, if she's clearly not going to be mobilised because of her condition, there's no need for the form to go on there.

Code A Where, when . . . no. I mean you could argue that when she became . . . her mobility became better, then we would initiate it.

DC Code A You would initiate it? Right, okay.

Code A However, we'd be putting everyday, we'd be putting 'no mobility' wouldn't we, 'no mobility.'

DC Code A Yeah, right, I understand that. Okay, there's one or two things and this doesn't necessarily fall down you see this is a general question about the. . about the ward itself . . . I mean obviously .

Code A It's not very good, is it?

DC Code A Yeah, I mean that's one thing that's been sort of mentioned by the sisters is the notes, that there are gaps in days . . . for example, start with the nutrition on the 14th. . .

Code A I can't explain why there's nothing between the 14th and 21st.

DC Code A — Yeah.

DC Code A — Well obviously she wasn't in your care on the 14th. I think she came back on the 17th.

Code A — I do know that on the day that I came back, 'cos I already told you, I sent her lunch to the kitchen to have it minced. . .

DC Code A — . . to be minced, yeah. . . .``

Code A — . . . because she couldn't eat it.

DC Code A — Yeah, there is . . there is obviously evidence to suggest that she was . . . . .

Code A — Obviously I should have myself, I should have written on there, on the 17th and I didn't. I was probably busy sorting her pain relief out. . . .I was busy.

DC Code A — I think you've already mentioned before the daughters were there quite a lot and they did spend a lot of time in the room and they fed her.

Code A — They did, yes.

DC Code A — But obviously they're not responsible for filling in the . . .

Code A — They're not responsible for writing . . . we fall down very badly on our . . . .

DC Code A — Well no, the thing is I mean if the Health Care Worker didn't feed her and the daughters fed her, then I presume there would be an entry on the nutrition notes.

Code A — Well we should have done. We should have put 'fed by daughters, yeah.

DC Code A 'Fed by daughters' yes.

DC Code A Yeah, okay. So that's . . .

Code A Yeah, I do accept that.

DC Code A That's an ommision on whoever it fell down to on that particular day.

Code A Yeah.

DC Code A Okay of course we've got it again on the bowel movements there, but would that necessarily be filled in if she wasn't . . if her bowels weren't opened.

Code A If she didn't actually have her bowels open it wouldn't necessarily be filled in and sometimes on the night sheet, if she had a motion at night, it would be on there, you see.

DC Code A Mmm.

Code A (inaudible)

DC Code A And obviously the personal hygiene which I think is fairly. . there's quite a bit on there.

Code A That's quite comprehensive, yeah.

DC Code A Okay. Okay, nearly there now. Just one general thing about the contact record, um I understand that that again is not completed every time you go into the room or go to her bed and she's still asleep, or . . . .

Code A It's only filled in . . it's only completed if something happens .

DC Code A Significant in change and condition . . .

Code A Significant in change, yeah.

DC Code A Okay.

Code A I actually filled this bit in because fortunately, 'cos I had discussed with the daughters about her mother's medication. . .

DC Code A About her oromorph because she was in pain.

Code A Yeah and I mentioned the x-ray.

DC Code A 'Cos she was still showing signs of . . . was she showing signs of pain.

Code A Well I thought that perhaps . . you know that she could have put her hip out again.

DC Code A Mmm.

Code A and that in fact it does say she didn't.

DC Code A Were you, were you ever aware during the last, during the. . from the 17th onwards, and this is something that the two daughters state that they made mention to staff and I'm not clear whether it was yourself, that Haslar were prepared to take Code A back, should any problems occur.

Code A Yeah, this is why I initiated this x-ray.

DC Code A Right.

Code A Because they actually mentioned that Haslar said she should not be left in pain, which is right, isn't it?

DC Code A Yeah, yeah.

Code A . . and that she should go back if necessary.

DC Code A Yeah.

Code A So that is why she had that x-ray on that day that she arrived back from Haslar.

DC Code A Right, okay, so obviously when that was

assessed a decision would be made . . .

Code A She had the x-ray and it was decided no, that the hip was still in place.

DC Code A Right, and as you understand it, it was still in place.

Code A Yeah.

DC Code A Did you see the x-rays, or was that something you just . . .

Code A No, I don't read x-rays.

DC Code A Right, okay.

Code A . . . as a nurse.

DC Code A Oh right, but that's what came back, then that it was okay.

Code A Yeah, yeah.

DC Code A Who would it fall down to to read the x-ray?

Code A Well Dr Code A would look at it. The radiologist would look at it.

DC Code A Right, are they as like are the radiologists qualified to diagnose any problems on an x-ray.

Code A Yes, yes. I mean they would point out things if I wanted to see it.

DC Code A Yes.

Code A But I'm not, I haven't done anything . . you know along those lines of reading x-rays. I can see cracks in bones and things obviously, but . .

.

DC Code A But yeah, you're not actually qualified to assess them?

Code A No.

DC Code A — Okay. And in terms, this is probably a question that sounds like we're repeating ourselves, but it's just a point I want to cover, in relation to her mobilisation, um and from your recollection of Code A was she ever in a position where you could attempt to try and . . . .

Code A — No.

DC Code A — . . get her on her feet or physio or . . .

Code A — No.

DC Code A — . . anything of that nature.

Code A — No, I met her she that morning she arrived back from Haslar.

DC Code A — Mmm yeah okay.

Code A — . . in a lot of pain and distress. . .

DC Code A — Right.

Code A — . . . I've never seen her able to mobolise.

32.20 DC Code A — Right, okay. Now this is another question on the sort of palliative care side, in relation to hydration and food. . .

