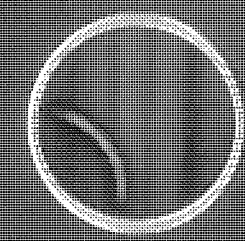
FFw/157/06

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER



24

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

1. Index of all evidence obtained
2. Generic Case File
3. Generic Case File (exhibits)
4. Generic Case File (exhibits)
5. Generic Case File (further exhibits)
6. Generic Case File further evidence re: Code A
7. Generic Case File further evidence - interviews with Code A
8. Code A Volume 1
9. Volume 2
10. Additional Evidence
11. Hospital Medical Records
12. Code A Volume 1
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14. - further evidence
15. - further evidence
16. Hospital Medical Records
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18. Code A Volume 1
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20. Hospital Medical Records
21. Hospital Medical Records
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24. Code A - further evidence
25. police interviews with Code A
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49. Volume 2
50. Hospital Medical Records
51. Further evidence re: Code A
52. GP Records for Code A
53. GP Records for Code A
54. Copy Extracts from Patient Admission Records
55. Extracts from controlled drugs record book dated 26 June 1995 - 24 May 1996

56. Code A (Eversheds) file: 1 of 2
57. (Eversheds) file: 2 of 2
58. Medical Records
59. Further Medical Records
60. Further Medical Records
61. (Police) - Witness Statements file
62. (Police) - Transcripts of Interviews file
63. Code A (Experts' Reports and Medical Records)
64. Code A Eversheds) file: Experts' Reports and Medical Records
65. Clinical Team Assessments for Code A
66. Clinical Team Assessments for Code A

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AI

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 0901 Time concluded: 0940

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

Interviewer(s):

Other persons present: Code A - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This interview is being tape recorded. I am Code A Code A My colleague is?
	Code A
	I'm interviewing Code A Doctor will you please give your full name and your date of birth?
	Code A

Code A

Also present is Code A who is Code A solicitor. Can you please introduce yourself here for me?

Certainly it's Code A and I am Code A Code A solicitor.

Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 0901 hours and the date is the Thursday the 6th of April 2006 (06/04/2006). At the conclusion of the whole interview process doctor, I will give you a notice explaining what will happen to the tapes okay. I must remind you doctor that you're still entitled to free legal advice. Code A is here as your legal advisor. Have you had enough time to consult with Code A in private or would you like further time?

Fine thank you.

If at any time you wish to stop the interview and take legal advice, then if you just say doctor and we will stop the interview and you can do that. I'd also like to point out that you have attended voluntarily and so you're not under arrest, you've come here of your own free will and so if at any time you wish to leave you know you're free to do so okay.

Thank you.

Code A

I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court and anything you do say may be given in evidence. Do you understand that caution doctor?

I do.

(Inaudible) I'll break it up again anyway. The caution can be broken into three sections. The first, which is the very simple bit, is that it is your right not to say anything when asked questions by us okay. The second part is the slightly more confusing part and that is if this matter should go to court, and as I say 'even if this matter should go to court' it may harm your defence if you wish to rely on something as part of your defence, if you've had the opportunity to mention it now. In other words a court might think, or draw an inference and say: "Why didn't you say that earlier?" The third and last part again is quite simple, the interview is being recorded and so should the matter go before a court a transcript of the interview can be read out, or the tapes can be played. Are you quite happy with the sound of that?

Thank you.

On this occasion the room is equipped with a remote monitoring facility, it's that red light on top of the tapes there doctor. When that red light is on it means it's being monitored, and it is being monitored at the moment by

Code A It's being monitored purely just to facilitate any enquiries we might want to do as a result of this interview quickly. When those tapes are turned off though nothing can be heard in this room throughout the remote facility, so if you want to take legal advice or anything like that you can do in this room, it can't be heard. So that will be me speaking to you the majority of the time, Code A will be taking some notes and he will also be asking some questions. Now Operation Rochester, this is an investigation that's being conducted by the Hampshire Constabulary and it started in September 2002, so this particular investigation has been running for over three years now. It is an investigation into allegations of the unlawful killing of a number of patients at the Gosport Ware Memorial Hospital between 1990 and 2000. Now no decision has been made as to whether an offence, or any offence has been committed but it's important for you to be aware that the offence range being investigated runs from potential murder right the way down to assault. Now part of the ongoing enquiries is to interview witnesses who were involved in the care and treatment of the patients at the hospital during that period. You were a clinical assistant at the Gosport War Memorial Hospital at the times of these deaths, so your knowledge of the working of the hospital and the care and the treatment of the patients is very central to our enquiry. Today doctor in this interview we will be concentrating on the patient Code A Code A He was a 68 year-old-man admitted to Dryad Ward on the 23rd of August 1999 (23/08/1999) from the Queen Alexandra Hospital. He died on the 3rd of

September 1999 (03/09/1999). Now I'm going to ask you quite a few questions today and all these groups of questions will come under particular topics and headings, and what I'll try to do is I'll endeavour to explain each topic at the start.

Code A

Can I just indicate the,...

Uh-huh.

...just confirm again the nature of the advise that I've given Code A that she should make 'no comment' to the questions that you put her and invite her to indicate if she accepts that advise and for the reasons that she's previously stated to.

(Silent.)

Yeah that's okay. Now that's the advice given to you by your solicitor, it's entirely up to you whether you take that advice, but I still have a duty to ask you a number of questions, which I propose to do okay. Right the following questionnaire is designed so that we can try and get an explanation from you as to the role you performed in the care and treatment of Code A The questions follow on from the initial 'prepared statement' that you tendered during a voluntary interview in 2005. The explanations or lack of that you give will be considered by the senior investigating officer as to whether they will ultimately be sufficient evidence to formulate criminal

charges. The asking of each of these questions seems fundamental to the overall investigation of this case and will therefore take some time. Now it is important that you are given sufficient time to understand and reflect on the question and any answer before we ask you further questions, so there will be gaps after the questions, this is purely so that you can consider your reply. Now you were given copies of Code A Medical Records back in 2005. Is that correct?

Code A

Correct.

And I am confirming that as well.

Yeah. And you've also got a copy of your own 'prepared statement', is that right?

(Silent)

Right the first topic area I would like to cover today is 'clerking'. Now clerking the patient is essential to ensuring that the patient's needs and treatments are identified and that suitable care plans are put in place. And what I want to establish is what you believe is the purpose of 'clerking' and what your own procedures were? I also want to try and identify what you see as the role of either the nurse or the doctor in clerking? (Pause) The GMC, General Medical Council booklet for Good Medical Practice, which we have a copy of here, a photocopy of, and it's got an identification reference of CSY/HF/2. In here, I'll leave this if you want

to consult it doctor, it states that 'Good clinical care must include adequate assessment of the patient's condition based on the history and symptoms and, if necessary, an appropriate examination'. And it goes on after that to say - 'In providing care you must keep clear, accurate, legible and contemporaneous patient records, which report the relevant clinical findings with decisions made, the information given to patients and any drugs or other treatments prescribed'. And it also goes on to say – 'Good clinical care must include taking suitable, prompt action where necessary', and that's going to form quite an important part of today's questions. Also it says – 'Prescribe drugs, including repeat prescriptions only when you have adequate knowledge of the patient's health and medical needs'. Doctor did you provide a suitable and adequate assessment of Code A care?

No comment.

What is the purpose of the clinical assistant in the context of looking after patients?

No comment.

Code A

We have here a copy of the Job Description for the Clinical Assistant at the hospital and it's got an identification reference of GJQ/HF/14, and it lists thirteen duties. Have you read this document?

No comment.

Code A

(Pause) The duties, the thirteen duties are to visit the units on a regular basis and to be available on call as necessary. To ensure that all new patients are seen promptly after admission. To be responsible for the day-to-day medical management of patients. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up-to-date and reviewed regularly. To complete upon discharge the Discharge Summary, an HRM60. To ensure the prompt preparation of Death Certificates and Cremation Certificates where appropriate. To take part in the weekly consultant rounds. To prescribe, as required, drugs for the patients under the care of the consultant physicians in geriatric medicine. To participate, wherever possible, in the multi disciplinary case conferences and discussions related to the patients on the unit. To provide clinical advice and professional support to other members of the caring team. To identify opportunities to improve services so that a high level of care can be provided within the resources available. To be available, when required, to advise and counsel relatives and to be responsible for liaison with the general practitioners with whom the patient is registered with other clinicians and agencies as necessary. Did you carry out these duties in your role?

Code A

No comment.

How often doctor would you visit the patients?

Code A

No comment.

I believe you have said in previous statements that 'you would visit the patients Monday to Friday between half-seven and nine o'clock (that's in the morning), virtually every lunchtime and quite often about 1900, seven o'clock in the evening especially if you were the duty doctor'. Is that correct?

No comment.

Doctor could you take me through what your daily routine was?

No comment.

As I mentioned before you've implied that 'you visit the hospital between half-past-seven (0930) and nine o'clock every morning'. Is it correct that you then have your GP Practice to attend between nine (0900) and eleven (1100) every morning?

No comment.

And quite often don't leave until half-eleven (1130)?

No comment.

(Inaudible – mumbles).

Code A

Now that was every morning Monday to Friday. Is it correct that you also had other duties at your practice?

No comment.

Did you have other clinics to attend?

No comment.

Did also, on a Tuesday evening, have an evening surgery between half-past-four (1430) and quarter-past-five (1715)?

No comment.

Is that in rotation with your partners?

No comment.

Did you used to conduct post-natal, the post-natal clinic on a Monday afternoon...

No comment.

...between half-past-one (1330) and half-past-three (1530)?

No comment.

On a Thursday, again in the afternoon, did you attend an anti-natal clinic between half-past-one (1330) and four o'clock?

Code A

No comment.

And on a Friday afternoon between half-past-one (1330) and three o'clock and immunisation clinic?

No comment.

Is your name included on the Obstetric list?

No comment.

Doctor (pause) this is information that was requested back in January 1990, it's a questionnaire, a medical list and local directory of family doctors and it actually has an identification reference of...

GJQ/HF/1.

Oh lovely thank you. Which has been filled in by hand. On Page 13, is that your signature doctor?

No comment.

In relation to Code A why was he admitted to the Gosport War Memorial Hospital?

No comment.

And what was the purpose of his stay?

Code A

No comment.

And why was he admitted to Dryad Ward?

No comment.

Well where did Code A come from before he went to Dryad Ward?

No comment.

Doctor is it correct that Code A came on the 23rd of August 1999 (23/08/1999) from the Queen Alexandra Hospital?

No comment.

Doctor what is 'continuing care'?

No comment.

(Inaudible – speaks to Code A

Doctor can I draw your attention to a document...

CSY/HF/4.

HF/4, Portsmouth Health Care NHS Trust. It's the Department Of Medicine For Elderly People Essential

Information for Medical Staff. There is an entry here about 'continuing care and long stay', and on the fifth (5th) paragraph it says: "It is often difficult to know on first encounter if the patient on the ward whether they are appropriate for continuing care or not. Patients who are severely physically disabled and require a medical input can go to continuing care for a period of assessment over a few weeks to one month. If at the end of that time they have complex medical problems that need continuing input from nursing, medical and other professionals, and their Barthel score is lower than four our to twenty (4/20) then they should be appropriately cared for on continuing care. Some of these patients will improve with time, in which case the situation would have to be reviewed. Those patients who do not need regular input from a specialist team would be most appropriate for nursing home care. This assessment should be explained to patients and their families'. Now would you say that that is a fair definition of continuing care?

Code A

No comment.

Is that a definition you are familiar with Code A

No comment.

So what is the difference between 'continuing care' and 'rehabilitation'?

No comment.

Code A

And 'palliative care'?

No comment.

(Pause) Doctor if I may draw your attention to Page 54 of the medical notes for Code A which are BJC/34 and they're the clinical notes. On the 23rd of August 1999 (23/08/1999), which is when Code A came into the hospital, he was seen by a doctor. Are they your notes doctor?

No comment.

Now there's a page of notes here where the patient has been initially seen by a doctor and it was Code A

Code A There's on full page of notes there. Is that what you would expect to see when the patient was clerked?

No comment.

On either admission or transference of a patient to the ward, what process should then take place?

No comment.

Code A

Is that what clerking is?

No comment.

Who should carry out this function?

No comment.

Should it be a doctor?

No comment.

Should it be a nurse?

No comment.

Were you present at the time of Code A admission?

No comment.

What notes would be available at the time of Code A Code A admission?

No comment.

Would the notes from the Queen Alexandra Hospital accompany Code A to the War Memorial Hospital?

No comment.

Code A

So what is then the purpose of the initial clerking?

No comment.

What is an adequate assessment for the patient's condition?

No comment.

Again if I show you again Page 54, I've shown you that before, it's a page of notes made by a doctor, that's on Code A Code A initial attendance at the hospital on the 23rd of August 1999 (23/08/1999). For the rest of his stay there's less than a page. Now in fact I believe you've just made two more entries on there. (Pause) Is that what you would say was that 'an adequate assessment for the patient when they arrived at the hospital'?

No comment.

(Pause) Shall we take the doctor through that entry Code A

Yeah.

That entry doctor, you have a copy available I believe in front of you, if you just have a look at it. It reads (1) Obesity, (2) Arthritis bilateral knees, (3) Immobility, (4) Pressure sores. On a high protein diet. Query Myeloma 13/08/1999, HP stable, Q15 29, constipated on Doxazosin, MST = very good better in himself, 0JVP, CVS. Now do

you think that that was a reasonable example of how to clerk-in a patient?

No comment.

Now Code A actually suffered a fall and that's why he was initially admitted to the Queen Alexandra Hospital. Again I'll draw your attentions to Pages 44 and 45 of the medical notes. There's two pages here as an initial assessment for the clerking. Is this what you would expect to see?

No comment.

So why is this initial assessment important?

Code A

No comment.

What examination did you carry out on Code A

No comment.

So what baseline were you and your colleagues going to have if Code A condition changed?

No comment.

Would this one page assessment and clerking on Page 54 of medical notes, is what the baseline is?

Code A

No comment.

Is it your normal practice just to write on notes at the time of admission that you're happy for staff to confirm death?

No comment.

Had you formed the opinion that Code A was at the terminal phase of his life?

No comment.

If you had, why?

No comment.

Because after the initial assessment the next entry of his clinical notes is the 26th of August, and your last sentence on that eight line entry was: "I am happy for the nursing staff to confirm death." What was wrong with Code A Code A

No comment.

(Pause) Again Code A ead out the initial assessment, or clerking and it appears as obesity, arthritis, immobility and pressure sores and Myeloma. Was there anything else wrong with Code A

No comment.

Code A

At that stage doctor, although it was (inaudible) Myeloma, at that stage his HP was stable. Was that significant to you?

No comment.

And his mental test score has been recorded as 'very good'. He's not suffering from any pain he's better in himself. It would appear that he is obese, the immobility is probably because of the obesity and he has pressure sores. What else was wrong with the man?

No comment.

It directly links to clerkings initial assessments, and I would like to see if I can identify what you consider to be the fundamental purpose of initial assessments of a patient?

No comment.

Can I just ask her one more question please?

Yeah sure.

Doctor just going back to that you wrote: "I am happy for nursing staff to confirm death," on the 26/08 after Code A Code A had seen him on the 23rd. What was he dying of?

No comment.

Code A

You must have thought he was dying for you to have written that surely?

No comment. (Somebody coughs)

Okay.

Right so we'll move on to 'initial assessment' then doctor and I'd like to identify what you consider to be the fundamental purpose of the initial assessment with a patient, specifically this will include what routine you follow and the reasons behind the assessment and what the benefit is to both the patient and the medical practitioners. Okay I'm going to quote from the Good Medical Practice from the General Medical Council, which is CSY/HF/2, the copy it's still on my desk there, and that states that 'good clinical care must include adequate assessment for the patient's condition based on the history and symptoms and, if necessary, an appropriate examination'. Now I believe that the purpose of the initial assessment should be to provide a contemporaneous record of a doctor's interaction with their patient for analysis by all medical staff. What was your standard practice when it came to initial assessments?

Code A

No comment.

What is the purpose of an initial medical assessment with a patient when they arrive on the ward?

Code A

No comment.

Who would you expect to make an entry on the medical notes?

No comment.

Who would you be expecting to read the entry?

No comment.

So as the clinical assistant doctor when would you see a patient for the first time?

No comment.

Now the initial assessment in the case of Code A was conducted by another doctor, Code A When did you first see the doctor, uh first see the patient?

No comment.

Your first notes were recorded on the 26th of August, which is three days later. Why would that be?

No comment.

So what physical examination of Code A did you carry out?

Code A

No comment.

What assessment, or examination did you carry out on Code A Code A

No comment.

Just the basic things then doctor, who took his temperature.

No comment.

Who took his pulse?

No comment.

Who took his blood pressure?

No comment.

Who listened to his heart and lungs etcetera?

No comment.

And where was this recorded?

No comment.

Now just taking Code A what were you treating him for?

Code A

No comment.

You've had access to the medical notes now, do you know what you were treating him for?

No comment.

What medical management did you put in place for Code A Code A

No comment.

What was your Medical Care Plan for Code A

No comment.

If I refer to Pages 82 and 83 of Code A medical notes, BJC/34, it's the Nurses' Care Plan and it's to deal with Code A obviously and his bowels. On the 23rd of August the problem identified is that due to immobility Code A was prone to constipation, there was then a desired outcome, which is to try to achieve a regular bowel movement pattern. The evaluation date (inaudible) was daily. Well the nursing action was for, to try and encourage adequate fibre in Code A diet, to encourage adequate fluid intake, to ensure privacy at all times and to administer...

(Inaudible)

Code A

...(inaudible) as prescribed, and then after that there's all the notes made by the nurses PWO – bowels open. Is that what you would say was a well laid out Nursing Care Plan?

No comment.

And there are Nursing Care Plans then for all sorts of aspects for Code A care, there's urinary catheter, his personal hygiene and it goes on. Who instructs the nurses and what care plans should be put in place?

No comment.

Well where do the nurses get their directions from?

No comment.

Who sets the care plans?

No comment.

So how do nurses know what care plans to put into place?

No comment.

Is it something that's left to chance and the nurses just put in whatever care plans that they see fit?

No comment.

Code A

So what directions are given to them by doctors?

No comment.

Have you got anything?

Yeah. (Pause) When Code A came in on the 23rd Code A wrote down a full page from his initial assessment and it looks like the nurses have taken up on that, so they've got a reasonably clear lead as to what they should be doing with Code A and Code A has just read out one page of the Nursing Care Plan and it looks as if the Nursing Care Plan is fairly reasonable and there are a few pages of it. You have been told, you have been cautioned at the start of this interview doctor and I think it's important for us to remind you that your solicitor has advised you to go 'no comment', but we will remind you that this is an opportunity for you to tell us what you know about Code A in particular. Now if you look at this, in the absence of a 'no comment' interview, in the absence of anything from you it looks to me, looking at it, as if you just let the nurses get on with caring for Code A with minimal input from you.

Code A

No comment.

We again you say 'no comment', but that is an interpretation that I can put on that at the moment, there's very very little written by you in these medical notes,...

Code A

No comment.

...so do you just rely on the experience of the nurses to just get on and look after Code A as best they can?

No comment.

Thank you.

With the clerking and the initial examination, Code A Code A he noted that Code A ongoing problems were obesity, arthritis in his knees, immobility, pressure sores and constipation. He noted that Code A Code A was on a high protein diet, he queried Myeloma on the 13th of August 1999 (13/08/1999), his haemoglobin was stable, he was better in himself with a good mental test score and no pain. So there was little to find on examination of him, but his obesity, swollen legs and pressure sores, is that correct doctor?

No comment.

I can refer you back to Page 54 of the medical notes if you wish.

No comment.

But it does look like yet another example of you relying on nurses to inform you of any changes in the patients'

conditions. Is that what was happening at the War Memorial doctor?

Code A

No comment.

If I refer you again doctor back to the document GJQ/HF/14, it's a Job Description and other duties. Duties (3) to be responsible for the day-to-day medical management of the patients, and (4) to be responsible for the writing up of the initial case notes and to ensure that follow-up notes are kept up-to-date and reviewed regularly. That's your job description doctor, did you do that?

No comment.

If you didn't, who did?

No comment.

Anything on that?

No.

Right that tape is on about forty (40) minutes so it will buzz in a minute. What I'll do then is I'll, we'll stop the interview here and put another tape in, so the time by my watch is 0940 hours and we'll turn the recorder off.

THE INTERVIEW CONCLUDED – THE TAPE MACHINE WAS SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RESTRICTED

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AK

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1034 Time concluded: 1116

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

Interviewer(s): Code A

Other persons present: Code A SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This interview is being tape recorded I am Code A Code A and my colleague is?
	Code A
	I am interviewing Code A Doctor will you please give your full name and your dated of birth?
	Code A

Code A

Thank you.

Also present is Code A, who is Code A solicitor. Can you please introduce yourself and your full name?

Yes certainly. I am Code A and I am Code A solicitor.

Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 1034 hours and the date is the 6th of April 2006 (06/04/2006). At the conclusion of the whole process I will give you a notice explaining what will happen to the tapes. I must remind you doctor that you're still entitled to free legal advice. Code A is here as your legal advisor. Have you had enough time to consult with Code A Code A in private or would you like further time?

Fine thank you.

If at any time you do wish to stop the interview doctor to take legal advice just say and the interview will be stopped in order that you can do this.

Thank you.

I'd also like to point out that you have attended voluntarily, you're not under arrest and you've come here of your own free will. So if at any time that you wish to leave you're

free to do so okay.

Thank you.

I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention, when questioned, something which you later rely on in court. Anything you do say maybe given in evidence. Do you understand that caution?

Thank you.

Is there any need for it to be broken down again this time?

No thank you.

Okay. As I've said before on this occasion the room that we're in has been equipped with a monitoring facility. Whenever the red light is on that means that somebody is listening to the interview. Today Code A Code A is monitoring the interview with the lights on. (Somebody clearing throat) Nobody can listen to any conversation in this room when those tapes aren't playing doctor okay. Right if I can just confirm doctor that we've had a quick comfort break, but there's been no conversation about this matter whilst the tape's been off.

None at all.

Thank you. If I can doctor I'd like to move on to issues

surrounding the pharmacy and that's the 'prescription and administration of controlled drugs', it's a specialist subject in it's own right and I seek an explanation now as to how you were involved in pharmaceutical prescriptions. I would also like to know your level of training and understanding of the drugs that you prescribed and their uses. How did you ensure doctor that you were up-to-date in the knowledge that you had in respect of pharmaceutical issues?

No comment.

What pharmaceutical training had you received at the time of Code A admission to hospital?

No comment.

What further pharmaceutical training had you received since your initial qualifications?

Code A

No comment.

How would you know what drugs to prescribe to a patient?

No comment.

How would you learn about new drugs that are available for administration?

No comment.

Code A

How would the pharmacy at the Gosport War Memorial Hospital work in relation to the availability or the suitability of medicines and drugs?

No comment.

How many pharmacists worked at the Gosport War Memorial Hospital in 1999?

No comment.

Doctor what is the BNF?

No comment. (Somebody clears throat)

Have you got a reference number for this?

CSY/HF/12.

Doctor I'll show you the BNF number 42, September 2001. Is this a book that you're familiar with?

No comment.

I think I'll leave that on the desk should you wish to refer to it. A similar book, that's the other one, is the NPF, Nurse Prescribers Formulary, and that's got a reference of GJQ/HF/17, this one is dated 2002/2003 (inaudible). Is that a book that you're familiar with?

Code A

No comment.

What is its purpose?

No comment.

What is the purpose of the BNF?

No comment.

How often would you refer to it?

No comment.

And finally book wise GJQ/HF/18, which is the PCF, which is the Palliative Care Formulary. Is this a book that you are familiar with doctor?

No comment.

What is the purpose of that book?

No comment.

And how often would you refer to it?

No comment.

(Coughs) Were any of the drugs used in the treatment of

Code A new or seldom used?

Code A

No comment.

What was the purpose of the Wessex Protocols in relation to prescribing medicines to patients?

No comment.

Have you got a copy of that one?

Sorry which one?

Wessex Protocols.

(Pause) No I haven't got a copy or it would be here.

No?

No sorry.

(Inaudible)

(Pause)

That's it. (Pause) Have you got a reference number? We're using that as a copy aren't we?

Yeah, which is (pause) CSY/HF/3.

Code A

Okay CSY/HF/3 is a copy of the Palliative Care handbook and I have one here, a photocopy, and it's actually a photocopy of this small book Advice On Clinical Management. Is this a book that you're familiar with doctor?

No comment.

It's referred to often as the Wessex Protocols, it's a book, it's the 5th addition, Advice On Clinical Management, but this one is Countess Mountbatten House, Southampton University Hospital NHS Trust. That is in association with all the Wessex Specialist Palliative Care Units. How often did you refer to this book?

No comment.

(Pause) What was the purpose of the Wessex Protocols in relation to prescribing medicines to patients doctor?

No comment.

What pharmacy guidelines were available for prescribing the medicines within the Gosport War Memorial Hospital?

No comment.

Where was the pharmacy at the Gosport War Memorial Hospital?

Code A

No comment.

How accessible was the pharmacy?

No comment.

What were the opening times of the pharmacy if any?

No comment.

Code A

Regarding the pharmaceutical side of things, did you not have a responsibility as a general practitioner to keep up-to-date with drugs administration and prescribing?

No comment.

Do you get provided with training up dates regarding these matters?

No comment.

Did you, at any stage, feel that you needed that sort of training?

No comment.

Did you fully understand (pause) each drug that you were prescribing?

Code A

No comment.

In other words did you feel confident that you understood what that drug would do and why you should prescribe it?

No comment.

If you didn't, did you ever take steps to rectify that?

No comment.

Were steps available to you at the time?

No comment.

Did you ever seek advice from anybody in relation to the prescribing of controlled drugs?

No comment.

Were you confident in your ability to ensure that each patient had the correct drug for their needs?

No comment.

Okay.

Going back to your Job Description, GJQ/HF/14. Duty number (8) was to prescribe, as required, drugs for the

patients under the care of the consultant physicians in geriatric medicine. (Clears throat) So that was one of your duties. Would you not be duty bound to keep up-to-date?

Code A

No comment.

Right. Prescriptions. Now prescribing medicines doctor there's a requirement to complete different parts of a Prescription Chart. Now what I want to do now is try and get an explanation as to how the 'clinical assistance' was involved in the prescription of medicines and what protocols you followed. Now could you please describe the process undertaken in the prescribing and administering of controlled drugs?

No comment.

Have you got a reference for this?

CSY/HF/10.

And that identification refers to a (inaudible) in Gosport, an NHS Primary Care Trust Prescription sheet, which I am opening out for the doctor. Could I just take you through this chart and perhaps you can identify certainly if we have anything wrong. Once you open the document out there's three pages, there's an area on the top half of the first place, which is 'for once one and pre-medication drugs'. Who is responsible for completing that part of the form?

No comment.

Under that is 'as required prescriptions', which there's a box for the approved name of the drug, the route that is to be taken, the dose, the date and the pharmacy and the signature of the doctor and the special directions, and next to that is the administration record, which I believe the nurses complete is that correct?

No comment.

Who is responsible for completing the left hand box on the 'as required prescription'?

Code A

No comment.

Would that be a doctor?

No comment.

Again on your actual Job Description, GJQ/HF/14, one of your duties is to prescribe 'as required drugs' for the patients under the care of the consultant physicians in geriatric medicine. So would it be fair for me to think, as you accepted the job as 'clinical assistant', that that was one of your responsibilities to complete these?

No comment.

On the middle page, again the left hand side of it, it would

appear for the doctors, that's for 'regular prescriptions'. Were you responsible for completing any of this?

No comment.

And that goes on to the next page, and finally the 'daily review prescriptions', what are they?

No comment.

Right on the back there's an area 'for nursing use only, exceptions to prescribed orders'. What is this used for?

No comment.

Code A

Is this completed by a nurse when, for some reason, a prescribed order hasn't been taken...

No comment.

...or has been refused by the patient?

No comment.

Or even on occasions vomited?

No comment.

(Pause) What was your prescribing policy doctor?

Code A

No comment.

What medicines and drugs did you prescribe to Code A

Code A

No comment.

What is the difference between 'once only drugs', 'as required drugs' and 'regular drugs'?

No comment.

(Pause) Why are ranges of drugs prescribed for patients?

Code A

No comment.

I'm just showing you a Prescription Chart, how do you think that Prescription Chart should be completed?

No comment.

So what is a 'Proactive Prescribing Policy'?

No comment.

Is this a policy where a range, quite often a large range of drugs is prescribed?

No comment.

Code A

How did this policy come about?

No comment.

What was its purpose?

No comment.

Who authorised this policy?

No comment.

Was this your policy we're describing?

No comment.

Where could I find this policy?

No comment.

What is meant by 'telephone prescribing' doctor?

No comment.

Am I right in thinking that 'telephone prescribing' would be a nurse phoning the doctor, the doctor making a prescription over the phone, the phone had been passed to a second nurse and the prescription repeated and then both nurses, or one of the nurses would make an entry on the record, countersigned by the second nurse and later signed

by the doctor when the doctor comes in. Is that correct?

No comment.

So what is the purpose of a doctor on call?

No comment.

Is part of the purpose of a doctor on call to conduct telephone prescribing?

No comment.

Is it also expected of a doctor on call to, if required, attend the hospital?

Code A

No comment.

If there is a doctor on call, and if there is the availability of 'telephone prescribing', why was there 'proactive prescribing'?

No comment.

What was the necessity of prescribing for such wide ranges of drugs?

No comment.

Was 'telephone prescribing' a recommended form of

prescribing drugs?

Code A

No comment.

Was it something that you were encouraged to do?

No comment.

Were you ever discouraged from doing it?

No comment.

Did you do it frequently?

No comment.

(Pause) Did you try to avoid 'telephone prescribing'?

No comment.

If you had a Proactive Policy, would that negate the need for anybody to phone you up?

No comment.

(Pause) What's the purpose of the 'proactive prescribing'?

No comment.

(Pause) Was it something that you used frequently?

Code A

No comment.

Did you, on a personal level, prefer 'proactive prescribing' to 'telephone prescribing'?

No comment.

Okay.

(Pause) With 'proactive prescribing' and the ability to write up prescriptions possibly before they were needed, would that make your busy life easier?

No comment.

Will I be correct in thinking with 'proactive prescribing' that that would negate the need to attend the hospital, and it would negate the need to be telephoned...

No comment.

...or certainly minimise those opportunities?

No comment.

Because again as part of your Job Description is you're expected to be on call is that correct?

No comment.

Code A

Was that a lifestyle issue doctor?

No comment.

Did you proactively prescribe purely on medical terms on what was best for the patients...

No comment.

...or was it a lifestyle issue?

Code A

No comment.

(Pause) Do you think it would have been preferable, particularly with the use of Diamorphine, to have prescribed in a way that would allow nurses to contact you should the patient need to have his dose varied...

No comment.

...as opposed to the Proactive Prescribing Policy that you adopted?

No comment.

Okay.

Code A

Who administers the prescribed drugs?

No comment.

What training do the nurses have for the administration of the drugs?

No comment.

Can any level of nurse administer drugs?

No comment.

What is the purpose of the drug registers?

No comment.

What has to be recorded in them?

No comment.

Why have there been drugs prescribed but no administered?

No comment.

Code A

No.

Code A

Let me move on if I can then doctor to 'syringe drivers'. Now the use of a syringe driver, what we've found so far, is normally dictated by a doctor and that there are different reasons for employing a syringe driver, one of which is once a patient can no longer take oral medicine. I want to seek an explanation now as to why a syringe driver was utilised in this case, in particular in the way in which you would envisage the driver to be used. So we'll start off doctor with what training had you had for the use and deployment of syringe drivers?

No comment.

And what is a syringe driver?

No comment.

How long had syringe drivers been in use in 1999?

No comment.

But why is a syringe driver used?

No comment.

And what kinds of patients are most suitable for syringe drivers?

No comment.

Code A

Who talks to the patient, or the family regarding the use of syringe drivers?

No comment.

Well how does a syringe driver work?

No comment.

Who prepares the drugs for administration via a syringe driver?

No comment.

Right. We've got a photocopy now of the instructions for the use of the Ambulatory syringe drivers. This is a notice that was found on the ward in Dryad Ward, it's got a reference number of CSY/HF/8. First of all doctor have you seen this before?

No comment.

It's titled Graseby Medical Instructions For The Use Of (inaudible) Syringe Drivers, and it depicts that there are three types of syringe drivers, the Variable Syringe Driver MS16, a Fixed Syringe Driver MS18 and the Variable Speed Driver MS26. What are the differences between these syringe drivers?

No comment.

Code A

What is the difference between the MS16A and the MS26?

No comment.

Has one got a boost facility?

No comment.

What is a boost facility?

No comment.

I believe they are actually both different colours. What colour was the syringe driver used in the case of Code A Code A

No comment.

So why was Code A given drugs by way of a syringe driver?

No comment.

And correct me if I'm wrong doctor, but Code A was still able to take oral medicine. Why wasn't he given pills, or Oramorph instead of a sub cut syringe driver?

No comment.

Code A

(Pause) Why was it necessary to put Code A on a syringe driver?

No comment.

(Pause) Why isn't there an entry on the Medical Records that the use of a syringe driver was now deemed necessary?

No comment.

Page 55 are the only notes made by you and there's no mention of a need for a syringe driver.

No comment.

So who deemed it necessary then?

No comment.

Was it you?

No comment.

Was it Code A

No comment.

Did Code A prescribe drugs?

No comment.

Code A

Why is there an entry in the nursing notes that a syringe driver is being used?

No comment.

(Pause) Is the use of a syringe driver a significant factor in the care of a patient?

No comment.

Code A

Yes. Doctor we've just gone through the suitability and usage of syringe drivers for particular types of patients, and we see that this syringe driver was started on the 30th of August. Code A has already asked you one question saying: "Why was a syringe authorised and started on the 30th when Code A was still able to take oral medicine?" Can you remind me why that was?

No comment.