Code A — Yeah.

DC Code A — When would circumstances dictate that you wouldn't be able to provide food or drink for a particular patient?

Code A — The only reason we wouldn't give food or drink to a patient is if we would harm them.

DC Code A — Right, okay and what would that be.

Code A — If they were unable to swallow. If we thought there's a possibility that it went into their lungs

and kill them.

DC Code A — Right, okay. Would there be other ways of providing fluids?

Code A — We do provide . . we don't use IV drips on our ward. . .

DC Code A — Yeah.

Code A — . . because we have no medical cover 24 hours, there's no doctor on the ward for 24 hours . . .

DC Code A — Right.

Code A — . . and we're visited daily as we said by a Doctor. Now we have, we would have given her perhaps sub cup fluids, which means we use the same bag as the IV fluid, we use a little needle called a butterfly needle . . .

DC Code A — Oh right.

Code A — . . that we would put under the skin on a fleshy part - we find a fleshy part of skin, perhaps here, if it's likely to be pulled out.

DC Code A — That's at the back

Code A — It's a very tiny little needle we would put just under the skin, 'cos it's sub cutaneous. . .

DC Code A — Yeah, yeah.

Code A — With a plaster on the top - very slowly over 24hours we would drip a litre of fluids um saline probably . . .

DC Code A — Okay.

Code A — . . normal saline into the patient, but at that time that wasn't initiated, it wasn't standard practice.

DOCUMENT RECORD PRINT

DC Code A — Right, how long has that been . . .

Code A — That's been standard, I know Code A may have the actual date. I would say over the last year from my recollection. . . or maybe not that long, but . . .

DC Code A — When you say standard practice, is that standard practice for the Daedulus Ward or is that throughout the Trust . . .

Code A — All throughout the Trust. . . .

DC Code A — For the Trust, is that for the whole of the Trust?

Code A — You actually have yeah, a procedure from the Trust. . .

DC Code A — Right, okay.

Code A — . . . whereby we can follow this. However, I don't think that nurses can initiate it, we're still following Doctors' orders.

DC Code A — Doctor's . . huh huh.

DC Code A — And that wasn't in place at that time? No?

Code A — It wasn't in place. No.

DC Code A — Okay and . . .

Code A — But that is the only way we could hydrate a patient that couldn't swallow.

DC Code A — So I take it that the condition Code A was in and the . the. . the combination of the medicine she was taking, put her in a position that she couldn't swallow, she couldn't eat and she couldn't hydrate.

Code A — I think even before she had the medicine she was having great difficulty . . . .

DOCUMENT RECORD PRINT

DC Code A . . problems . . . . . .eating?

Code A Eat and drink, yeah.

DC Code A Okay, but obviously there's procedures in place now. Are there still occasions when even providing fluid sub-cutaneously would be. . um would not be carried out, you know for the patient's benefit, are there circumstances ?

Code A No, all the patients now, basically what we do now is if they don't manage to take in orally about 1000 millilitres . .

DC Code A Right.

Code A . . a day, then they have a sub cut overnight.

DC Code A Oh right, okay, but are there any times when it would be decided well it's for the benefit, the patient's own comfort.

Code A If a patient was dying, okay, if a patient was dying, we probably wouldn't do that.

DC Code A No, okay and why would that be?

Code A Because medical opinion will tell you that there's research to prove that the patient will probably be more comfortable without sub cup.

DC Code A Oh right, okay. Right, well I think we're just about there aren't we?

DC Code A Yeah.

DC Code A Okay. Is there anything you'd like to add?

Code A I'd like to say that I, I, I find it difficult to come to terms with the fact that people who can be so friendly to the staff on a day to day basis, can give us the chair, can send staff books and

letters um can complain.

DC Code A — Okay. Thank you. Anything . . .

Code A — I'm not happy with the way that it was all presented to the staff on the ward. We've had to um . . it's not your fault probably, but we've had to gather information from and if . . where we could and I'm not happy with that.

DC Code A — Okay just to let you know that. . I think Code A Code A will back us up on that . . Mr Code A probably got more documentation relating to Code A time in hospital than we have and er . . .

Code A — I'm not going to admit that on tape.

DC Code A — . . . . . but the disclosure that the police have given Code A which at the end of the day and I'm going to pass the buck here, is Code A Code A responsibility to make sure that . . .

Code A — I wasn't blaming you.

DC Code A — Yeah, I know, is that everything that we've got that we refer to during this interview, Code A Code A has had.

Code A — And so's Code A

DC Code A — Yeah that's right, I'm saying . . .

Code A — Yeah, I just feel that it's been dripping in bits and pieces. Nobody came and said, okay this complaint has been made . . .

DC Code A — And we appreciate it's two years old.

Code A — Yeah.

DC Code A But me and Code A have only been with it for six weeks. The police investigation only started 6 weeks ago and hopefully myself and Code A and my other colleagues that are working on this matter, are being as professional, as expeditious as we can possibly can to get this matter as cleared up as possible, cos we are aware that you poor people have been sitting on this for two years. But hopefully we'll draw it to conclusion very shortly.

Code A We have been sitting on it for two years because we thought with the initial investigation . . .

DC Code A That was it, yeah.

Code A That's it.

DC Code A Okay then. Right Is there anything else you'd like to add?

Code A No.

DC Code A No? Anything you'd like to clarify?

Code A I don't think so.

DC Code A Anything you said that you feel . . . . ? I'll hand you a notice explaining the tape recording procedure, which is under these piles of paper somewhere. I'd like you to complete it and return it to me before you leave the room. There it is. The time by my watch is 11.56 and I'm turning the recorder off.

MG15(T)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

SDN : ☐ ROTI : ☒ Contemporaneous Notes ☐

Person interviewed : Code A

Police exhibit no. :
Number of pages :
Signature of interviewing officer producing exhibit :

Place of interview : **Park Gate Police Station**

Date of interview : **28 June 2000**

Time commenced : **10.19** Time concluded : **10.58**

Duration of interview : **39 minutes** Tape reference numbers ◆ : **44/00/30648**

Interviewing Officers : DC Code A DC Code A

Other persons present : Code A - **Saulet & Co Solicitors, Portsmouth**

Tape Counter Times◆	Person Speaking	Text
	DC Code A	This interview is being tape recorded, I am DC Code A Code A, the other police officer present is...
	DC Code A	DC Code A
	DC Code A	I'm interviewing Code A, please can you give your full name and date of birth?
	Code A	Code A thirty first of January nineteen sixty four.
	DC Code A	Okay and also present is...
	SOLICITOR	Code A from Saulet and Co Solicitors, Portsmouth, Legal Advisor.
	DC Code A	Okay this interview is being conducted at Park Gate Police Station on the twenty eighth of June, two thousand and the time

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text

by my watch is 10.19. At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes and I'll also remind you that the legal advice you have is accessible throughout the interview and the interview can be delayed at any time for you to seek further advice, okay.

Code A Okay.

DC Code A Okay, right this is basically an explaination of why we're here and what we're aiming to achieve. The Hampshire Police have undertaken an investigation into the circumstances into the death of Code A on the twenty first of August nineteen ninety eight at Gosport War Memorial Hospital. The investigation centers around an allegation that Code A was unlawfully killed as a result of a course of treatment that was embarked upon between the seventeenth and twenty first of August whilst admitted to this hospital. We are seeking to interview those members of nursing staff who had a duty of care to Code A during that time and who in some cases may have provided her with direct nursing care or treatment in order that an account can be obtained in particular circumstances and

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 2

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		issues that existed between those dates. I emphasise this is a search for the facts and your account and answers will be carefully assessed in the light of information arising from other interviews with staff and general correspondence. As a result of this interview and several others further guidance will be sought from professional bodies and ultimately the Crown Prosecution Service on how we should proceed. Your solicitor has been provided with relevant material prior to this interview commencing, I must emphasise that you are not under arrest and you're free to leave at any time. Your right to free legal advice in private extends throughout the period you're at the police station, okay. Now the next bit is a caution, you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court, anything you do say may be given in evidence, okay. Do you understand that?
	Code A	Yes.
	DC Code A	Alright, it's quite harshly worded but there's a couple of points I would say it's, what we're seeking is basically an account from

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		people if they're prepared to give it on various points that we're going to cover and basically a decisions not going to be made by the likes of me or Code A or basically the Police Service on its own. We will be seeking professional advice from someone who's got knowledge of medical matters and background and how these things work so it's not going to be a sort of blind decision or a witch hunt or anything, it's a considered process, okay. Alright, so as I say that's what we're looking into, I think to start off with what I'd like to do is if you could explain your role within the hospital and you know what your responsibilities are and what sort of things you cover, if you could do that?
3.33	Code A	Erm well I'm a senior staff nurse on light duty, I start my shift in minor injuries although I am in overall charge of the night nursing staff...
	DC Code A	Right.
	Code A	...during the course of the night duty in the absence of the night sister, so from the hours of er eight fifteen to about ten thirty I'm based in minor injuries and don't have a lot to do with the ward until after that time.

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 4

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	Right, okay so what sort of times do you work? What are your hours?
4.08	Code A	Erm my shift starts at eight fifteen at night and I finish at seven forty five in the morning.
	DC Code A	Okay.
	Code A	So from ten thirty until seven forty five I'm around, based on Dryad ward but visit all the other wards in the hospital, I'm available if needed.
	DC Code A	Okay. What sort of things would you, would you be doing around the wards then? What would your sort of role be there?
	Code A	Helping in er nursing care erm mostly superivisory things, checking of medication, erm relieving trained staff when they go for breaks, really anything that's required of me.
	DC Code A	Okay so if there was anything untoward you would expect to be notified?
	Code A	I would, yes.
	DC Code A	Okay and depending on what sort of the problem was, you would obviously act on that?
	Code A	I would assist or help or whatever I could do.

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 5

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	Okay. If it was a problem that required a doctor, what sort of things, examples could you give where a doctor would be called and what procedure would you follow in order to call one?
5.24	Code A	Erm if one of the members of staff were concerned about one of the patients erm if they felt it was urgent they would probably contact a doctor directly, different staff do different things erm some of them might call me to check the patient first erm if it's something we felt that the doctor could intervene with and would give medical care or advice then we'd contact them directly, if not we would monitor the patient and call them as we felt necessary.
	DC Code A	Right, okay. Just going over your sort of experience, how long have you been a trained nurse?
	Code A	I've been a trained nurse for nearly fourteen years.
	DC Code A	Okay, and what sort of areas have you covered in that time?
	Code A	I've only worked at really Gosport War Memorial Hospital...
	DC Code A	Oh, okay.
	Code A	...worked there for thirteen years.
	DC Code A	Okay so is that primarily with elderly patients?