Because not only was he able to take oral medicine, but a nursing note on the same date, on Page 63 of those notes, (someone coughs) a nursing note states that 'a very small amount of diet taken, mainly puddings'. So that implicates, doesn't it, that Code A was still eating, grant you in smaller doses, but he was still eating. If he was able to eat puddings, was he able to take Oramorph?

Code A

No comment.

The nursing note goes on to say, amongst other things, 'encourage fluids', which again indicates, does it not, that he was drinking still. Is that right doctor?

No comment.

And yet the syringe driver was authorised. Did Code A Code A fit the criteria for the commencement of a syringe driver?

No comment.

And the interesting point about that entry on Page 63 is that the nurse who wrote it and says that 'he was taking mainly puddings and he was to be encouraged to have fluids', was the same nurse who started off the syringe driver having apparently discussed it with you and that nurse was Code A Code A Have you got any comment to make about that doctor?

No comment.

Why would Code A start a syringe driver on a patient who was still able to drink, who was still able to take oral medicine, who was still able to eat?

No comment.

Code A

Was she acting on your instructions?

No comment.

Did you authorise the use of that syringe driver at that time?

No comment.

Was she acting on your authority Code A

No comment.

Should you have allowed the use of that syringe driver at that time?

No comment.

Have you got any further questions Code A

Along the same lines, on the 29th of August 1999 (29/08/1999) nocte, which is night, a nurse has written 'slept for long periods, Oramorph given as prescribed', and then 'complaining of left abdominal pain'. And then on the 30th of August, the next day, was Code A entry, which reads exactly 'condition remains poor, syringe driver commenced at 1445, Diamorphine 40 milligrams, Midazolam 20 milligrams, no further complaints of abdominal pain, very small amount of diet taken mainly

puddings, re-catherised this afternoon, dressing, draining of the fluids and the dressings also reviewed'. So the whole entry for the 30th of August says, first of all it says 'syringe started' and later still 'still able to eat'. I just find it puzzling doctor; can you shed any light on it?

No comment.

Having started off the syringe driver doctor and you apparently having authorised it why then, it being surely a significant factor in the care of Code A why then did you not make a record in the notes explaining why the syringe driver was started?

No comment.

Code A

I say it's probably because you felt unable to do so given the note in the Nursing Record,...

No comment.

...because surely your justification for using the syringe driver would have been 'unable to take oral medicine, unable to eat, unable to drink, commence syringe driver', that would go directly against what the sister had written wouldn't it?

No comment.

(Pause) Were you at the hospital when Code A

spoke to you about the syringe driver?

No comment.

(Pause) If Code A was in enough pain to require Diamorphine through a subcutaneous syringe driver, what was causing that pain?

No comment.

I'll come back to that one. Now I'd like to talk to you doctor about some drugs now and there are three drugs in particular that were prescribed and administered to Code A Code A I just want to see if we can clarify and get a further explanation as to the specific reasons behind the prescribing of these drugs and their uses and effects. Now firstly I would like to talk about Oramorph. Why was this drug, Oramorph, prescribed?

Code A

No comment.

Why and when was this drug administered?

No comment.

The drug was administered at 1445 hours, who authorised the drug?

No comment.

Code A

(Pause) What time did you see Code A

No comment.

(Pause) So what was the purpose of this drug?

No comment.

(Pause) Why was no other form of painkiller prescribed as an alternative to a strong opioid?

No comment.

(Pause) A little more interesting, on Page 172 of the Medical Records, which are BJC/34, if I pull the original out for you the very first entry at the doctor it says Oramorph 10 – 20. Because you've prescribed 10 – 20, how does anyone know what to administer?

No comment.

(Inaudible – mumbles) then how much has been administered?

No comment.

Code A

Yeah. If I was a doctor on call and I'd come out to see Code A Code A after one of those doses was administered,

how would I know what amount of Oramorph he'd received?

No comment.

Because it doesn't tell me there does it? It could be 10, it could be 20, and presumably it could be 15. Would you expect a doctor to have to go back to the drug book to check it out?

No comment.

Why have you prescribed that in such a way then?

No comment.

Code A

(Pause) (Coughs) Actually what is Oramorph doctor?

No comment.

And what is its purpose?

No comment.

And where does Oramorph sit on the Analgesic Ladder?

No comment.

Again doctor Midazolam, what is Midazolam?

Code A

No comment.

Well why is Midazolam used?

No comment.

And more specifically why was it used in relation to Code A

Code A

No comment.

Is it a sedative doctor?

No comment.

Are there any other kinds of sedatives that can be used?

No comment.

This drug appears to be commonly used in patients at the terminal end of an illness, is this why this drug was prescribed to Code A on this occasion?

No comment.

Did you consider Code A was at the terminal phase of his life?

No comment.

Code A

How would you know how much Midazolam to prescribe?

No comment.

Whom was he diagnosed by as being in need of Midazolam?

No comment.

What is the purpose of prescribing a range of parameters for the administration of the drug (TAPE BUZZES).... Hang on. Right we'll have to turn the tapes off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AJ

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 0942 Time concluded: 1017

Duration of interview: 35 MINUTES Tape reference nos.
(→)

Interviewer(s): Code A

Other persons present: Code A - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the interview with Code A Code A The time is 0942 hours. Doctor can I just ask you to confirm that while the tapes were off there has been no conversation about this matter?
	None.
	Thank you. Right the same people are present. I must remind you doctor that you are still under caution as well. I would like to move, if I may, on to 'existing treatment and

conditions', and in this case it is the case of Code A Code A What specific ailments was he suffering from? I will ask questions to get an understanding of why you've prescribed various medicines, also to seek an explanation as to what Medical Records would have been available to you and what you would have reviewed, and in order to offer the correct and appropriate care medical practitioners should be aware of pre-existing medical history, prescriptions and care plans. So what notes would have been available to you when a patient arrived at the ward?

No comment.

What process would you normally follow upon a patient's arrival at the Gosport War Memorial Hospital?

No comment.

What was Code A suffering from that necessitated him being admitted to the hospital in the first place?

Code A

No comment.

Would it be right in saying obesity, swollen legs and pressure sores?

No comment.

(Pause) What medication was Code A taking at the

time of the transfer?

No comment.

(Pause) On the Drug Chart, which is on Page 170 and 168 actually, that reveals that he was on, he was continued on regular Doxazosin 4 milligrams once a day, Frusemide 80 milligrams once a day and (Inaudible) 40 milligrams twice a day, Paracetamol 1 gram four times a day. He was commenced on Magnesium Hydroxide 10 millilitres twice a day, I believe that's a laxative and that was subsequently taken intermittently, which was two doses on the 24th and one dose on the 25th, two doses on the 28th, 29th and one dose on the 30th, and as required Gaviscon. Is that correct doctor?

Code A

No comment.

What was the purpose of these drugs?

No comment.

Now later Oramorph was prescribed, why was this?

No comment.

(Pause) On Page 172 of Code A medical notes (pause), Oramorph was prescribed on the 26th of August. Why was this doctor?

No comment.

(Pause) Where is it recorded what the Oramorph was prescribed for?

No comment.

It's not is it doctor?

No comment.

Why isn't it recorded anywhere?

No comment.

Code A

Doctor I think we've established that it wasn't recorded. This patient came into hospital in 1999 and we are now in the year 2006. If we can't glean from the records why he was on Oramorph then, how could anybody looking at the records in 1999, how can anybody tell what it was for then as well. So if we don't know how did anybody know then?

No comment.

How did the nursing staff know what he was on the Oramorph for?

No comment.

How would any other medical personnel know what he was

on the Oramorph for?

No comment.

If somebody was called out during the night or over a weekend when you weren't available, how would they know what the Oramorph was for?

No comment.

Similarly when you wrote in your note: 'Happy for staff to confirm death," on the 26th of August. If another doctor had been called out, how would they have known what he was dying from?

Code A

No comment.

I think that's a fairly reasonable question to ask doctor don't you?

No comment.

I think a doctor being called out to examine Code A Code A after you wrote that note, would be entitled to know why you wrote it.

No comment.

Similarly he'd be entitled to know why you prescribed Oramorph.

Code A

No comment.

Code A

He wouldn't have been just entitled, he would need to know wouldn't he doctor?

No comment.

Right. But on the same point wouldn't Code A Code A be entitled for any doctor treating him to understand what his current condition was?

No comment.

And how could a doctor being called out understand what the current condition was properly assessing if you hadn't written down what you had done?

No comment.

(Pause) Doctor I'd like to move on and talk about the purpose of Code A stay and of your aims, your plans. Now care plans are put in place to allow a nurse and medical practitioner to follow a particular course of action. The progress of the patient is going to be monitored and the results reviewed and then the care can be altered accordingly. What I want now is to try and get an explanation as to how you were directly involved in the

process of establishing care plans. What is the purpose of a 'care plan' doctor?

No comment.

What input do you have in that 'care plan'?

No comment.

What was the 'care plan' that was put into place in respect of Code A

No comment.

Did that 'care plan' ever change?

Code A

No comment.

If it did why did it change?

No comment.

Who was the main nurse for Code A

No comment.

From the notes I believe that to be Code A What was her role?

No comment.

Code A

Now I think Code A will be, as the main nurse have more contact than any other nurse with Code A Code A and she certainly would have some sort of direct responsibility. So what did you discuss with her?

No comment.

What have you recorded as the 'care plan'?

No comment.

So was Code A left to her own devices?

No comment.

Who decided on what the 'care and treatment plan' would be for Code A then?

No comment.

How would the 'care plans' be drawn up?

No comment.

Well doctor who was responsible for the treatment of Code A Code A on a day-to-day basis?

No comment.

Code A

Who was in overall charge of the care of Code A

No comment.

(Sneezes) Excuse me. What planned investigations were you going to carry out?

No comment.

Code A do you want to ask anything?

No.

(Sneezing) I'm having a sneezing fit I'm sorry.

No comment.

Only this then, Code A sneezes) did you just leave the 'care plans' to the nurses?

No comment.

Did you have no input into the 'care plans' at all?

No comment.

Well surely the nurses would need some guidance from the doctors, otherwise why have doctors?

No comment.

Code A

Okay.

Right. Medical Records then doctor. The recordings of interactions with patients, as we've said before, is a fundamental requirement of the Health Care Professional. In the Good Medical Practice, it's set out by the GMC that states that 'a doctor must keep clear, accurate, legible and contemporaneous records which report the relevant clinical findings and decisions made, the information given to patients and any drugs or other treatment described. That's on Page 3 of the Good Medical Practice, which is left on the desk, CSY/HF/2. So feel free to browse through that doctor. In addition that booklet states, well there's a booklet called Withholding and Withdrawing Life Prolonging Treatments...

Code A

GJQ/HF/15.

...and on Page 30 of this document, or this book, it specifically states that 'the decision making process should be recorded'. Now with these documents in mind, I want to seek an explanation as to how you completed Medical Records, and in particular those records of Code A Code A And I'll leave this book here for you as well doctor?

Code A

No comment.

Doctor what would you record in the Medical Records of a

patient, and what importance did you place on the completion of the records?

No comment.

What would you expect to see recorded in the patient notes on a day-to-day basis?

No comment.

And in that question I include the nursing and medical notes doctor?

No comment.

Code A

Did you normally complete records to the standards set out by the GMC?

No comment.

In fact in relation to the Good Medical Practice, the GMC booklet CSY/HF/2, doctor can you confirm if you got a copy of this booklet each year when you renewed your subscription?

No comment.

Right the records of Code A Other than on the Prescription Charts, there are only two pages of clinical notes for the War Memorial Hospital, which you have made

entries on the 26th and the 28th of August. Where in those entries doctor have you recorded that Code A was in pain?

No comment.

Would you like to see these?

No comment.

Where on Page 54, which is the initial assessment by Code A is it recorded that Code A was in pain?

No comment.

Code A

In fact would be right to say it was recorded that 'he was not in pain'?

No comment.

Doctor what is the Analgesic Ladder?

No comment.

Show me your description bit.

Sure.

That yellow piece.

Code A

(Pause) Just before we leave that last section doctor...

For the benefit of the tape Code A talk amongst each other regarding the Analgesic Ladder.

Before we leave that last section about Code A being in pain and you haven't recorded anywhere in those notes what the pain was or where it was, I'm sure like Code A Code A 've seen lots of Medical Records over the years in various cases I've worked on and is it not a common practice for doctors to draw diagrams of parts of the body indicating where a pain is emanated from, am I right?

Code A

No comment.

And isn't that, the reason for that is so that it makes it clear to anybody else who picks up on that patient to see where pain is coming from?

No comment.

So it indicates, it clears up any ambiguity as to where the pain is coming from, not necessarily what's causing it but where it's coming from?

No comment.

For instance where the patient is complaining of the pain?

Code A

No comment.

I don't think I've seen any diagrams from you regarding patients' pain. I

No comment.

Do you not feel that that is a good idea to draw diagrams of patients then?

No comment.

Is that a practice that you don't adhere to? I

No comment.

Is it a practice you disagree with or some reason?

No comment.

In fact Page 45 of these medical notes, QA notes there's some diagrams here doctor, these are the sort of things that Code A was talking about. Do you make any such diagrams?

No comment.

Doctor we've just asked you about the Analgesic Ladder haven't we, and I am confident that you must be aware of the Analgesic Ladder. Am I right?

Code A

No comment. (Somebody coughs).

From exhibit CSY/HF/6, these are blank Gosport medical documents from the War Memorial Hospital this is, I'm showing you a yellow copy, it's a newish document I believe. Can you see that?

No comment.

Would you like to have a look at it?

No thank you.

It sets out the Analgesic Ladder and it says that 'this is adopted from the WHO Analgesic Ladder and it's very very similar to the one available to you in the Wessex Protocol and it starts off (somebody coughs), it's in several steps isn't it? The first step being Step (1) Mild Pain and this is drugs, which are non-opioid such as Paracetamol, Diclofenac, Co-prox (pause), yes sorry Diclofenac etcetera, etcetera, yes, yeah? And then as the pain increases to a moderate pain you move up the ladder to weak opioids such as Codeine with Paracetamol, Co-codamol, Dihydrocodeine, Tramadol, etcetera, and then eventually we end up, if pain increases to severe pain, to Step (3) which are your strong opioids and these are basically your Morphine based drugs aren't they doctor?

Code A

No comment.

So these would be your Oramorphs, MSTs, Diamorphine, Morphine. Is that right?

No comment.

Is the Analgesic Ladder something that you follow when prescribing medicines for analgesics and painkillers?

No comment.

Were you aware of the Analgesic Ladder in 1999?

No comment.

Code A

So what previous painkillers had Code A been prescribed?

No comment.

Is that right Paracetamol four times a day doctor?

No comment.

Why isn't there any documentation, and I know we keep coming back for this, but why isn't there any documentation relating to why Morphine or other strong analgesics were prescribed?

No comment.

Code A

Why was Oramorph prescribed without an alternative?

No comment.

And why isn't there an entry in the Medical Records explaining why Code A was prescribed Diamorphine?

No comment.

Code A

No.

(Inaudible) about the topic about Ward Rounds and these are an opportunity for doctors and nurses to review a patient aren't they to discuss and decide upon further or change treatment? So as such they too are an integral part of a doctor's duties, and what I'd like to do is get an explanation from you as to how you conducted your rounds, and the role that you saw ward rounds played in the care and treatment of a patient and in particular Code A So how often did you conduct your rounds doctor?

Code A

No comment.

Will I be right in saying that in the document that we've given an identification reference of GJQ/HF/14, which is the Job Description for the Clinical Assistant at Gosport

War Memorial Hospital, Duty (1) was to visit the units on a regular basis and to be available on call as necessary. Did you do a round every time you visited the wards?

No comment.

Who would you conduct your rounds with?

No comment.

What time of day would you conduct your rounds doctor?

No comment.

Now you've previously stated that you visited the ward every morning between half-past-seven (0730) and nine (0900), most afternoons and some evenings. We know that you had certainly three afternoon commitments with the surgery, but you certainly state that 'you visited the hospital every morning'. Would you conduct a round every morning?

Code A

No comment.

What was the purpose of the ward rounds?

No comment.

How long did they take?

Code A

No comment.

If you conducted ward rounds, would the nurses accompany you?

No comment.

Would the nurses have any input into the rounds?

No comment.

(Coughs) In what form did the ward rounds take place?

No comment.

Would the ward rounds consist of visiting each patient at their bed, or you conducted in an office with the nursing staff?

No comment.

How often did the consultants conduct, well the consultants conduct their rounds?

No comment.

Again Duty (7) from your Job Description, which is GJQ/HF/14, states that you should take part in the weekly consultant rounds. I would assume from your Job Description that the consultant rounds were weekly. Did

you take part?

No comment.

What time of the day did the consultant rounds take place?

No comment.

Was it after nine o'clock?

No comment.

Did you attend a consultant round with regards to Code A

Code A

No comment.

Did you ever attend any consultant rounds?

No comment.

Because I'm having a problem working out your actual daily schedule again doctor. It was a busy day that you had, half-past-seven (0730) until nine o'clock at the hospital, nine (0900) until half-eleven (1130) at the surgery, afternoon clinics. When did you ever have time to do a consultant's round?

No comment.

Code A

Was that just a blatant disregard for one of your duties?

No comment.

And if you did attend them, how did their rounds differ from yours?