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 6

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	Yes.
	DC Code A	So fourteen years experience has been based sort of covering...
	Code A	...The same type of patient.
	DC Code A	...same type of patient, yeah and how long have you been a senior staff nurse?
6.31	Code A	Er I think around three years.
	DC Code A	Okay. I've got the duty sheet somewhere, have you had a chance to look at them and remember what you were doing between the seventeenth and the twenty first?
	Code A	I've had a quick look.
	DC Code A	Thank you. Well I'll show you it now just to....
	Code A	Okay, yeah.
	DC Code A	...which is the duty sheet from August ninety eight and I think that's you...
	Code A	...That's me yep
	DC Code A	...there so looking down on the twentieth and is says hosp, which I guess is short fo hospital...
	Code A	...(inaudible) I was on duty.
	DC Code A	...so that mean's you're on duty at the hospital?

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 7

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	Yes.
	DC Code A	At that time, okay so that would be the twentieth and the ...
7.12	Code A	...Twenty first and the twenty second.
	DC Code A	...obviously and the twenty second of August, okay. Do you have any memory of Code A
	Code A	Only a vague recollection, I can recall the night she died, I remember the family being present on the ward and I can remember I think it was one of the daughters I couldn't say which one asked me if I saw another colleague would I...she had a book she wanted to pass on to one of my colleagues...
	DC Code A	...Oh right.
	Code A	...and would I do that...
	DC Code A	...Okay.
	Code A	...and that was really all I had to with either Code A or her family.
	DC Code A	Right, do you know who, what colleague that was?
	Code A	Er Staff nurse Code A
	DC Code A	Code A okay and do you know what the book was?
	Code A	Something to do with erm I think either spiritualism or that type

Signature(s) : DC Code A

761

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		of thing. I think one of the daughters had been reading it during the course of visiting her mother and I think they chatted about it so one of the daughters thought she might like to read it once they'd finished.
8.16	DC Code A	Right, okay. So you actually went down to the...you were at the ward when ....
	Code A	...After she died.
	DC Code A	...after she died. Was that because you were notified by someone or...?
	Code A	...Yes.
	DC Code A	...were you already down there?
	Code A	I normally visit the wards after I've finished in minor injuries but I'm almost certain I would have been contacted, I would have visited the ward straight after, as soon as I'd finished in minor injuries.
	DC Code A	Yeah, okay. You obviously had this conversation with the daughter about the book?
	Code A	Yes.
	DC Code A	Do you recall any other conversation?

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 9

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	No.
	DC Code A	In particular any concerns she had about her mother or any problems she had regarding the treatment or..?
8.56	Code A	No.
	DC Code A	No, okay. During the twentieth which is a Thursday and onto the Friday, when you start work do you have like a briefing at all with the wards at any point?
	Code A	Myself?
	DC Code A	Yeah, are you sort of notified about any particular problems with...?
	Code A	...Usually erm the, as I visit the wards the whoevers in charge of that ward will normally tell me of any patients they're concerned about or during the course of the night I will ask myself if they've got any patients they're concerned about.
	DC Code A	Right.
	Code A	As the patients don't often change I have a vague idea of many of the patients on the ward.
	DC Code A	So you build up a picture?
	Code A	Yeah.

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 10

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	Okay, I mean do you ever other than the point where you were notified of Code A death, were you ever spoken to about her condition or any problems that the staff were having with her or with the family in any way?
9.57	Code A	I think I probably had been told by members of the staff that there were problems with the family but not of any specific problems.
	DC Code A	Right, okay it was nothing you had, obviously you didn't have any direct involvement with them and in terms of the medical side of it, in terms of Code A
	Code A	...Yes.
	DC Code A	...Do you recall having any conversation about her condition or ....?
	Code A	...No.
	DC Code A	...any problems with that?
	Code A	Not that I can remember.
	DC Code A	Okay. Did you other than coming down seeing Code A after death, did you see her beforehand on the twentieth or the twenty first before she died?
	Code A	Erm I possibly might have looked in on her during the course of

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 11

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		the night...
	DC Code A	...Yeah.
	Code A	...not so I can remember.
10.43	DC Code A	Not so you can remember.
	Code A	Nothing sticks in my mind.
	DC Code A	Okay, alright. I think what we'll do now then is I've got obviously the health record for Code A which she's got the contact notes and the care notes. If you'd like to take a look through. As I understand it these contact notes are made by members of staff on the ward or..?
	Code A	...Yes.
	DC Code A	...obviously consultants or doctors who come in and have something to write. If you have a look and just see if there's any ones there that are relevant to you, anything that you've completed.
	Code A	(looking through documents). No, not in the contact record. (looking through again) nothing.
	DC Code A	Nothing there, okay.
	Code A	Nothing that I can see.

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **12**

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	When would you complete or you would have needed to complete a contact record, not just in this case but generally (inaudible)?
12.13	Code A	Really if I'd spoken to relatives erm to do with patients care, if I'd had any direct contact with the patient or if I'd taken any telephone calls.
	DC Code A	Right, okay. Would you complete it when you attended a patient and there was no change in her and she was asleep for example, would you feel the need to complete it then?
	Code A	All that would normally be completed would be a nursing care plan which would be dated and signed.
	DC Code A	Right, okay.
	Code A	The only time we make any comment is if there is any difference in the care required.
	DC Code A	Okay so if her condition has changed in any way or there's a difference to medication or something like that?
	Code A	Yeah that would probably have been recorded.
	DC Code A	That would be recorded?
	Code A	Yes.

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 13

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	But generally if conidtions the same, still asleep or no change then you wouldn't necessarily record it?
	Code A	Record it, no.
	DC Code A	Okay, okay. Where you aware regarding Code A of the drugs she was being administered?
13.22	Code A	Yes, I think so.
	DC Code A	Okay, can you recall what...?
	Code A	...Erm diamorphine, midazolam and I can't remember off hand what else.
	DC Code A	Okay, well if I show you the prescription record here relating to Code A and perhaps if you can look and agree with me that looking at this there's four that were loaded on with a syringe driver?
	Code A	Yes.
	DC Code A	On the eighteenth, which is the hyoscine, midazolam...
	Code A	...Midazolam
	DC Code A	...the haloperidol...
	Code A	...Haloperidol
	DC Code A	...and the diamorphine?