No comment.

Well did they differ?

No comment.

If you saw Code A every day, why didn't you make an entry in the medical notes each time?

No comment.

Code A

What was the nurses' responsibility when it came down to ward rounds?

No comment.

The nursing staff?

No comment.

We touched on it there whether the ward rounds were an act

of you physically walking from bed to bed and physically seeing each patient. Did you actually do that doctor?

No comment.

Or did you conduct them more as an office conference perhaps?

No comment.

Was it the case that you sat in an office with the nursing staff and discussed the patient?

No comment.

Code A

The notes already indicate that you placed quite some responsibility on to the nursing staff. Was this another example of how you conducted your rounds or not?

No comment.

Did you encourage or allow the nursing staff to conduct ward rounds on their own?

No comment.

Did Code A in particular conduct ward rounds on her own?

No comment.

Code A

If you weren't in hospital for some reason and legitimately that would probably happen wouldn't it on some days? Would Code A conduct (somebody coughs) a ward round on her own?

No comment.

If she did, was that the practice that crept in gradually until she was doing more ward rounds than perhaps she should have been doing?

No comment.

Okay.

Doctor what I want to talk about is 'consultants' assessments and their responsibilities'. As we know consultants certainly play and integral part in the care and treatment of patients. I think it's essential that we give you the opportunity to offer an explanation as to how the role and the function of consultants is performed in the respect of Code A and also I would like to know if you've had any concerns that you may have raised and raised them to whom. But did you have any concerns and how many consultants supported you at the Gosport War Memorial Hospital?

No comment.

Code A

If you did, when did you raise these concerns?

No comment.

Again if you did, how did you raise these concerns?

No comment.

Where would a written record of these concerns be found?

No comment.

Why would you have concerns?

No comment.

Who was the consultant that was responsible for the care of Code A whilst he was a patient on that ward?

No comment.

What did you understand the consultant's responsibilities to be?

No comment.

Well what involvement did the consultant have with Code A Code A o your knowledge?

No comment.

Code A

Did you have any concerns as to how the consultants performed their role in respect of this patient?

No comment.

Were you given sufficient support by the consultants in order to carry out your own work?

No comment.

How was this support offered?

No comment.

Did you ever raise concerns with anyone?

No comment.

If you did, whom did you raise these concerns to?

No comment.

(Coughs) And if you did, when did you raise these concerns?

No comment.

And probably more importantly, why did you raise concerns of anyone?

Code A

No comment.

Code A

I think Code A was the consultant...

He was.

...in this case wasn't he doctor? Yeah and Code A has confirmed it by reading from your notes. Did you have any problems with Code A

No comment.

I understand that Code A was involved, and Code A was a registrar above yourself and below Code A Did you raise any concerns regarding either of those two doctors?

No comment.

Did you have any concerns with those two doctors?

No comment.

If you had had concerns, how would you have raised them? Would you have known how to raise them?

No comment.

Code A

You had, part of GJQ/HF/14 your Job Description, a letter accompanying it from Code A and it states in there that 'should you have any grievance relating to your employment, you are entitled to discuss the matter in the first instance with the consultants to whom you are responsible'. Did you ever do that?

No comment.

'And where appropriate, you can consult either in person or in writing with the personnel officer'. That's the nearest hospital. And it goes on to say that 'there is a Section 32 of the General (Inaudible) Council Conditions Of Service that you can also refer to affecting your conditions of service. Did you ever do that?

No comment.

And there is an agreed disciplinary procedure available to you in the Personnel Department at St. Mary's. Did you ever have a look at that?

No comment.

Did anything happen at Gosport War Memorial that led you to go down that path?

No comment.

Code A

Did you have any personal issues with Code A Code A

No comment.

Did you have any personal issues with Code A ..

No comment.

...that would prevent you from making a complaint that it was justified?

No comment.

Okay.

Again the tapes have about three or four minutes to go, I think we'll change the tapes. In fact we might take a ten minute break now actually.

Yeah.

All right. Is there anything you wish to clarify at the moment doctor?

No thank you.

Is there anything you wish to add?

No thank you.

Code A

The time by my watch is 1017 hours and I am going to turn the recorder off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AL

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1121 Time concluded: 1155

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

Interviewer(s): Code A

Other persons present: Code A SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the interview with Code A Code A I am Code A the other officer present is?
Code A	Thank you. The time by my watch is 1121 hours. The last tape finished before we could actually give an end time and that was 1116 hours that the last tape ended. It's just really

been a change over of tapes. Doctor can you confirm it's the same people in the room?

I can.

Would you care to confirm whether there's been any conversation about this matter while the tapes have been off?

None at all.

Okay doctor. I must still remind you that you are still under caution. We were talking about Midazolam weren't we?

Code A

(Silent)

Right. What is the purpose doctor of prescribing a range of parameters for the administration of this drug, Midazolam, i.e. 20 – 80 milligrams?

No comment.

Is this what is known as 'proactive prescribing'?

No comment.

Why doctor did you prescribe a range of this drug to Code A

Code A

Code A

No comment.

How would the nurses know where to start within this range?

No comment.

Where is it recorded within the medical notes your prescribing instructions to the nurses as to why, when and by how much the dose can be altered within this range?

No comment.

And by whom?

No comment.

How would a nurse know why to alter the dose?

No comment.

How would a nurse know when to alter the dose?

No comment.

And very importantly, how would a nurse know how much to alter the dose by?

No comment.

Code A

Doctor would you expect to see an entry in the notes as to the justification for this drug being administered?

No comment.

What safe guards were in place to ensure that Code A did not receive an excessive dose of Midazolam?

No comment.

What part did the Wessex Protocols play in the prescription of Midazolam?

No comment.

Did they play any part at all?

No comment.

(Pause) Why didn't you follow the guidelines for the prescription of Midazolam, i.e. arrange starting at 5 milligrams a day?

No comment.

Code A

No.

Code A

Doctor Diamorphine. What is Diamorphine?

No comment.

Why is Diamorphine used?

No comment.

(Interference on tape) What kinds of analgesics are normally used (inaudible interference on tape) Diamorphine?

No comment.

Where does Diamorphine fit within the Analgesic Ladder?

No comment.

Why didn't you record what the purpose was for Diamorphine on the records?

No comment.

Why was the Diamorphine written up to 200 milligrams?

No comment.

Would you have allowed a nurse to administer this much without you reviewing the patient?

Code A

No comment.

How would you stop this happening?

No comment.

Why was a Proactive Prescribing Policy needed if you were seeing the patients every day?

No comment.

(Pause) In your Job Description, GJQ/HF/14, your very first duty is 'to visit the units on a regular basis and to be available on call as necessary'. If you complied with this duty, what was the necessity for proactive prescribing?

No comment.

Duty (4) to be responsible for the writing up of initial case notes and to ensure that follow-up notes are kept up to date and reviewed regularly. Why haven't you performed this duty doctor?

No comment.

Where is it recorded, bearing in mind that duty, on how much the nurses can increase the dosage of any drug when arranged as prescribed?

No comment.

Code A

(Coughs) (Pause) What checks and valve safes were put in place to prevent overdosing?

No comment.

(Pause) Why was Diamorphine prescribed to Code A

No comment.

Is it normal to prescribe Diamorphine as a required drug?

No comment.

Was Code A in his terminal phase in your view?

No comment.

How was he diagnosed as being in need of Diamorphine?

No comment.

How would you decide how much Diamorphine to prescribe?

No comment.

What is the purpose of prescribing a range of parameters for the administration of a drug, i.e. 20 – 80 milligrams?

Code A

No comment.

And why did you prescribe a range of this drug to Code A Code A

No comment.

And very importantly, how would the nurses know where to start within this range?

No comment.

(Pause) Where is it recorded then within the medical notes the prescribing instructions to the nurses as to why, when and by how much that those can be altered within this range and by whom?

No comment.

Would you expect to see an entry in the notes as to the justification for this drug being administered?

No comment.

What would you consider to be an excessive dose of Diamorphine for Code A

No comment.

Code A

What safeguards were in place to ensure that Code A did not receive an excessive dose of Diamorphine?

No comment.

What part did the Wessex Protocols play in the prescription of Diamorphine?

No comment.

That's that little book that's already been produced on the table doctor. Did it play any role at all?

No comment.

Why didn't you follow the guidelines for the prescription of Diamorphine, i.e. arrange starting it at 10 milligrams a day?

No comment.

(Pause) Did you ever seek advice from anyone regarding your prescribing regime in respect of Code A

No comment.

Why didn't you?

No comment.

Code A

(Coughs) How do you know that you're prescribing regime did not lead to a worsening of Code A condition?

No comment.

Where is the reasoning behind this recorded?

No comment.

Why wasn't this recorded?

No comment.

Doctor there's no justification documented in the medical notes for the use of Diamorphine or Midazolam and the syringe driver, why is that?

No comment.

Why isn't there any record of an ongoing assessment?

No comment.

There weren't any documentation notes to explain why Code A Code A required increases in the doses of Diamorphine from 40 up to eventually 90 milligrams over a three-day period.

Code A

No comment.

When did you consider that Code A had entered the terminal phase of his life?

No comment.

Why did you consider Code A had entered the terminal phase of his life?

No comment.

What change had taken place of Code A for you to reach this conclusion?

No comment.

Where did you record this (coughs)?

No comment.

Were you qualified to make this diagnoses doctor?

No comment.

Were you qualified to diagnose and provide palliative care to Code A

No comment.

Was that your responsibility?

No comment.

Did you refer these decisions to a consultant?

No comment.

Did you ever refer to a consultant?

No comment.

Code A

Code A

Yeah. Regarding the lack of notes on on-going assessment, I think it's quite appropriate with analgesics, but particularly with Diamorphine, which is, is that the strongest one you can prescribe doctor?

No comment.

Don't you have a duty to regularly review that (somebody coughs) dosage on the patients?

No comment.

Because otherwise how do you know what effect it's having on them?

No comment.

Code A

Did you ever go back to him to find out whether the Diamorphine was having a good effect,...

No comment.

...or bad effect?

No comment.

Did you ever check him for his, do that simple pupil check that I understand some doctors do...

No comment.

...whereby you can state, you can see from the state of the pupils whether the Diamorphine is having the right effect, or too much effect, i.e. if it makes them drowsy?

No comment.

Well let's go back then to (pause) when you originally prescribed to him... Can I just take the BNF?

Yeah it's here.

Does, in the BNF, tell me if I'm reading it right, I would like you to have a look at it, does it not indicate that 'you should start at 5 milligrams of Diamorphine subcutaneously'?

Code A

No comment.

Because he was on 10 milligrams of Oramorph wasn't he?

No comment.

But the starting dose in the syringe driver was 40 wasn't it?

No comment.

Well you prescribed it...

No comment.

...and you apparently authorised it.

No comment.

Well I'll tell you then it started at 40 on your prescription and apparently on your authorisation. Is that right?

No comment.

Or are you saying that a nurse has now administered that without authority?

No comment.

Code A

Well let me show you, this is a blow up from the Prescribing For The Elderly, which is in the BNF, and you will see on there that for the Morphine Sulphate 10 milligrams every four hours. If you go across it goes to 20 milligrams of Diamorphine. Well you didn't even start there did you, I asked you just now 'why didn't you start at 5 milligrams?', or suggested you could have done, but you don't start there you go right to 40. So if I show you that and I'll introduce that as GJQ/HF/21, if I show you that you can see that that's quite a dramatic jump isn't it?

No comment.

Not only is it a dramatic jump to 40, so it looks as if it is completely out of the guidelines, is that right?

No comment.

I'm just wondering why Morphine Sulphate wasn't used because you've missed that.

No comment.

Now let's just go back to the 10 milligrams of Morphine - yes? And let's just think about the date when you prescribed the Diamorphine (somebody coughs), because if you look at the prescription charts on Page 171 you'll see that you prescribed the Diamorphine 40 – 200, again in a huge range on the 26th and at that stage you had also prescribed the Oramorph 10 – 20 so you didn't, presumably

that was arranged where you're authorising the nurses to administer up to 20 milligrams of Oramorph. Is that right or wrong?

No comment.

Going on your prescription, would the nurse have been wrong to give Code A 20 milligrams of Oramorph?

No comment.

That was on the 26th and that was the same day that you authorised the Diamorphine.

No comment.

Code A

So how did you know what the correct dose of Diamorphine would be before he had even started on that Oramorph prescription...

No comment.

...because that was a variable range wasn't it according your prescription?

No comment.

Well we've told you doctor this is your opportunity to tell us things if we've got the wrong end of the stick and so we

repeat: "This is your opportunity to tell us." What was the thinking behind that?

Code A

No comment.

Because how do you know what his requirement would be in terms of Diamorphine before you had given the Oramorph its chance?

No comment.

Well I'll take you back to when the Diamorphine was started on the subcutaneous dosage. Did you authorise the commencement of the syringe driver?

No comment.

Did you need to authorise the commencement of a syringe driver?

No comment.

(Pause) If a nurse lets, for arguments sake you are in the hospital at the time, could a nurse start that syringe driver of her own accord?

No comment.

A significant factor in the treatment of Code A Code A is just about to start. Should that nurse have contacted you?

No comment.

Did that nurse contact you?

No comment.

If the nurse had contacted you, should that be recorded?

No comment.

Code A

Well I suggest it should have done, it should have been recorded by the nurse shouldn't it?

No comment.

And then it should have been recorded by you.

No comment.

Well why wasn't it recorded by you?

No comment.

It wasn't recorded by the nurse either was it?

Code A

No comment.

She said that 'she started the syringe driver', but she doesn't say in her note that she's had a conversation with yourself, or any other doctor come to that.

No comment.

In fact it's for that doctor, in your own prepared statement you wrote: "I anticipate that the nursing staff would have liaised with me prior to commencing with the Diamorphine and Midazolam and that this would have been set up on my instruction directly if I had been at the hospital, or otherwise by phone," but you don't know do you?

No comment.

Well given there's 'no comment' from you again doctor, I am now thinking along the lines that what about this for something that may have happened? The nurse has started that syringe driver without your authority and a dose far exceeding the guidelines and using the table in the BNF. Is that what happened?

No comment.

Would that explain why you did not make a record afterwards?

No comment.

Code A

If that was the scenario and you came into the hospital and saw that Code A had been started on a syringe driver without your authority and on too high a dose range, what could you have done? What were your options?

No comment.

Could you have made an entry in the nursing notes, in the medical notes saying 'a mistake had been made'?

No comment.

Could you have stopped the syringe driver?

No comment.

We've already seen that he was able to eat and drink and take oral medicine, so could you have gone a different route and changed his medication?

No comment.

Were you covering up for Code A Code A

No comment.

Code A

Do you think that you and Code A at this time, followed the guidelines and the procedures correctly?

No comment.

(Pause) Doctor if I can take you back to Page 54, Page 55 of these notes (pause), it will be Page 55, the Medical Records, PJC/34, your very first entry on the 26th of August 1999 (26/08/1999), the very last line of that entry which was signed by you doctor. Can you confirm that?

Confirmed.

"I am happy for nursing staff to confirm death." What does that mean doctor?

No comment.

And why is it recorded there?

No comment.

Is there a difference between confirming and verifying and certifying death?

No comment.

If there are, what are the differences?

No comment.

Code A

And what was the normal practice to be followed by nurses upon the death of a patient?

No comment.

And why is this statement written a number of days prior to Code A death?

No comment.

In fact this statement was written on the 26th of August doctor, Code A didn't die until the 3rd of September, it's a week. More is the point that this will appear, as far as the notes are concerned, the clinical notes, in your first interaction with Code A the previous note on the 23rd of August said: "No pain," and then yours he is almost written off: "I am happy for nursing staff to confirm death." Why would that be written that early on?

No comment.

Code A

No comment.

(Pause) Doctor when you wrote: "Happy for staff to confirm death," what brought you to the conclusion, what were the inferences on you that led you to that conclusion to write that?

Code A

No comment.

You clearly felt that he was dying, or could die. Is that correct?

No comment.

And possibly when you're not in the hospital. Is that correct?

No comment.

What were you aware of when he had his treatment at the QA Hospital?

No comment.

Well we know that Code A had obviously read the notes because of his clerking-in of Code A on the day he came in on the 23rd, and in those notes at the QA he had been written up, at least once, 'not for resus'. Were you aware of that?

No comment.

Did that influence you in writing: "Happy for staff to confirm death."?

No comment.

Code A

What is your understanding of that term 'not for resus'?

No comment.

Well to put it crudely it doesn't mean 'to let the patient die' does it?

No comment.

My understanding is that if the patient would say fall into cardiac arrest, something along those lines, he would not be considered for resuscitation in that circumstance, is that right?

No comment.

(Somebody coughs) So did that term influence you when you wrote that?

No comment.

Well what made you write it then?

No comment.

What did you feel he was dying from?

No comment.

Code A

What were the signs of him dying?

No comment.

Okay Code A

(Pause) I'm going to do a bit more on that. (Pause) 'Not for resuscitation', paragraph 25 of your statement. 'It was my impression that when I assessed Code A on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to the (inaudible) was quite inappropriate. Any such transfer was very likely to have had a further serious effect on his health'. So you're saying in your statement that you were influenced by previous decisions that he was not for resuscitation. Is that correct doctor?