767

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	Yes.
	DC Code A	Okay now as I understand it these initials here are the people that have actually loaded the driver and administered the drugs?
	Code A	Yes, yes.
	DC Code A	Okay, are there any entries there that are relevant to yourself?
14.19	Code A	No, not that I can see.
	DC Code A	Okay. In relation to this syringe driver, what are the thoughts behind using a driver and what are the advantages of using?
	Code A	Syringe drivers normally used for patients that can't take medication orally or to give continuous pain relief or continuous medication. It's a more erm how can I put it, it's a more constant form of medication instead of getting peaks and troughs you see, allergies or any other type of drug.
	DC Code A	Right, okay so as I understand it there's no time when the drugs will start wearing off for example and start feeling pain again, it gives a...
	Code A	...It shouldn't do, you can't, if the patients pain increases you could possibly get breakthrough pain where other medication might be required but the idea behind a syringe driver is that the

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 15

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		patient should remain pain free.
	DC Code A	So presumably then when you would administer a drug like a pain killer four hourly...
	Code A	...Yes.
15.23	DC Code A	...okay for the first couple of hours they're pain free and then apparently it starts to wear off so the idea of this then is to slowly administer it so they're pain free for that long?
	Code A	That's right.
	DC Code A	Okay. Would you mind just going over the drugs and just explaining what they're designed to do? Like an exam (laughs).
	Code A	Yeah (laughs). Erm oromorph is oral analgesia er morphine based, diamorphine is similar but given intravenaeously, subcutaneously or intromuscularly usually given through the syringe driver, hyoscine can be used, is usually used for drying up sort of respiratory secretions, can be given for erm abdominal pain, midazolam is a muscle relaxant erm some patients when they're dying tend to get twitchy or rigid and that helps to relax the body. Do you want me to go through (inaudible)?
	DC Code A	Yeah I think there's some duplications actually but yeah if you...

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 16

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	...Er haloperidol, haloperidol can be used as a sedative but I also believe it can be used as erm an anti-emetic as well, if a patients feeling sick or if you feel they're agitated that would be given, I thinks that's it really, it's mostly haloperidol on this side.
16.50	DC Code A	Yeah and there's a lactulose which is (inaudible)...
	Code A	Lactulose is given for..to regulate bowels...
	DC Code A	...Right, okay
	Code A	...as an empiriuant.
	DC Code A	Okay. Just looking at the doses for the diamorphine...
	Code A	...Yep.
	DC Code A	...and the other drugs...
	Code A	...forty milligrams, yep
	DC Code A	...forty milligrams to ....
	Code A	...to two hundred milligrams.
	DC Code A	...to two hundred, and obviously you've got the haloperidol which is five....
	Code A	...Haloperidol which is five to ten milligrams, midazolam twenty to eighty milligrams, hyoscine two hundred to eight hundred micrograms.

Signature(s) : DC Code A

770

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 17

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	Right, okay does that mean that that's on a sliding scale or that there's some discretion there by whoever administered the drugs as to the amount?
17.34	Code A	To a degree it's normally discussed with the, the GP visits each morning during the week and it's normally discussed then, if we feel that we need to increase anything then we've got the leeway there should we need to.
	DC Code A	Right, so in another case then...
	Code A	...Yep.
	DC Code A	...over a..overnight a patient was starting to feel more pain for example how would you flag that up for the doctor, would you actually see the doctor in the morning?
	Code A	Yes if erm the patient was in a lot of pain during the night then I would probably contact a doctor during the night.
	DC Code A	Right.
	Code A	Erm but it we've got some leeway we coul...usually we have an idea of what the doctor wants us to do at some point during the patients care she would have given us an indication of what she wants or the nursing staff on the ward but generally it's first thing

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **18**

Record of interview of: **Code A**

Tape Counter Times ◆	Person Speaking	Text
		in the morning...
	DC **Code A**	...Okay.
	Code A	...when she arrives.
18.35	DC **Code A**	And in August ninety eight that would have been Doctor **Code A**
	Code A	Doctor **Code A**
	DC **Code A**	I'm right in saying she would come in on a daily basis?
	Code A	She does, not always every...not always at the weekend, I think if she's on call at the weekend then she come's in or if she's around she come's in...
	DC **Code A**	...Yeah.
	Code A	...but Monday to Friday she's in every day or (inaudible)
	DC **Code A**	Okay am I right in saying when it's out of hours there's, you either contact Doctor **Code A** or...?
	Code A	...Her surgery so I think there's only one GP in her surgery that is possibly on call but it's usually health call which is a deputising service.
	DC **Code A**	Yeah like a call out sort of scheme?
	Code A	Yes.