No comment.

The meaning of 'not for resuscitation' is quite specific isn't it? I believe a medical judgement has been made that 'in the event of the patient's heart or breathing stopping unexpectedly, cardio respiratory arrest, there is little or not chance of cardiopulmonary resuscitation being successful, that is it being medically futile and should not be attempted. This is usually on a background of a progressive life threatening illness or other significant medical problems'. What was Code A progressive life threatening illness?

Code A

No comment.

And the status of 'not for resuscitation', that does not mean that the patient is automatically excluded from receiving appropriate treatment for other medical problems that may arise. I mean even patients that are suffering from really advanced cancer who may be admitted seriously unwell with an infection, they would be treated for the infection wouldn't they doctor?

No comment.

(Pause) I find it (clears throat) hard with the medical notes as they are that on Page 54 Code A is saying 'his mental score is very good, he's better in himself, there's no pain' and that's on the 23rd of August, and on the 26th of August you're writing him off doctor aren't you?

No comment.

Code A

That's quite a line there doctor. Had you given up hope of saving Code A s life...

No comment.

...at that stage?

Code A

(Silent)

At that stage doctor?

No comment.

(Pause) But what was his progressive life threatening illness?

No comment.

Obesity, arthritis in both knees, immobility, pressure sores? I just don't see the life threatening illness so far? Cellulitis. (Pause) (Clears throat) (Inaudible – mumbles).

Yeah.

I don't want to move on to, if we start something else we'll probably get into too big a subject,...

Yeah sure.

...so I think now would be a good time to actually end this interview and take a lunchtime break shall we say, okay. Is there anything you wish to clarify doctor?

No thank you.

Is there anything you wish to add?

Code A

No thank you.

Okay. As I said before I'll give you the notice explaining what will happen to the tapes at the end of the whole process. The time is now 1155 hours and we will turn the recorder off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AM

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2004

Time commenced: 1311 Time concluded: 1349

Duration of interview: 38 MINUTES Tape reference nos.
(→)

Interviewer(s): Code A

Other persons present: Code A - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This interview is being tape recorded, I am Code A Code A My colleague is?
	Code A
	I am interviewing Code A Doctor will you please give me your full name and your dated of birth?
	Jane Ann BARTON, Code A

Code A

Also present is Code A who is Code A solicitor. Can you please introduce yourself and your full name?

Certainly. It's Code A and I am Code A Code A solicitor.

Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 1311 hours and the date is Thursday the 6th of April 2006 (06/04/2006). At the end of the whole procedure that's when I'll sort out the paperwork for the tapes okay. I must remind you doctor that you're still entitled to free legal advice. Code A is here as your legal advisor. Have you had enough time to consult with Code A n private or would you like further time?

Fine thank you.

Okay. If at any time you wish to stop the interview and take legal advice just say and the interview will be stopped in order that you can do this. I'd also like to point out that you have attended voluntarily, you're not under arrest and you have come here of your own free will. So if at any time that you wish to leave you're free to do so okay.

Thank you.

I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention, when

questioned, something which you later rely on in court and anything you do say maybe given in evidence. Do you understand that caution doctor?

I do.

I broke it down earlier this morning, is there any need for me to break that caution down now?

No thank you.

Likewise, the same as this morning, on this occasion the room that we're in has been equipped with a monitoring facility. Whenever that red light there is on it means that somebody is listening to the interview, this afternoon it's Code A who will be monitoring the interview. When the tapes aren't running and it's not in record mode, no conversation can be heard in this room by that facility okay. Right (clears throat) now we've had a break for lunch doctor, can I just ask you to confirm that there's been no conversation between us, the police, and yourself regarding this matter when the tapes haven't been running?

Code A

None at all.

Thank you. What I would like to move on to now doctor is Death Certificates. The completion of a Death Certificate is a formal legal requirement that can only be undertaken by a medical practitioner. There are specific guidelines to

be followed and what I'd like to try and get is an explanation from you as to your understanding of what was required of you in the completion of this process. Now I have in front of me the Medical Certificate Of Cause Of Death for Code A We'll have to give that an identification reference I believe won't we?

Yeah. The next one will be 22.

So it's CSY/HF/22. Can you see this doctor?

(Silence)

Who completed this Death Certificate with regard to Code A

No comment.

Code A

(Pause) At the bottom of this certificate doctor is a, well there is a certificate saying: "I hereby certify that I was in medical attendance during the above named deceased's last illness and that the particulars and cause of death above written are true to the best of my knowledge and belief." And it has a signature; can I ask you to confirm if that is your signature?

(Pause) Yes.

And underneath is written Code A with your address. And the cause of death, which took place on the

3rd of September 1999 (03/09/1999) has been recorded as 'myocardial infarction' and the approximate interval between the onset of this illness and death you recorded as five days. Is that correct?

No comment.

(Coughs) What procedure did you follow when certifying or recording the death of this patient?

No comment.

What procedure did you follow in certifying or recording the death of any patient?

No comment.

Code A

Who informed the registrar or coroner?

No comment.

Who decided the cause of death?

No comment.

Why was the death recorded as myocardial infarction?

No comment.

(Pause)

For the benefit of the tape Code A and Code A talk between themselves, which is inaudible.

Isn't that right doctor that this process should be carried out by the consultants or senior clinician?

No comment.

Why were you completing the certificates?

No comment.

(Pause) Here on this certificate there doctor it states that 'a post-mortem was not being held and the patient was seen after death by you'.

Code A

For the benefit of the tape, Code A and Code A talk between themselves, which is inaudible.

Supervision doctor, and this gives you an opportunity to explain how the line management operated at the hospital and whether the supervision that you were provided with was efficient. What supervision were you given or provided with in respect of the care of Code A Code A

No comment.

Were you happy with the level of supervision?

Code A

No comment.

Were you happy with the training that you had been provided with in order to care for patients whilst a Clinical Assistant at the War Memorial Hospital?

No comment.

If there were any deficiencies what were they?

No comment.

If there were any deficiencies how did you try to address them?

No comment.

At the time of Code A admission to the Gosport War Memorial Hospital, did you have any concerns regarding your personal workload?

No comment.

How would you report whether you had any concerns regarding staff or workload issues?

No comment.

What concerns, if any, did you have about the Gosport War

Memorial Hospital at this time?

Code A

No comment.

What training, in respect of any issues whether they were medical or pharmaceutical, did you raise in (inaudible due to banging in background)?

No comment.

Who was your line manager?

No comment.

And who did you supervise yourself?

No comment.

What would have been the correct route for you to take if you had any concerns about the level of supervision at that hospital?

No comment.

Did you have an appraisal system in operation there?

No comment.

How was your contract renewed at GWMH?

Code A

No comment.

Did you have, if you had an appraisal system or something like that, did you have the opportunity to discuss with your supervisors your role, how things were going etcetera?

No comment.

Did you, in any way; discuss your role and how it was going with any supervisors?

No comment.

Did you have any concerns about the way your role was going?

No comment.

You've already discussed previously, I believe, your (clears throat) role at the hospital and how things had not significantly changed from you starting there. In actual fact I think I was able to show you that the number of beds had decreased in the late '90s compared to the number that you were expected to supervise and be responsible for when you first took the role up, and yet you say in your first 'prepared statement' that 'things were getting too much'. Did you discuss that with anybody there at the hospital?

No comment.

Code A

Do you think that it had an impact on your ability to do your job at the hospital...

No comment.

...sufficiently?

No comment.

Efficiently?

No comment.

Professionally?

No comment.

Competently?

No comment.

Adequately?

No comment.

Code A

No.

Code A

What I'll do now is to try and take you chronologically through the Medical Records for the period that Code A Code A was on Dryad Ward. And probably the most simple place to start is with Page 54 and this is the initial assessments or clerking by Code A Now the clerking doctor noted that Code A ongoing problems were obesity, arthritis in his knees, immobility, pressure sores and constipation. It was noted that Code A Code A was 'on a high protein diet, queried melaena which was on the 13th of August 1999 (13/08/1999), his haemoglobin was stable, he was better in himself with a good mental test score and no pain. There was little to find here on this doctor, Page 54 which is in front of you if you want to examine it, that there was anything wrong with Code A Code A bar obesity, the swollen legs and pressure sores. Do you agree?

No comment.

We can move on possibly to the nursing notes now on Page 62. Do feel free doctor to have a look at any of these pages if you wish. Now they record that Code A was transferred from Ann Ward, I think it's at the Queen Alexandra Hospital following an episode of immobility and (inaudible sounds like sickle) sores, he was catherised, on a profile bed hoist only, able to feed himself and Code A Code A is waiting decision (inaudible) at the QA Hospital tomorrow'. Now several nursing plans, or Nursing Care Plans were produced, Page 78, Page 82, Page 84, Page 96 and these plans were for his immobility, in fact

he was prone to constipation. There was a care plan for the urinary catheter. Another care plan for the pressure sore areas. Who instigated these care plans?

Code A

No comment.

If the nursing staff had these care plans, whose directions were they following?

No comment.

(Pause) I think it's Page 170, which is a Drug Chart, that reveals he was continued on regular Doxazosin 4 milligrams once a day, Frusemide 80 milligrams once a day, (inaudible – Clexane?) 40 milligrams twice a day, Paracetamol 1 gram, or 1g four times a day. He was commenced on Magnesium Hydroxide 10 millilitres twice a day, which is a laxative and that was subsequently taken intermittently and as required Gaviscon. So that was the drugs that he was taking on the 23rd of August. So where doctor, when you look at the Nursing Care Plans, you look at the clerking, you look at the medication, where does it say that there is anything wrong with Code A bar his obesity, swollen legs and pressure sores?

Code A

No comment.

(Pause) On the 24th of August Mrs, this is quite interesting, on Page 90 is a handling profile (pause) and in this section for pain it is noted 'pain needs to be controlled'. Now this

is at odds with the medical notes, or the clerking, where it says that 'there was no pain'. Can you explain how this entry came to be?

No comment.

Pain is not mentioned anywhere else. 'His bowels were well open, there's no melaena specified and swabs were taken from his pressure sores from Microbiology'. (Pause) Right Page 207 (pause) should be a blood test result. The blood test revealed a haemoglobin of 12 grams/DL. The white cell count was 12.2x10 (inaudible – mumbles), it's on Page 207. Have you got that?

Yeah.

Code A

What does that mean?

No comment.

I think it also states that 'there's a marginally (inaudible) of 8.9 and a reduced albumin'. Now both these forms had been signed just there doctor J.A.B. Is that your initials?

No comment.

For the benefit of the tape Code A and Code A talk between themselves, which is inaudible.

Page 190 of the Medical Records doctor is (pause) a

Biochemistry Report authorised on the 26th of August 1999. Again there is the initials of J.A.B. written there. Is that your initials?

No comment.

I am going to hold it up in front of you doctor so that you can see it.

No comment.

Doctor would a doctor initial these reports to say that he or she had seen the results?

No comment.

Code A

What would those results indicate to you?

No comment.

Do you want to say anything Code A

Why do doctors initial those reports Code A

No comment.

Is it not to acknowledge that they have seen the report?

No comment.

Code A

(Pause) On the 25th of August doctor Code A was noted to have bowels open, melaena formed, leaking some fluid and later several loose bowel actions throughout the afternoon and evening, some fresh blood present, query due to medication, (inaudible) stopped to review later'. That's Pages 82 and 83. (Pause) Now the 'nursing summary notes' record that Code A had been passing fresh blood and queried. Was it due to the (inaudible) or the Clexane? And a verbal order from Code A was to withhold the six o'clock in the evening dose and review with Code A in the morning'. Did you review this the next morning?

No comment.

Page 171 says that Code A was also vomiting and Metoclopramide, 10 milligrams, was given at five-to-six (1755) in the evening. Code A was taking Temazepam 20 milligrams at five-past-ten (2205) that night and Loperamide 4 milligrams, which I believe is for diarrhoea as a one off dose' and it's a time that I can't quite work out I must admit, it's on Page 168. (Pause) On the 26th of August the 'nursing summary notes' record 'a fairly good morning, no further vomiting. Code A contacted re' (inaudible) or the Clexane and advised to discontinue and will repeat haemoglobin today and tomorrow, not for resuscitation, unwell at lunchtime, colour poor, complaining of feeling unwell. (Pause sounds like door being shut) This was seen by Code A his afternoon, await result of haemoglobin, further

deterioration complaining, query indigestion, pain in throat, not radiating, vomited again this evening'. Now verbal order from Code A 'Diamorphine 10 milligrams stat', which was given at six o'clock that evening. Did you see Code A on the 26th of August in the afternoon?

No comment.

What were you expecting from the results of the haemoglobin?

No comment.

Why did you give the verbal order for Diamorphine?

No comment.

Code A

Again on Page 55 I think it is, these should be your notes I think.

Yeah.

'Called to see pale, clammy, unwell. Suggest query myocardial infarction. Treat stat Diamorphine and Oramorph overnight. Alternative possibility gastro intestinal bleed, or GI bleed, but no haematemisis'. What made you think that it was possibly a myocardial infarction doctor?

No comment.

Code A

What is a myocardial infarction?

No comment.

Did Code A have any previous medical history of myocardial infarction?

No comment.

If Code A had suffered a myocardial infarction, what benefits would 10 milligrams of Diamorphine be?

No comment.

(Pause) You've got 'suggest query myocardial infarction'. Does that mean it was just a possibility it was a mycocardial infarction?

No comment.

The same with the 'alternative a possibility of a GI bleed'. With those two possible diagnoses, what did you do to treat Code A

No comment.

You also state 'he was not well enough to transfer to an acute unit, keep comfortable and I am happy for nursing staff to confirm death'. (Pause) Have you got any

questions on that Geoff?

My understanding doctor is that when a doctor puts a question mark in front of something, that is because something has happened to the patient that leads that person to believe that whatever follows the question mark may be occurring or may have occurred. Is that right?

No comment.

The fact that you put the question mark in front of myocardial infarction and then queried the gastro internal bleed in the case that you felt that that's what might be happening to Code A is that right?

Code A

No comment.

Now presumably a doctor wouldn't just think 'the person might be having this, the person might be having that' and then not do something to find out whether that person was having this or that. Is that right?

No comment.

What investigations did you then commence to find out what that patient, Code A was suffering from?

No comment.

All right that takes us up to the 26th where you're queering

the myocardial infarction or a GI bleed. What I am going to do then is just take you to some of the questions around your 'prepared statement'. (Pause) Geoff have you got a calendar? (Pause) Have you got an identification reference?

Code A

CSY/HF/23.

Thank you. Paragraph (3) of your statement doctor, I can see you have it in front of you, in that statement (clears throat) 'I indicated when I'd first taken up the post the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was, in effect, left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998. I confirm that these comments are indeed a fair and accurate summary of the position then though, if anything, it had become even more difficult by 1999 when I was involved in the care of Code A Geoff do you want to...

Code A

No comment.

Yeah, okay. Doctor so we look at this exhibit, which we're calling now CSY/HF/23, and it's a printout of the calendar months for August and September of 1999 and you can see from that that I'm showing you look that on the 23rd of August Code A was admitted to the ward, Dryad Ward, and on the 24th you made an entry on his records, on the 26th sorry not the 24th you made an entry didn't you on his records and you made entries into, I can't remember what the 24th was Code A do you know what it was?

No comment.

Yes on the Drug Chart.

No comment.

On the Drug Chart that's right. But in the main records you've only made two entries, the 26th and the 28th, the 28th being a Saturday. Now going on your previous history of what you've told us and what we've worked out of your daily routines, if we count out the number of days Code A Code A was in hospital, at your hospital, he came in on the 23rd, one, two, three, four, five, six, seven, eight, nine, ten, he was in for ten days in total. Now you say that 'you visited the hospital three times a day maximum, so that makes a total of thirty possible visits doesn't it? Thirty possible times you could have seen Code A given

that you think on the 26th, as early as the 26th you think he's possibly had a myocardial infarction or a GI bleed. You only have one other visit to him after that recorded. Is that right?

No comment.

How can you account for the fact that despite this man being go gravely ill that you have recommended the nurses to, or happy for them to confirm death. You've got no entries, very relative entries, very few entries in the notes, only two in his medical notes (somebody coughs) the 26th and the 28th. Can you explain that doctor?

No comment.

Explain, can you explain to us what the Speciality History sheet is for then?

No comment.

(Pause) Well can you tell us which of those days from the 23rd up to his death on the 3rd of September, can you tell us which of those days you were not available for?

No comment.

You say in your statement that 'the pressure is put on you on how busy you were and had become considerable in 1999'. The Dryad Ward Admissions book, which is

Code A

BJC/89, which I will put in front of you, it shows quite clearly that between the 17th of August 1999 (17/08/1999) and the 31st of August 1999 (31/08/1999), that's fourteen days, two patients were admitted to that ward Code A Code A and a Code A Now I accept that the other beds may be full, but you had two new admissions. Now part of your Job Description says that 'you must see new admissions'. Is that correct?

No comment.

Does that register indicate that that was a busy time?

No comment.

(Pause) It doesn't seem to doctor, or you tell us otherwise?

No comment.

Code A

(Pause) The last patient before Code A was almost a week before. Is that right?

No comment.