Signature(s) : DC **Code A**

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 19

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	Okay. In relation to the level of drugs that have been given as to how high an amount there is or how low an amount you know what sort of level are we talking about that's been administered?
19.24	Code A	Erm it's a moderate level.
	DC Code A	Okay and looking at those, those four drugs in particular...
	Code A	...Yes.
	DC Code A	...the fact they're on a driver, would you be in a position to comment on the condition of the patient, a patient if they're on that sort of type of drug on a driver?
	Code A	It would really depend on the patient erm I imagine she possibly would be unconscious but she might not be, probably asleep most of the time but rouseable.
	DC Code A	Mmm, okay. Did you see Code A 'cause you may be aware that she had two spells at the hospital, did you ever see her on the first sort of spell she was in the hospital?
	Code A	I might have done but I don't remember.
	DC Code A	You don't remember?
	Code A	No.
	DC Code A	Okay, because the question I was going to ask was could you

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **20**

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		comment on how it affected Code A these drugs?
	Code A	Yes erm as I don't remember seeing her before I can't really comment.
	DC Code A	No, okay. Alright so the fact that they've got a sort of between forty and two hundred for example of diamorphine and five to ten, so it doesn't necessarily mean that the staff have got carte blanche to...
20.53	Code A	...No
	DC Code A	...increase it? They would have to consult with a doctor would they?
	Code A	They would do plus erm trained staff know that there is certain amounts that they can increase things by erm if they've, if erm Code A was rouseable and they needed to give her say oromorph for breakthrough pain that would be calculated into the increased dose for the following day.
	DC Code A	Right, okay. Okay, so I mean we've covered obviously consultations with the doctor and ...
	Code A	...Yes.
	DC Code A	...if you had a concern about type of drug, or how it was affecting

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **21**

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		her or breakthrough pain...
	Code A	...Yeah.
	DC Code A	...and this is another question just hypothetical.
21.43	Code A	Okay.
	DC Code A	If you were to speak to a doctor in the morning and course of treatment is prescribed by that doctor...
	Code A	...Yes.
	DC Code A	...and it's one that you don't necessarily agree with because of your observations, is there a procedure in place where you could make representations in order to try and reverse that decision within the hospital? Is there like hospital guidelines of how you would go about doing that?
	Code A	I think there must be but I can't recall being aware of one, I think I would say directly to the GP.
	DC Code A	Yeah, okay.
	Code A	I mean she's quite approachable...
	DC Code A	...Yeah
	Code A	...you've always been able to do that.
	DC Code A	Yeah and again I'm saying this hypothetically...

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	...Hypothetically I understand that.
	DC Code A	If that wasn't to happen, if you spoke to the GP and the GP said no this is how it's going to be and you clearly weren't happy with that are you aware of any procedure in place where you, you know is there a hierarchy you would go through in order to speak to other people?
22.42	Code A	If the patient was prescribed something that I wasn't happy about giving erm if it wasn't detrimental to their health I would not give it, if it was something the patient needed but I still wasn't happy about giving I would contact er probably the manager on call and ask for their advice.
	DC Code A	Right, is that the clinical manager?
	Code A	It would, during the night it would be erm manager on call....
	DC Code A	...Right.
	Code A	...so it could be anyone.
	DC Code A	It could be anyone, okay.
	Code A	If it was during the day, the clinical manager or the hospital manager.
	DC Code A	Mmm, okay, during your career have you ever had a problem

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **23**

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		with a course of treatment that's been prescribed by anybody at the hospital?
	Code A	Not that I can remember.
23.30	DC Code A	Okay. It's never something that's come up? That you've had an issue with?
	Code A	Erm I think er years and years ago when I first starting working at the hospital erm syringe drivers were first coming into use and it wasn't necessarily explained to us how they were going to be used and erm why the drugs were being used that type of thing and I think probably a number of us voiced our concerns to the doctor at the time and the staff and we got training sort of afterwards.
	DC Code A	So that was like a training issue?
	Code A	Yeah not really a (inaudible).
	DC Code A	A bit like the police really they bring something in and don't tell you until...
	Code A	...Yeah which is often the case.
	DC Code A	Okay. What training do you get then? I mean do you get a certificate or some sort of record that you've...?

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 24

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	We get a yearly erm drug administration update...
	DC Code A	...Right.
	Code A	...at ward level and anything else is at the clinical manager's discretion or your own discretion, for palliative care drugs or drugs used in the syringe driver there are regular study days that we can attend and we're encouraged to do so.
24.44	DC Code A	Right, but that's more optional?
	Code A	Optional, yes.
	DC Code A	Okay, but you have a yearly....
	Code A	...Drug assessment.
	DC Code A	...drug assessment, okay. If you don't attend that I mean is it basically you're not authorised to use the driver or is it just...?
	Code A	I don't know to be honest because it's never come up (laughs)...
	DC Code A	...It's never (laughs), yeah, okay.
	Code A	...it's never arisen.
	Code A	Can I just clear one point up about the syringe driver (inaudible)
	DC Code A	Yeah, please do.
	Code A	Is it correct in saying that you don't have to be bed ridden to be on a syringe driver?

Signature(s) : DC Code A

778

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	No, people use them, ambulance people use them, people in the community use them.
	DC Code A	So you can walk around...
	DC Code A	...As I understand yeah, cancer patients can carry them around 'cause they're...
25.26	Code A	..Yes, I think hospice patients erm they might start off in the hospice with a syringe driver, get the pain control sorted out and then live a relatively comfortable life at home...
	DC Code A	...Yeah
	Code A	...over a period of time.
	DC Code A	Okay, yeah. Right, okay. Do you know who was sort of in charge and I accept what you're saying initially that you can't remember with...
	Code A	...Yeah.
	DC Code A	...with the family but you were sort of made aware that there was a problem with the family or there was some, some sort of problem with...
	Code A	...Yeah.
	DC Code A	...the daughters. Do you remember who was sort of in principal

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		charge of Code A treatment during that period of time?
	Code A	Nursing wise or doctor wise or...?
	DC Code A	Nursing and doctor wise?
	Code A	Erm I don't know who her named nurse was if that's what you mean...
26.14	DC Code A	...Right
	Code A	...so at night duty it would have been staff that were on because we have sort of a skeleton crew at night, you know we look after all patients equally.
	DC Code A	Yeah, yeah as I understand a named nurse is one who seems to have sort of some responsibility?
	Code A	Yes.
	DC Code A	But again obviously they have days off...
	Code A	...Yes.
	DC Code A	...and then it obviously falls to the ....
	Code A	...whoever
	DC Code A	...staff?
	Code A	Yes.
	DC Code A	Okay. What is the actual reasoning behind having a named

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **27**

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		nurse?
	Code A	So there's some continuity between relatives and patient and the nurse erm it's the one person they can speak to hopefully most of the time and the staff would have a familiar face to talk to and also that member of staff would also get to know the relatives perhaps better than if it was a different person every time.
27.10	DC Code A	Yeah, okay.
	Code A	You know build up a relationship of some sort.
	DC Code A	Yeah, so it's just to have a familiar face for the family and for the patient?
	Code A	Really, yes.
	DC Code A	Okay, right I think we've sort of gone over your, your role, there's just a few more questions I want to ask about the care notes...
	Code A	...Yeah
	DC Code A	...which are I think we'll go back a bit, we've covered the contact notes, we've obviously got the..I think that's the nursing care plan for nights isn't it...
	Code A	...Night care plan.

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 28

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	...what I'm showing you now?
	Code A	Yes
	DC Code A	And then we've got nutrition, constipation with a sort of (inaudible)...
	Code A	...Bowel chart.
	DC Code A	...bowel chart and then ...
	Code A	Hygeine
28:00	DC Code A	...personal hygeine?
	Code A	Yes.
	DC Code A	Okay, where are these notes kept when the patient is on the ward?
	Code A	Erm usually in the patients room, end of patients bed erm I believe Daedalus ward keeps there's at the end of the patients bed so they can be looked at before you attend to a patient.
	DC Code A	Right so you're able to see what's...
	Code A	..(inaudible) what the patient requires before you attend to the patient.
	DC Code A	Right, okay. Would you mind just taking a look through those and just see if those any relevant to yourself?
	Code A	Okay. (looking through documents). No.

Signature(s) : DC Code A

782

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **29**

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	Nothing there relevant to you?
	Code A	No.
	DC Code A	Okay. Now this is a general question, now obviously with this care plan there appears to be sort of a gap with the food and we've got on the twenty first, no food taken, then obviously goes back to the fourteenth which is when the previous time she was in. Is there any reasons that you're aware of why there would be gaps in these care plans?
29.18	Code A	I would imagine the staff just haven't had time to record what they have and haven't done.
	DC Code A	Okay, is there any other, I mean we've got the headings here, nutrition, constipation, is there any other care plan headings that maybe included in the health record?
	Code A	Mobility care plan erm any patient that, when the patient is first admitted it would be any problem that we would conceive the patient had that we could try to manage, mobility or lack of mobility would probably be a care plan.
	DC Code A	Right.
	Code A	So if a patient was bed bound it would give what type of nursing

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **30**

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		care we should give or equally if they were mobile how we would manage that patient, how we would protect their safety.
	DC Code A	Okay. So even if they were bed bound and there was obviously not a great deal you could do in terms of trying to remobilise you would still, there still should be a plan...
30.32	Code A	...There would be some type of care plan.
	DC Code A	Whose responsibility would that be to ensure that that plan is set out?
	Code A	The named nurse I would have thought.
	DC Code A	Right, okay so those forms should be set out?
	Code A	She should be in charge of the care plan and indicate what she wants, or flag up if she feels there's something lacking.
	DC Code A	Right so in terms of the mobility one and the others, would that be solely her decision as to...?
	Code A	...No it would be discussed with other members of the team. They would need to assess the patients mobility or lack of mobility and the type of treatment care she would require.
	DC Code A	Right, and would that include like Doctor Code A or any consultant?

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 31

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	Probably not, it might do but it would be mostly nursing care, I mean the nursing care plan so it would be whatever the nursing team would do.
	DC Code A	Yeah, okay. Okay, can you just go over again, we've covered it briefly but just go over the circumstances when you came down when Code A had died and you've mentioned the conversation with Code A Can you just go over that and what you did during that time you came down?
	Code A	From what I can recall I visited the ward at some point after finishing in minor injuries so it would have been sometime after nine fifteen, nine er ten fifteen, ten thirty.
	DC Code A	And this is on the twenty first?
	Code A	On the twenty first erm I can recall erm seeing the family on the ward, I believe they were attending to Code A (inaudible) and must have spoken to Staff nurse Code A who's was in charge of the ward that night, she would have contacted me and informed me that Code A had died and I would have visited the ward and asked if there was anything I could do to help, or if they needed me in any way.

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No.: 32

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	DC Code A	Mmm, okay. In that sort of case with Code A who you know obviously according to the notes, which obviously you weren't party to but death would have seem to have been expected.
	Code A	Yes.
	DC Code A	Would the doctor necessarily be notified at that time?
32.51	Code A	Not until the morning, not during the night, no.
	DC Code A	So in a normal procedure then, what would normally happen with the body?
	Code A	Erm death would be verified by a trained member of staff, two where possible but that's not always possible at night duty and then the body would go to a body store if it was an expected death.
	DC Code A	Okay and then what would happen in the morning?
	Code A	In the morning er the doctor would come and visit the body in the mortuary.
	DC Code A	Would they always come through the next day, what's the sort of time period that they sort of soon as possible, next day or...?
	Code A	I think it's as soon as possible or the next day but if it's during the