And the next patient after Code A was the day after. (Pause) Is that right?

No comment.

And does that represent a really busy time at the hospital

for you...

Code A

No comment.

...compared to other times?

No comment.

You see Paragraph (22) in your statement says that 'you state that you anticipate that you would have reviewed Code A Code A on the basis that you prescribed drugs for him on the 24th of August, that's Page 168 of your medical notes. Now you state in your generic statement on pages 3 and 4 that 'you visited patients every day and you would admit and write up charts etcetera. In addition you'd return to the hospital every evening to continue with these duties'. Code A is just showing you the calendar there, why then did it take you three days to make an entry in Code A Code A medical notes?

Code A

No comment.

Why isn't there any reference to his general condition, or comment re.: care plans or drugs?

No comment.

Let me take you back doctor to Paragraphs (12) and (13) of your statement. Paragraphs (4) to (11) are pretty much Code A Code A previous medical history, so if we go to

Paragraph (12) 'it was also noted on the 6th of August that in view of pre-morbid state/multiple medical problems, Code A Code A was not for CPR in event of arrest. A Barthel score was stated to have been assessed on the 5th of August (presumably the 6th of August in error) was recorded as zero, indicating that Code A was completely dependent'. Paragraph (13) Code A was reviewed by the specialist registrar the following day, 7th of August, who agreed, presumably on the basis of what was felt to be Code A poor condition at that stage, that he was not to be resuscitated in the event of arrest. It was suggested that his anti-hypertensive medication should be changed to an ACE inhibitor in view of the oedema and he was considered for a beta-blocker in view of his atrial fibrillation. His diuretic was changed lest it caused dehydration. Code A was given Flucloxacillin 500 milligrams 4 times daily, supplemented by Penicillin 500 milligrams four times a day to combat the cellulites'. Now this cardiac arrest and resus policy, I think we spoke about this earlier on this morning, what is the resus policy, or not for resus policy?

Code A

No comment.

Am I right in thinking that should somebody have a heart attack, or stop breathing, then for those purposes they're not for resuscitation?

No comment.

Code A

What about any illnesses they may have, should you still be treating those?

No comment.

I mean Paragraph (19) 'an entry in Code A records for 20th of August by the specialist registrar indicates that Code A was due for transfer to the Gosport War Memorial Hospital on the 23rd of August. The Specialist Registrar also noted that Code A remained not for resuscitation. A Barthel score measured on the 21st of August again recorded a score of zero indicating his complete dependence'. Yet on his arrival at the Gosport War Memorial Hospital it was six. Was that not an improvement?

Code A

No comment.

Any questions Code A

No.

The tape is about to come to an end so the time is 1359 hours, I am going to turn the recorder off.

INTERVIEW CONCLUDED. TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AN

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

Person interviewed: **Code A**

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1354 Time concluded: 1355

Duration of interview: 1 MINUTE Tape reference nos. (→)

Interviewer(s): **Code A**

Other persons present: **Code A**

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	(Tape faulty) Right there's been an interruption in that tape (tape faulty). TAPE ENDS

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AO

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

Person interviewed: **Code A**

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1359 Time concluded: 1443

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

Interviewer(s): **Code A**

Other persons present: **Code A**

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the interview with **Code A** **Code A** The time is 1359 hours. The reason we've had this second break was the fault in the tape machine, which hopefully has been rectified by changing it. Can I just ask you doctor to confirm that that is the reason why we took that break?
Code A	It is.
	And has there been any conversation about the matter

whilst the tape has been off?

Code A

None at all.

Thank you. Doctor we'll try and pick up where we left off and we were referring to Paragraph (24). This states, this is your statement, 'I do not know if I reviewed Code A Code A on the morning of 26th August. He was noted by the nurses to have had a fairly good morning. Code A Code A has recorded that Code A locum consultant geriatrician, was contacted and he confirmed that the Clexane should be discontinued and the haemoglobin repeated. Again, Code A was noted to be "not for resuscitation". Code A may have contacted Code A if I was unavailable that morning. The nursing record goes on to indicate that Code A then deteriorated at about lunchtime, that his colour was poor and that he complained of feeling unwell. I was called to see him, my entry in his records on this occasion reading as followed:- 26th of August 1999 (25/08/1999) called to see, pale, clammy, unwell. Suggest, query MI, treat stat Diamorph and Oramorph overnight. Alternative possibility GI bleed but no haematemisis. Not well enough to transfer to acute unit. Keep comfortable. I am happy for nursing staff to confirm death. As my note indicates, I was concerned that Code A might have suffered a myocardial infarction and accordingly I decided to administer opiates in the form of Diamorphine for pain and distress consequent on the possible mycocardial infarction, at a dose of 10 milligrams intramuscular. In addition, I

would have been conscious that he had large pressure sore areas on his sacrum and thighs, which would have been causing him significant pain and discomfort. I prescribed 10 milligrams Diamorphine intramuscularly to be given immediately, which is recorded on the Drug Chart as a verbal instruction. An alternative diagnosis, which I recorded was that Code A had had a gastro intestinal bleed'. Now you state that 'you were called to see Code A on the 26th'. This must have been after six o'clock in the evening. There's an entry on Page 168 that shows you gave a verbal order at that time to Code A Code A for Diamorphine. This is now nearly four days since Code A arrived. Well why is that the first time that you've seen him?

Code A

No comment.

On Page 168 of the medical notes (pause), (inaudible) Page 172 (pause) there are two entries for Oramorph there. Why is that?

No comment.

And also on Page 168 'once only and pre-medication drugs'. There are two prescriptions for Diamorphine on there. Why is that?

No comment.

That will be the only one that was given?

Code A

No comment.

Code A can I just say something here that obviously all questions are important, but we feel that the questioning around the Prescription Chart is very important to your client and can you just confirm that your client has had an opportunity to consult with those original charts?

You've provided the original Prescription Chart to Code A Code A it's available for her to consider, but I don't think it's appropriate for me to comment...

No thank you...

...further.

...that's fine, thank you very much for that cheers.

What other drugs did you prescribe on the 26th?

No comment.

(Pause) Now the Drug Chart shows that he received Diamorphine, 10 milligrams at six o'clock in the evening and that was the verbal order. As I pointed out the prescription was repeated below this one, it doesn't appear to have been given. 'Or a Morphine solution, Oramorph was commenced regularly, 10 – 20 milligrams every four hours with 20 milligrams at night', which meant Code A

Code A had continued until ten o'clock on the 30th of August 1999 (30/08/1999). Regular Oramorph solution 10 milligrams every four hours was also prescribed in the Daily Review Prescription. Is that where it should be?

No comment.

Because it appears as though it's duplication doctor, I just wonder if you could clarify?

No comment.

(Pause) Diamorphine 40 – 200 milligrams and Midazolam 20 – 80 milligrams subcutaneously over a twenty-four period were also prescribe on the 26th of August 1999 (26/08/1999) (coughs), that's on Page 171. Why was this doctor?

Code A

No comment.

Why did you prescribe these drugs?

No comment.

On Page 171 doctor...
Have you got it there Code A

(Inaudible)

Code A

...what explanation can you give as to why Code A has completed a prescription for Oramorph on Page 171 and you have countersigned it? That signifies it is blatantly not in your handwriting although signed by you with the blue pen, that Code A used elsewhere.

No comment.

Should she fill in that part of the prescription sheet?

No comment.

Did Code A prescribe it?

No comment.

Was this given as a verbal order?

No comment.

(Pause) You know that on the 26th of August 1999 (26/08/2006) doctor that the nurses contacted Code A Code A who is a locum consultant geriatrician who advised that the Clexane be discontinued and that Code A 's haemoglobin to be checked on the 26th and 27th of August 1999 (26-27/08/1999). The haemoglobin level on the 26th of August was 7.7, it's on Page 205.

For the benefit of the tape Code A and Code A talk between themselves, which is inaudible.

Code A

If you can just bear with me doctor.

For the benefit of the tape there is a long pause whilst Code A Code A and Code A talk between themselves, which is inaudible.

We'll have to come back to that Code A

Yeah come back.

We'll come back to that doctor. (Pause) Right still moving on here though throughout your statement doctor you refer to Code A being 'not for resuscitation', several times in your statement. What explicitly is your understanding of the meaning and implications of that term?

No comment.

(Inaudible) that a medical judgement has been made that in the event of a patient's heart or breathing stopping unexpectedly, cardio respiratory arrest, there is little or no chance of cardiopulmonary resuscitation being successful or medically futile and therefore it should not be attempted. Is that right doctor?

No comment.

Is this usually on the background of a progressive life

threatening illness, or other significant medical problems?

No comment.

Does this status mean that the patient is automatically excluded from receiving all appropriate treatment for other medical problems that may arise?

No comment.

(Pause) You know that Code A deteriorated about lunchtime on the 26th of August 1999 (26/08/1999) as he was reported 'to have had a fairly good morning'. This would have represented an acute deterioration in his condition. Your entry note that Code A was 'pale, clammy and unwell'. Does this suggest he was shocked?

Code A

No comment.

And I will invite you to look at these Medical Records yourself doctor if you wish, but why weren't his basic observations such as his temperature, heart rate and blood pressure recorded?

No comment.

What would these observations have told you?

No comment.

Code A

Why did you feel that it wasn't necessary to perform or record these findings?

No comment.

The nursing notes/entries suggest that 'he was complaining of indigestion with pain in the throat, which was not radiating', again associated with vomiting. Why did you query a myocardial infarction?

No comment.

What were the medical findings that led you to consider that he had a myocardial infarction?

No comment.

What examination, or tests did you undertake that would lead you to consider that he had a myocardial infarction?

No comment.

You also recorded that 'an alternative possibility was a gastro intestinal bleed, but note that Code A had not vomited blood', given Code A history of possible melaena, reported at the QA Hospital, which is on Page 54, and the fresh bleeding the day before. Why didn't you make any further enquiries to determine whether Code A Code A was suffering from a GI bleed?

Code A

No comment.

What is a GI bleed?

No comment.

(Pause) How should it be treated?

No comment.

(Pause) How was it diagnosed?

No comment.

So what medical findings led you to consider he may have had a gastro intestinal bleed?

No comment.

All that together doctor, on what basis did you satisfy that a myocardial infarction was the more likely diagnosis?

No comment.

Why was Code A prescribed Diamorphine for the treatment of pain due to his pressure sores?

No comment.

(Pause) At the Queen Alexandra Hospital his only

analgesic was Paracetamol. In the medical clerking whilst transferred to Dryad Ward, which is on Page 55 I think, and in the Nursing Care Plan relating to his pressure sores he only need Paracetamol. Why then was there a need to significantly increase the opioid levels?

No comment.

Why wasn't this decision making process recorded, especially as you were called in to specifically treat Code A Code A

No comment.

Code A

(Pause) Geoff do you want to ask anything?

No not at the moment Code A

No comment.

Paragraphs (25), (26) and (27) then doctor. Paragraph (25) – 'My impression when I assessed Code A on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to an acute unit was quite inappropriate. Any such transfer was very likely to have had a further deleterious affect on his health'. (26) – 'The nursing note for the 26th of August indicates that we were to await blood test results. There was then a further deterioration later in the day, with Code A

complaining of indigestion and a pain in his throat, which was not radiating'. Paragraph (27) – 'The blood count taken on the 26th of August subsequently showed that Code A Code A haemoglobin had dropped to 7.7 grams, a substantial drop from the 12 grams, which had been recorded two days earlier'. Now the part where you state that Code A was very ill and in view of his condition and a previous decision that he was not for resuscitation, transfer to an acute unit was quite inappropriate'. Could you explain that to me doctor?

Code A

No comment.

(Pause) Why, although ill and deemed not for resuscitation, does this exclude Code A from receiving appropriate medical care?

No comment.

(Pause) Why, given your clinical description of Code A Code A being shocked, did you not undertaken simple observations such as temperature, pulse and blood pressure?

No comment.

(Pause) If you were convinced that a myocardial infarction was likely, why didn't you perform an ECG to help make the diagnosis for a myocardial infarction?

Code A

No comment.

(Pause) Given that you considered the possibility of a gastro intestinal haemorrhage why not, in addition to the simple observation, get into contact with the laboratory to obtain a result of the haemoglobin taken earlier that day?

No comment.

Because as we know, and you've put in your statement doctor, it turns out we've revealed the drop of haemoglobin to 7.7., a considerable drop. (Pause) During Code A Code A acute deterioration, which was considered significant, why didn't you discuss it with Code A or Code A or the medical team on call at the QA Hospital?

No comment.

If a patient becomes unexpectedly, or acutely unwell doctor, wouldn't it generally be appropriate to identify the reason for it and to investigate appropriate medical management?

No comment.

(Pause) And taken into account this patient's particular circumstances, could this include insuring they are cared for in an environment best suited to meet their medical needs?

Code A

No comment.

So what you said doctor is 'he was so ill that he couldn't be transferred'? (Pause) What would happen if Code A had been at home and his wife found him in this way?

No comment.

Would it have been reasonable to expect that an ambulance would be called and he would be taken to a hospital where he would be cared for?

No comment.

Well would a doctor make a decision that he's so ill moving him would be deleterious to his condition so we'll leave him at home?

No comment.

Because surely the same would apply at the Gosport War Memorial Hospital. If the hospital is not set up to deal with the man's condition, would it not be appropriate to move him doctor?

No comment.

Having made the diagnoses that he was suffering from

myocardial infarction, or a gastro intestinal bleed, both serious but both treatable, why did you choose to leave him on Dryad Ward?

No comment.

Why didn't you perform an ECG?

No comment.

We know that there was an ECG available at the hospital. Where was it doctor?

No comment.

(Pause) Actually doctor let me show you the Lab Report that we couldn't find just now. (Pause) His specimen was taken on the 26th of August 1999 (26/08/1999) and this shows the drop (pause) in the haemoglobin had dropped to 7.7 grams from 12 grams from two days earlier. Is that your signature on that doctor?

No comment.

I know you've seen that doctor because you mentioned it in your own prepared statement, so I am showing you it again it is Page 205 of the copy file.

Code A could, what you've got in your hand, could you read the bit there for the doctor?

Code A

Code A

Yes it says Comment – Many attempts were made to phone these results, no answer from Gosport War Memorial switchboard.

So the lab had obviously realised that there's a drop, they want to get those results through. Why didn't you phone the lab when you suspected a GI bleed?

No comment.

What attempts did you make to treat either of the illnesses that you diagnosed?

No comment.

What would the treatment for myocardial infarction be?

No comment.

And what is the treatment for a GI bleed?

No comment.

Do you know what a GI bleed is?

No comment.

Would I be correct in thinking that even a medical student would understand that a GI bleed could be a medical

emergency?

No comment.

In fact it has been mentioned to me, and I did put it to test, that you can put GI Bleed into Google and find out that it's a medical emergency.

No comment.

If you weren't sure, why didn't you take advice?

No comment.

Code A

(Pause) What are the specific guidelines on the usual management of acutely ill patients at the Gosport War Memorial Hospital?

No comment.

Were there any guidelines, or protocols, or practices in existence that would specifically prevent, or encourage the transfer of acutely ill patients to the main hospital?

No comment.

(Pause) What facilities for general resuscitation were available, e.g. the ability to obtain venous access, (inaudible) venous infusion or fluid?

Code A

No comment.

For blood transfusions, things like that?

No comment.

When did you become aware, doctor, of the full blood count result from the 26th of August?

No comment.

Because we can see you were aware of it at some time because you initialled it doctor.

No comment.

(Pause) Why wasn't it documented in his medical notes?

No comment.

Did you notify Code A or Code A with the result?

No comment.

You signed that Lab Report doctor, which is Page 205, and given that a large drop of haemoglobin had been demonstrated, on what grounds did you continue to consider a myocardial infarction more likely?

No comment.

Not only did you regard it as 'more likely', it was recorded as the cause of death.

No comment.

What made that the stronger diagnosis than your alternative diagnosis of a gastro intestinal bleed?

Code A

No comment.

So that was in light of the Lab Report that you received showing that significant drop in blood?

No comment.

Code A

Doctor you've recorded 'query melaena', myocardial infarction sorry 'and possible GI bleed', and Code A has just asked you 'what steps you took to eliminate one or the other'. So in other words to find out what was wrong with Code A You've got an opportunity now, today, to tell us what steps you took to find out what was wrong with Code A What steps did you take doctor?

Code A

No comment.

Code A

What steps could you have taken doctor?

No comment.

For instance regarding myocardial infarction, could you have arranged for an ECG to be performed?

No comment.

And would that have indicated to you that he had or didn't have myocardial infarction?

No comment.

Similarly we've just discussed GI bleed and as I understand it if somebody is bleeding lower in the intestine you're stools would come out red. Is that right?

No comment.

And if it's higher they come out black tarry. Is that right?

No comment.

And it is one of the simpler diagnoses to make I believe isn't it...

No comment.

...for even a junior doctor?

Code A

No comment.

How would you go about investigating whether a patient had a GI bleed?

No comment.

Well you can ask for blood results, blood tests couldn't you?

No comment.

And in fact bloods were asked for weren't they?

No comment.

Code A had asked for the blood tests.

No comment.

And was it not your plan to await lab results...

No comment.

...for Code A

No comment.

Well you did wait for blood results didn't you?