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **33**

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		week Doctor Code A would be in during the day first thing in the morning, so I imagine she goes straight down.
	DC Code A	Okay just a couple of more questions, this is another general one in relation to sort of patient care. In relation to feeding and providing water for a patient what circumstances would cause a patient not to be given food and water?
33.57	Code A	If they weren't able to swallow, if erm or if they had a swallow problem we felt that given them food or water would be detrimental to their health.
	DC Code A	Right, okay. I take it that's for choking?
	Code A	Yeah, you know if their conscious levels were not good or they've had a stroke or for some reason they had a swallow problem so to prevent choking.
	DC Code A	Okay, would there be other ways of providing some sort of fluid?
	Code A	Fluids could be given subcutaneously or intravenously but we don't give, we don't have the training or the staff to give intravenous fluids.
	DC Code A	Right.
	Code A	We don't have medical cover, you know doctor cover at night

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		with...most of the time during the day so it's not done at Gosport War Memorial Hospital.
	DC Code A	Okay and what reasons would there be for not giving fluids subcutaneously?
	Code A	If it was not thought, if it was not felt that it was required by the doctor I would imagine. If erm it was not going to make any difference to the patients condition you know improve it or do anything.
35.10	DC Code A	Right.
	Code A	Then I imagine it wouldn't be given.
	DC Code A	And I ask this knowing that your sort of contact with Code A Code A was minimal.
	Code A	Yes.
	DC Code A	But are you saying then in a case where a patient is dying and you know they've got drugs to give them a pain free death, a decision may be made that to hydrate them would actually be detrimental to them?
	Code A	Erm I think it would be considered inappropriate.
	DC Code A	Right. The reasons for that are?

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **35**

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	Patients dying already and hydration would not really make any difference.
	DC Code A	It wouldn't actually improve their health?
	Code A	No.
	DC Code A	It would probably prolong it wouldn't it?
36.01	Code A	Possibly.
	DC Code A	Right, okay.
	Code A	It wouldn't really improve their condition.
	DC Code A	Okay, just a couple, couple more just to try and clear up a few things. We've talked about the handing over procedure in the morning where you, I mean would you talk to Doctor Code A on a daily basis during the week?
	Code A	I myself erm would see Doctor Code A on my own ward because I'm actually ward based although I'm in charge of the hospital at night.
	DC Code A	Right, okay.
	Code A	Otherwise it would probably be the day staff that hand over to Doctor Code A depends what time she arrives on each ward.
	DC Code A	Right, so to hand over to Doctor Code A would you necessarily

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
		comment on Daedalus ward patients to Doctor Code A
	Code A	Sometimes I have done.
	DC Code A	Sometimes and what reasons would that be for? Would that be because there's a particular problem with them or...?
	Code A	If I'm concerned about them in any way or felt they needed some change to their care or even if she's asked me, she's asked me before.
37.02	DC Code A	Oh what to have a look out for somebody...
	Code A	...Yeah
	DC Code A	...report back?
	Code A	Because she knows I visit the ward she might, you know she might well ask me about a patients condition, how have they been during the course of the night.
	DC Code A	Right, okay. Do you recall having any conversation with Doctor Code A about Code A on the ...
	Code A	...No
	DC Code A	...Friday morning it would have been?
	Code A	Not that I can recall.
	DC Code A	No, okay. Is there anybody else involved in these handover?

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 37

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	Erm no because it's a reasonably informal type of thing, Doctor Code A would arrive on the ward and it would be just a few minutes erm and she would get her main handover from the day staff, we would handover to them and then they would handover in further detail. We do make comments sometimes if we feel medication needs changing or whatever, we do sometimes make comments in the ward diary on Dryad ward and I can't say the same for Daedalus I don't know what they do.
38.02	DC Code A	You don't know what they do?
	Code A	But that's usually just minor things that we might not have time to bring up at the handover.
	DC Code A	Okay so the handover could involve basically all the nursing staff?
	Code A	It's usually the nurse in charge of the day shift, she would do a round, visit each patient in turn.
	DC Code A	Okay
	Code A	Some would be discussed in the office and Doctor Code A from what I've seen usually likes to visit each patient.
	DC Code A	What about the clinical manager, where would..?

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 38

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	That may well be the person who does the round with Doctor Code A if she's the nurse in charge of that ward that day then she probably or he would probably do that round.
	DC Code A	Okay but is it a case that it would vary from shift to shift who would do the round?
	Code A	Yes, yes.
38.52	DC Code A	Okay. Right I think we've covered everything we need to so far. Is there anything you would like to add?
	Code A	Don't think so.
	DC Code A	Okay. Just to sum up then really, your contact with Code A Code A was minimal, you may have looked in on her on the Thursday night into Friday morning but that's not something that...?
	Code A	...It doesn't stick in my mind.
	DC Code A	...that doesn't stick in your mind?
	Code A	No, so
	DC Code A	And obviously you came down after death and had a conversation with Code A about the book, Code A for her?

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 39

Record of interview of: Code A

Tape Counter Times ◆	Person Speaking	Text
	Code A	Yes.
	DC Code A	And that's basically your contact with the family?
	Code A	(inaudible) contact that I can recall.
	DC Code A	Okay, is there anything you'd like to clarify?
	Code A	Erm I don't think so, I'm sure there will be afterwards but not at the moment.
	DC Code A	I'm handing you a notice explaining the tape recorder procedure, I'll hand that to Code A Complete the lower half and return before you leave the room and the time by my watch is eleven fifty eight and I'm turning the recorder off.
	DC Code A	It's ten fifty eight.
	DC Code A	Ten fifty eight, sorry.
		END OF INTERVIEW

Signature(s) : DC Code A

◆ Not relevant for contemporaneous notes