Code A

No comment.

And when I say that you just waited. Is that right?

No comment.

What else could you have done to establish whether Code A had a GI bleed?

No comment.

Did you consider and endoscopy?

No comment.

What are the considerations for an endoscopy with a patient suffering (somebody coughs), suffering from a GI bleed?

No comment.

You'd put it down on the paperwork that 'he might have a GI bleed' and yet it looks as if you haven't followed this up.

No comment.

Code A Well the lab obviously recognised that he was a medical emergency and tried to contact the hospital, but couldn't get through. We can't blame you for not answering the phone can we? No

one is seeking to, but what steps did you take to get the results of those blood tests?

Code A

No comment.

Well when did you see those tests then?

No comment.

You signed them didn't you?

No comment.

We've already asked you 'why you didn't feel that he could go to the QA Hospital'. In Code A case doctor. No let me start again, if you had gone out to a patient at home with the same symptoms that Code A Code A had, i.e. you queried whether that patient lying in their bed at home had an myocardial infarction or possibly a GI bleed. Would you have just left them in their bed at home?

Code A

No comment.

I take it you wouldn't, and I take it you would have caused him to treble nined (999) to the nearest hospital. Would you have done that?

No comment.

Code A

Why didn't you do that with Code A

No comment.

Do you feel that Code A was at a disadvantage because he was already in your hospital then?

No comment.

If you weren't willing to have him transferred to an acute bed, do you feel he was at a disadvantage?

No comment.

Right now we'll move on then to Paragraph 28. You state that 'you were concerned that Code A should receive appropriate medication to relieve his pain and distress, and therefore gave him Oramorph 10 – 20 milligrams four times a day and 20 milligrams at night'. So what dose of drug was given to Code A during the day?

No comment.

Was it 10, or was it 20 doctor?

No comment.

Page 172 of the notes show that a range was available, but the record does not show what dose was given. Why is

this?

Code A

No comment.

When this range is given, who decides on the size of the dose given?

No comment.

(Pause) And what safeguards were in place preventing the inadvertent, or inattentive administration of these drugs to Code A

No comment.

So what doses of Morphine did Code A actually receive that day?

No comment.

I'll change it slightly then, what explicitly was the pain and distress that Code A was in?

No comment.

It's this range of drug again doctor isn't it? 10 – 20 milligrams four times a day, 20 milligrams at night. If I was to pick up those medical notes as a nurse, how would I know whether to give 10 or whether to give 20 milligrams?

Code A

No comment.

Or would the choice just be mine?

No comment.

Geoff do you want to ask anything?

Yeah. Not only that doctor, we showed you earlier on this 'prescribing elderly medicine' blown up chart taken from the BNF GJQ/HF/21, and we showed you, did we not, that we had the 10 milligrams Morphine Sulphate oral solution and you'd prescribed 40 milligrams of Diamorphine, which was beyond the guidelines, above the guidelines, you should have been prescribing say 20 milligrams, and Chris has just said: "What safeguards did you put in place to make sure that Code A didn't receive the wrong drugs, or too much of the drugs?" because as we pointed out with the Oramorph how would a nurse know whether to give the 10 or the 20?

Code A

No comment.

And similarly how would a nurse know whether to give 10 milligrams of Oramorph and on this chart it's second in the table on the weaker side, or 200 milligrams of Diamorphine which is way down here look on the right hand side.

No comment.

Code A

What prevents a nurse from doing that doctor...

No comment.

...because that is the open range you've prescribed isn't it...

No comment.

...on the same day that you prescribed the Oramorph?

No comment.

Do you think that is an acceptable way to write up a Prescription Chart?

No comment.

In answer to what Code A has just been asking, Paragraph (29), you actually say 'I also wrote up prescriptions for Diamorphine 40 – 200 milligrams subcutaneously over 24 hours, together with 20 – 80 milligrams of Midazalam via the same route on an anticipatory basis, concerned that further medication might be required in due course to relieve Code A pain and distress. It was not my intention that this subcutaneous medication should be administered at that time. The nursing record also indicates that I saw Code A Code A wife explaining her husband's condition and the medication we were using. I anticipate I would have

indicated to Code A that her husband was very ill indeed and in all probability that he was likely to die'. As Code A said 'you've written up prescriptions with Diamorphine 40 – 200 milligrams on the same day as you've written Oramorph 'on an anticipatory basis'. If that was the correct way of doing things doctor, where in the medical notes does it say that?

No comment.

Well where in the medical notes does it say 'to advise the nurses that this is just on an anticipatory basis and that you would require contacting'?

No comment.

I can't see any safeguard.

Code A

Well let's just take that on a little bit further doctor, let's expand on that because 'safeguard' is the appropriate word I think because when the Diamorphine syringe driver was started it was started, was it not, by Code A

No comment.

And yet you haven't recorded your authority anywhere for her to start that?

No comment.

Code A

It's possible isn't it that she didn't have your authority to start it specifically?

No comment.

'It was not my intention that this subcutaneous medication should be administered at that time'. So at what time was it to be administered?

No comment.

And how was that to be conveyed to the nurses?

No comment.

Because it seems it was started with nothing down on paper from you even post a decision. Did you give verbal authority for that medication to be started at that time?

No comment.

What I say it doesn't look as if (TAPE BUZZES), it doesn't look as if you have does it? And what is to stop, well I'll let you answer that question first, it doesn't look as if you have does it?

No comment.

And what was to stop that nurse from prescribing anywhere between the 20 milligrams of Diamorphine up to the 200?

Code A

No comment.

She seemed to start it where she thought fit?

No comment.

What was to stop her from prescribing, from administering 200 milligrams from the start?

No comment.

The buzzer sound, if we change the tapes over. Is there anything you wish to clarify?

No thank you.

Is there anything you wish to add?

No thank you.

And are you happy to continue straight on?

(Silent)

Yeah. Okay the time is 1443 hours and I am turning the recorder off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RESTRICTED

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AP

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1453 Time concluded: 1537

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

Interviewer(s): Code A

Other persons present: Code A SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the interview with Code A Code A The time is 1453 hours and a short break was taken at the end of the last tape for comfort reasons etcetera. Can you just confirm doctor that the same people are present?
Code A	Yes.
	And also that there has been no conversation whilst the tapes have been off about this matter?

Code A

None at all.

Thank you. Code A you were.

Yes where was I? (Pause)

Well if it helps at all you had asked: "What was to stop her...

Yes.

...administering 200 from the start?" Code A indicated: "No comment," and the tape ended.

Thank you very much.

So just to pick up on that last question then doctor, on that chart what was to stop Code A or any of the other nurses from going straight to 200 milligrams of Diamorphine on setting up that syringe driver?

No comment.

What were the guidelines in place for commencing a syringe driver at the hospital at the time?

No comment.

If you had authorised Code A say for arguments

sake over the phone, how should she have recorded that in the notes?

No comment.

Would she have needed another nurse with her to record what you had said?

No comment.

Did you trust Code A to carry out your instructions?

No comment.

Code A

Would Code A 'anticipate' - to use one of your words, would Code A anticipate your instructions?

No comment.

Were there ever times when Code A did things thinking that you were authorising post, i.e. she would do something and then get your authorisation after it had been done?

No comment.

Code A

Was this something you allowed her to do? (Somebody coughs)

No comment.

We know that you placed great trust in the nursing staff, or it seems that you placed great trust in the nursing staff. Was this yet another example of it?

No comment.

Code A

Just to continue on the Diamorphine aspect of things. Is it correct doctor that a drug such as Diamorphine is licensed?

No comment.

And within that licence there are particular ways that you can use that drug?

No comment.

Can you use a drug like Diamorphine in an unlicensed way?

No comment.

And if you were (clears throat), what would you be

expected to do in order to record that?

No comment.

(Clears throat) Again on Diamorphine doctor, when you visited Code A on the 26th of August 1999 (26/08/1999) you were concerned that Code A may have suffered a myocardial infarction and accordingly you decided to administer opiates in the form of Diamorphine for pain and distress consequent on the possible myocardial infarction at a dose of 10 milligrams intramuscularly. Well first of all (inaudible) myocardial infarction is. My understanding is it is a heart attack, is that correct?

No comment.

Code A

And my understanding is that Diamorphine can be administered for pain from a heart attack, but what would the correct dosage be?

No comment.

You'd prescribed a dose of 10 milligrams intramuscularly. Is it right that that is double the licence dose?

No comment.

Should that not have been a 5 milligram intramuscularly?

No comment.

Code A

Was that a mistake?

No comment.

(Pause – clears throat) But having diagnosed a possible heart attack, how important is the previous medical history in making such a diagnosis?

No comment.

What previous medical history has Code A got with heart problems?

No comment.

(Clears throat) Well what are the symptoms for a heart attack?

No comment.

Could that be chest pains?

No comment.

Nausea and/or abdominal pain?

No comment.

Anxiety?

Code A

No comment.

Light headiness, cough?

No comment.

Nausea with or without vomiting?

No comment.

So if some of these symptoms were present and you made a diagnosis of a possible heart attack, what tests should you do?

No comment.

An electrocardiogram or an ECG as most people know it, when should that be obtained?

No comment.

You are an experienced doctor and you have to undergo an awful lot of training to get to the position you are doctor and we are just detectives with no medical training, but my understanding is is that an ECG should be obtained as soon as possible after presentation to the examining doctor. ...

No comment.

Code A

...Why didn't you get an ECG?

No comment.

Is it right that approximately one half of patients have diagnostic changes on their initial ECG?

No comment.

Would it be right that an ECG should be preformed on any patient who is older than forty-five years and is experiencing any form of chest or stomach discomfort?

No comment.

And would that included new epigastro or nausea?

No comment.

(Pause) So again just carrying on from what Code A was asking, on what basis did you determine a dose range of Diamorphine 40 – 200 milligrams over twenty-four hours and Midazolam at 20 – 80 milligrams over twenty-four hours and it would be necessary for Code A

No comment.

Why was it necessary to adopt a more proactive prescribing policy in this case?

Code A

No comment.

Doctor you've been called into the hospital specifically to attend to Code A and it was seven in the evening, so you don't have to deal with anyone else in the ward it's just Code A and you'd be returning to the ward twelve hours later, so why was it therefore necessary to prescribe that range of drug?

No comment.

Geoff?

At the end of Paragraph (29) doctor the last sentence is: "I anticipate I would have indicated to Code A that her husband was very ill indeed and in all probability that he was likely to die." Now it's a question I've asked before today that that line demands the questions again, what was he likely to die of?

Code A

No comment.

What was causing his likely death?

No comment.

You'd written that day: "Possibly had GI bleed or may have been myocardial infarction." You hadn't even established what was wrong with him had you?

No comment.

If you felt at that stage that his life was being threatened, why didn't you cause some form of investigation into his symptoms?

No comment.

But you're quite willing to tell a wife that 'her husband is dying' and at that stage you don't even know what is wrong with him.

No comment.

Code A

As I understand it both conditions are serious, but are they not both reversible with correct treatment?

No comment.

Would you expect somebody with a GI bleed to die?

No comment.

Do you expect any patient with myocardial infarction to die?

No comment.

But you did in this case didn't you?

Code A

No comment.

So what was the difference between Code A

No comment.

How did you form the opinion that he was likely to die?

No comment.

Code A

You see again with your note on the 26th of August (pause) 'query MI – treat stat Diamorph, unless it's query a heart attack, and Oramorph overnight. Alternative possibility GI bleed but no haematemisis'. Did you do anything to find out which, if any of these symptoms, which of, if any of these diagnoses was correct?

Code A

No comment.

Because I can't see it recorded anywhere else in your notes. Now Code A the consultant, reviewed this patient, I think it was on the 1st of September, we will come on to that, how was he to know what you've done and what you think?

No comment.

Code A

How about 30 then doctor?

Could we just go back to 29 again Chris?

Yeah go on.

Sorry. Paragraph (27), the blood count taken on the 26th of August subsequently shows that Code A haemoglobin (HB) had dropped to 7.7 grams. You obviously feel that that is significant and it probably was significant wasn't it? But I am interested in to why you've put that at Paragraph (27) before Paragraph (29) where you're talking about his wife. Presumably you're seeing his wife the same day you wrote up the Diamorphine, which was the 26th of August and you're seeming to link 29, Paragraph (29) to Paragraph (27) aren't you?

Code A

No comment.

But you can't have your cake and eat it doctor can you (somebody coughs) because we have asked you: "When did you see that Lab Report with the 7.7 grams on it?" If you recall we showed it to you, it's open for you to have a look at again, we showed it to you and it states on there that 'the lab were trying to contact the War Memorial Hospital, but couldn't get through' and the date is the 26/08, so which way round is it doctor? Did you know about the lab result on the 26/08?

Code A

No comment.

Code A

If you had of known about the lab result on the 26/08 you could have linked it with his possible GI bleed obviously and you could have informed Code A that her husband was badly ill, very poorly, but even so was it still, was it the case that that was a reversible condition at that time?

No comment.

I say to you you wouldn't have known would you at that time?

No comment.

How could you have known when you spoke to Code A Code A that her husband probably had a condition that was likely to lead to death?

No comment.

I mean you certainly seem to be pretty convinced that Code A Code A had suffered a heart attack or possibly a GI bleed. If we go to the Death Certificate, the Cause Of Death, in the box you actually noted that 'Code A had been suffering from myocardial infarction five days prior to his death', that was the 29th of August. So what made your mind up then that on the 29th of August you knew that Code A was having a heart attack or suffering with heart problems?

Code A

No comment.

So where was this recorded in the notes?

No comment.

You had already decided that that's when he, that's when it was diagnosed and that's when he was suffering from this. How were you going to treat this?

No comment.

So what changed between your note on the 26th of August then and the 29th of August when according to the MCCD, when the myocardial infarction was diagnosed, and on the 26th it was 'query myocardial infarction – query GI bleed'.

No comment.

How do you know he had a heart attack on the 29th of August?

No comment.

Well I've been through the treatment, what I believe the treatment for a suspected heart attack is. What would you say this treatment should be?

No comment.

Code A

As in this report how would Code A know, the consultant, the doctor who has overall responsibility for this patient, how on earth could he be aware of your diagnosis if you haven't even written this down?

No comment.

Did you discuss it verbally with Code A

No comment.

Did you discuss it with anyone?

No comment.

And again moving on to Paragraph (30) of your statement doctor. 'On the morning of the 27th of August 1999 (27/08/1999) Code A appeared to have stabilised somewhat'. Right 'I would have reviewed Code A again the following and indeed the Nursing Record confirms that I attended to see him then, therefore relying on the nurses' notes. Code A had recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Code A apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Code A was said to remain poorly. 10 milligrams of Oramorph were

administered four hourly, together with a further 20 milligrams at night as prescribed, so that Code A received a total of 60 milligrams that day, though this was seemingly not enough to remove his pain and discomfort when his dressings were being changed. The nursing records indicate that he appeared to have a comfortable night'. So (pause) we are now on the 27th doctor. So by the morning of the 27th of August Code A appeared to have stabilized somewhat more. In addition, you would have had ample of opportunity to have obtained the result of the haemoglobin taken the day before. Why then at a time when Code A could have transferred more safely was this not done then?

No comment.

If his condition had stabilised or he was suffering, possibly suffering from a GI bleed or a heart attack and you and the hospital are not capable of treating this, would it not have been better to have sent him to a hospital that could?

Code A

No comment.

Code A pointed this out earlier that 'it would appear that Code A was actually disadvantaged by being on your ward when suffering from these illnesses that were treatable, very serious conditions but treatable. What did you do to treat them?

No comment.

Code A

What did you do in order that anyone could help Code A Code A

No comment.

When did you discuss with Code A or the gastroenterologists, or medical team on call Code A Code A condition in particular the drop in his haemoglobin?

No comment.

Why didn't you discuss him?

No comment.

Paragraph (31). 'I reviewed Code A again the following morning and on this occasion I made a note in his records, which read reads as follows:- The 28th of August 1999 (28/08/1999) remains poorly but comfortable, please continue opiates over weekend'. Were you aware of the blood results at this time?

No comment.

What action did you take?

No comment.

Code A

His blood results are here and they are saying that 'there is a significant drop' and we know you were aware of them at some time because you've signed the Lab Report. If you weren't aware and you hadn't received the Lab Report why didn't you phone the lab?

No comment.

You queried a GI bleed. Wouldn't these results have been important?

No comment.

The 28th, that was a Saturday, you didn't have the practice pressures on you, why didn't you write a more detailed note then?

No comment.

Now this was coming up to the August bank holiday, so you were aware that the Monday was going to be a bank holiday. If this being the case, who was going to review Code A if his condition deteriorated?

No comment.

You stated: "Please continue opiates over the weekend." How were the nurses to know how and when to increase the drugs?

Code A

No comment.

What safeguards have you put in place this time?

No comment.

Paragraph (34) doctor. You write 'I do not know if I would have seen Code A again the following morning, Monday the 30th of August, that being a bank holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Code A Code A condition remained poor and later that day at 2.45pm (1445) the syringe driver was set up to deliver 40 milligrams of Diamorphine and 20 milligrams of Midazolam subcutaneously. I anticipate that Code A Code A would have continued to experience pain and clearly in view of the significant sacral sores, it was highly likely that he would have been experiencing further significant discomfort'. So you state that 'Monday the 30th of August was a bank holiday and you have no way of knowing whether you were on duty, but you know that at 2.45pm (1445) a syringe driver was set up containing Diamorphine 40 milligrams and Midazolam 20 milligrams subcutaneously over twenty-four hours'. Why was a syringe driver considered necessary?

Code A

No comment.

Code A

Why were these drugs prescribed?

No comment.

But why isn't there anything in either the doctors' or nurses' records to suggest that this decision was discussed with a doctor?

No comment.

Right you stated that Code A would have been experiencing pain from his abdomen or sacral sores'. The notes do not suggest that the sores were a significant cause of pain do they doctor?

No comment.

In fact the Nursing Care Plan for sleeping, entry on the 29th of August, it records that Code A complained of left sided abdominal pain and queried whether this was related to his bowels'. Why therefore is Code A commenced in these drugs?

No comment.

I see you're there on a Saturday, you went on the Sunday, you possibly went on a Monday. Who authorised this?

No comment.

Code A

Code A

No.

(Pause) Paragraph (35) of your statement doctor. 'In view of his poor condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying. Code A Code A had received 60 milligrams of Oramorph daily over the preceding three days and the administration of 40 milligrams of Diamorphine subcutaneously over twenty-four hours did not represent a significant increase. Code A Code A would have started to have become inured to the opiate medication and an increase of this nature was, in my view, entirely appropriate to ensure that his pain was well controlled. Indeed, the nursing record goes on to state that there were no further complaints of abdominal pain and Code A was able to take a small amount of food'. Like you said Code A received 60 milligrams of Morphine each day over the preceding three days, and on this basis the administration of Diamorphine, which was 40 milligrams subcutaneously over twenty-four hours, did not represent a significant increase'. How do you personally calculate an appropriate dose of subcutaneous Diamorphine based on a patient's previous oral Morphine dose?

Code A

No comment.

Code A

Now Code A been through this with you as well. Are you aware of that chart?

No comment.

(Pause) As we understand it the total twenty-four hour oral dose of Morphine is divided by three or occasionally by two, hey Code A

That's right.

So an appropriate dose, i.e. Diamorphine at 20 milligrams over twenty-four hours would generally be considered an appropriate conversion on this occasion. Is that correct doctor?

No comment.

Why was Code A doubled therefore?

No comment.

The first three lines of that paragraph, 'In view of his condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying'. What was he dying of?

No comment.

Was he dying of a myocardial infarction?

No comment.

Did he need to die of a myocardial infarction?

No comment.

Isn't myocardial infarction for a heart attack? Is it treatable?

No comment.

Well what did you do to treat it?

Code A

No comment.

Did you do anything?

No comment.

You say 'it was your second diagnosis of a GI bleed'. Is that treatable?

No comment.

What can you do to save a person that is suffering a GI bleed?

No comment.

Code A

Is it always a terminal condition?

No comment.

But you were concerned to ensure that he did not suffer pain and distress as he was dying. Would it not have been better doctor to have tried to cure the underlying cause rather than increase the dose of the Diamorphine?

No comment.

Code A

Well doctor you have been given a copy of those Medical Records, a full copy of the Medical Records that are available and you've had some time to read them through and then make this statement that you've presented to us and in this Paragraph (35) I'll draw your attention to five words 'poor condition, terminally ill and dying'. Not anywhere there does it say what his poor condition was, what he was terminally ill with or what he was dying from. Even now, seven years later, when you read this Hospital Record, even now you cannot state, can you, what was causing his death.

Code A

No comment.

I am saying to you, I put it to you that at that stage you did not know what his condition was did you?

Code A

No comment.

But you were content to assume that he was dying,...

No comment.

...so content that you told his wife that he was dying according to you,...

No comment.

...so content that you failed to find, or to investigate the cause of his condition,...

No comment.

...so content that you merely ramped up the analgesic to keep him pain free,...

No comment.

...but you had already suspected that he might have one of two reversible and treatable conditions.

No comment.

Why in Paragraph (35) have you not said what he was dying from?

Code A

No comment.

Right Paragraph (36) then doctor. 'I anticipate that the nursing staff', it's 'I anticipate' again isn't it? 'I anticipate that the nursing staff would have liaised with me prior to the commencement of the Diamorphine and Midazolam and this would have been set up on my instruction directly if I had been at the hospital, or otherwise by phone'. Doctor this is a direct contrast to Paragraph (34). You state that 'nursing would have liaised with you and that the Diamorphine and Midazolam would have been commenced on your instruction'. So therefore did you authorise the commencement of that Diamorphine?

No comment.

If you did, why didn't you put an entry in the notes when you next came on duty as you had previously?

No comment.

Did you have an arrangement with Code A that she could commence patients on syringe drivers with Diamorphine when she deemed it suitable?

No comment.

Well who therefore made the decision to increase Code A Code A Diamorphine by at least double the amount?

Code A

No comment.

Well that is a significant increase, it's double the amount doctor.

No comment.

Well what is the purpose of medial practitioners reviewing patients and deciding on levels of prescriptions then?

No comment.

(Pause) You said 'this would have been on your instruction directly if you had been at the hospital, or otherwise by phone'. What's the effect then of doubling the Diamorphine?

No comment.

Code A

Yeah. 'I anticipate that the nursing staff bla, bla, bla. This would have been set up on my instruction directly, or otherwise by phone'. Well let's take 'directly' shall we. If it was directly, I'm assuming that you are there in the ward. Let's take 'directly', let's assume it was 'directly', you were there in the ward. Why didn't you make a record there and then on the notes that you had authorised the setting up of that driver?

Code A

No comment.

No you didn't did you? So let's assume that it wasn't directly.

No comment.

Let's go then for 'or otherwise by phone' then surely (somebody coughs) if it was by phone again there would be some record wouldn't there?

No comment.

But there isn't is there?

No comment.

So let's go for another possibility, which you haven't put down in Paragraph (36) and that is that Code A set up the syringe driver on her own...

No comment.

...without speaking to you?

No comment.

Had you had an arrangement with Code A that she could put up the syringe driver when she felt it was the right time to do so?

Code A

No comment.

Was that an arrangement that was common practice between the two of you?

No comment.

Was that an acceptable arrangement do you think?

No comment.

Okay. Well let's go for another option then and let's say: "Is it possible that Code A did that of her own accord without any consultation with you?"

No comment.

And what was to stop her, you had prescribed the Diamorphine and the Midazolam; you'd given the broad range. Was she entitled to set up the syringe driver because you had already prescribed it?

No comment.

And if that last one was the case, is that why there's no record of it?

No comment.

Code A

Well is it doctor? Is it: "Let's leave well alone and let's hope it doesn't get noticed."

No comment.

(Pause) Obviously if it had been done on the telephone, if authority had been given over the telephone there would be more likely I suppose to be an entry because the policy says that 'it would have to be signed by two nurses'. Is that not correct doctor?

No comment.

Let's take Paragraph (37) and Paragraph (38) then doctor. 'On the morning of the 31st of August Code A was recorded as having had a peaceful and comfortable night, though he then passed a large amount of black faeces that morning. I believe I would have seen Code A again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered and that he would have remained comfortable. Similarly, I would probably have seen Code A again on the morning of 1st of September, but would have been unable to record this. I anticipate that his condition was again unchanged. Five separate pressure sore areas were noted by the nurses. A Barthel score of only 1 was recorded'. So you stated that 'on the morning of the 31st of August Code A was recorded as passing a large amount of black faeces'. Isn't this a pure indication of one of your queried diagnosis, of

your indication of a gastro intestinal bleed?

Code A

No comment.

And I will ask you again next to the dates that we have got. When did you obtain or review that full blood count that you signed?

No comment.

Why didn't you refer Code A to a more senior colleague at this point?

No comment.

So according to you doctor Code A was either suffering from a heart condition, or a GI bleed according you're your entry on the 26th of August. You've commenced him on varying, increasing doses of Diamorphine. You say that you, you stated somewhere, on the 26th, the 27th, the 28th, the 31st and the 1st of September you've made two entries in the notes and neither of which reasons why he has been given any medication. There was no evidence that an ECG, or any tests to address his heart condition had been thought about or carried out. And in relation to his GI bleed you wrote 'A large form of haemoglobin levels, passing of black stools' and yet again there was no record of investigations for treatment plans, or referrals to senior colleagues, why not?

Code A

(Silent)

Doctor why not?

No comment.

So what care were you providing for Code A

No comment.

(Pause) Were you just allowing him to die?

No comment.

Anything Code A

Yeah. And it's very similar to a set of questions I asked you a few moments ago doctor. Paragraph (37) – 'He then passed a large amount of black faeces that morning'. Paragraph (27) I think it was when 'you agree that you signed the Lab Report with a 7.7 reading on (inaudible). Previous to this you've written into this statement that 'you queried myocardial infarction plus you queried 'possible GI bleed', and now you have got the clearest indication that that is probably what he has got a GI bleed because you've put on here 'passed a large amount of black faeces'. Black faeces plus the 7.7, what is that an indication of doctor?

Code A

No comment.

Code A

Well we both know don't we that that is an indication of a GI bleed, and yet even now at this stage, in this prepared statement, prepared statements you've had time to write it, we haven't asked you to do it in five minutes, even now Chapter 30, or Paragraph (37) you still haven't written down what is wrong with Code A and that's the clearest indication yet that we've got so far and we'll carry on with the questioning, but expect another question on that in a minute doctor.

No comment.

Right doctor we'll move on to Paragraph 41. Code A Code A recorded later in the Nursing Records that the syringe driver was renewed at 7.15pm (1915) with 60 milligrams of Diamorphine and 60 milligrams of Midazolam subcutaneously as the previous dose was not controlling Code A symptoms. It appears therefore that Code A was experiencing yet further pain and discomfort. I anticipate that the nursing staff would have contacted me and that I authorised this moderate increase in his medication in order to alleviate the pain and distress'. So on the evening of the 1st of September now then 'the first Diamorphine was increased to 60 milligrams and Midazolam to 60 milligrams over a twenty-four hour period', that's at quarter-past-seven (1915) in the evening because the previous dose wasn't controlling the symptoms (coughs). Code A has recorded this, you haven't. Who has authorised the change in dosage?

Code A

No comment.

So that's a Diamorphine increase of 50% and the Midazolam dose was trebled. Why was this?

No comment. (TAPE BUZZES)

Where is it recorded in the records that Code A was in pain or distress?

No comment.

So you're going to say that 'you anticipate that the nursing staff would have contacted you and you have authorised this moderate increase in his medication'. Well moderate is 50% of Diamorphine and trebling the Midazolam, but where have you authorised this?

Code A

No comment.

Was it over the telephone?

No comment.

In which case an entry would have been made by the nurses. Is that correct?

No comment.

Code A

Were you there?

No comment.

In which case you have signed it yourself?

No comment.

Or did Code A just authorise it herself?

No comment.

I'll let you think about that for a moment doctor because I'm going to take this opportunity to change the tape. The time is 1537 hours and I am going to turn the recorder off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AQ

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

Person interviewed: Code A

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1538 Time concluded: 1605

Duration of interview: 27 MINUTES Tape reference nos.
(→)

Interviewer(s): Code A

Other persons present: Code A SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This is a continuation of the interview with Code A Code A The time is 1538 hours and the date is the 6th of April 2006 (06/04/2006). Doctor can you just confirm that it's the same people present in the room please?
	It is.
	And has there been any conversation about this matter while the tapes have been off?

Code A

None at all.

Okay. Just so that we can (pause – clears throat) re-cap on this, we were discussing Paragraph (41) and who actually authorised this increase in the medication. (Pause) So where was it recorded in the records that Code A was in pain?

No comment.

And where was it in the records who authorised this?

No comment.

Am I right in thinking had it been a telephone authorisation that two nurses would have signed the records?

No comment.

Am I right in thinking that had you been at the hospital you would have signed the prescription sheet?

No comment.

Code A

No not at the moment.

No. Paragraphs (42) and (43) then. 'That night Code A Code A was noted to be incontinent of black tarry

faeces, but otherwise he had a peaceful night and the syringe driver was said to be satisfactory. I believe I would have reviewed Code A again the following day, the 2nd of September. The nursing records show that his medication was again increased, the Diamorphine to 90 milligrams and the Midazolam to 80 milligrams subcutaneously. I anticipate again that Code A would have been experiencing pain and distress and that I and the nursing staff were concerned that the medication should be increased accordingly to ensure that he did not suffer pain and distress as he died. That night Code A Code A was said to remain ill, but comfortable and the syringe driver was satisfactory'. So Code A was noted to have had a peaceful night, however Diamorphine was increased to 90 milligrams over a twenty-four period from 60 and the Midazolam to 80 from 60 and that was at 1840 hours on the 2nd of September. Why was this doctor?

Code A

No comment.

However there is no mention of pain and distress from the nursing or medical notes. Who authorised this increase?

No comment.

Did you authorise it?

No comment.

Personally?

Code A

No comment.

Or by phone?

No comment.

Or was it unauthorised?

No comment.

(Pause) Also it's mentioned in Paragraph (42) – 'That night Code A was noted to be incontinent of black tarry faeces otherwise he had a peaceful night'. What is that significant to?

No comment.

So we've gone from the 26th of August where you've query a GI bleed and you queried a heart attack. Well we are now on, I believe, the 1st of September (pause), overnight on the 1st of September I believe. So four or five days and you have quite a few pointers now as to what might be wrong with Code A haven't you?

Code A

No comment.

(Clears throat) And this last one 'the black tarry faeces', am I right in thinking that that is indicative of a GI bleed?

Code A

No comment.

Albeit it could be indicative of a lot of things I'm sure, but you suspected a GI bleed, and why did you suspect a GI bleed doctor?

No comment.

And not only did you suspect a GI bleed on the 26th of August you, at some stage, had seen that Lab Report and you'd seen the drop in the haemoglobin. You must be pretty damn sure now that he was suffering from a GI bleed.

No comment.

So what did you do about it?

No comment.

(Pause) Code A

Was it too late to do anything about it?

No comment.

Well we're now up to, what was that Chapter what, Paragraph what Code A was it?

Code A

That was Paragraph, well that main bit with the faeces was Paragraph (42), but we're doing (42) and (43).

No comment.

Okay. So we've got Paragraph (39) 'passing melaena stools'. The end of Paragraph (39) 'poor prognosis'. Paragraph (40) 'terminally ill'. (Pause) Paragraph (42) 'incontinent of black tarry faeces'. (43) end of that sentence 'pain and distress as he died'. Code A was said to remain ill'. So several mentions to the things that were happening to Code A the stools, terminally ill, ill, pain and distress as he died and again right up to that including all the way up to Paragraph (43), you have failed to tell us in this prepared statement what was wrong with Code A

Code A

No comment.

You've been using hindsight, I think it's quite clear, throughout this prepared statement and even now you are not telling us what was clearly wrong with Code A Code A

No comment.

(Pause) Okay Paragraph (44) doctor. 'Sadly Code A Code A passed away on the 3rd of September 1999 (03/09/1999) at 1.50pm (1350). My belief was that death would have been consequent for myocardial infarction'. So

there you've pinned your colours to the mast and you said that it was a 'myocardial infarction'. So from the 26th of August until the 3rd of September at no stage did you say in your statement or in your notes what Code A was dying of, but when he's died you've said: "Yeah it was a myocardial infarction." What evidence is there that the cause of death was due to a heart condition?

Code A

No comment.

Because you have repeatedly referred to symptoms that suggest a GI bleed, and even with the benefits of hindsight doctor and the review of case notes that contained details that Code A had a digestion like pain, he was passing fresh blood and melaena stools and the drop in his haemoglobin. Do you really think, bearing all that in mind, was your diagnosis of Code A correct?

No comment.

I mean was it really a diagnosis other than you've given what you believe to be a cause of death?

No comment.

Possibly an incorrect cause of death.

No comment.

Even if Code A had died of a heart attack or a myocardial infarction and you were correct in your suspicions on the 26th of August, what did you do about it?

No comment.

Why didn't he have an ECG?

No comment.

When was his heart listened to?

No comment.

Code A

When were any tests done?

No comment.

Well we actually feel that everything might point towards a GI bleed, so when were any tests done for that?

No comment.

We had the blood test. When did you sign that and become aware of the drop in haemoglobin?

No comment.

Something that you record in your statement 'a significant drop'.

Code A

No comment.

Accompanying that with the black faeces and the passing of fresh blood, all this etcetera. What do you think Code A Code A died of?

No comment.

Why haven't you written any reference to the reason behind the prescription of any drug, not only in these records but also in any of the ten records that we've had?

No comment.

I admit it I'm just, I'm going to push the drugs to one side, but before I do that do you want to say anything?

Only when you get to Paragraph (44) doctor, when you were writing that where were you when you typed that?

No comment.

Well I think you were up against the wall weren't you, backed into a corner with nowhere to go because you realise what you've put on that Death Certificate and yet the evidence is pointing, and it has been pointing for several paragraphs now that it has been pointing to the other diagnosis that you did consider at one stage, but

seemingly ignored and that was that he had the GI bleed and yet you failed to investigate didn't you?

No comment.

You failed to investigate the myocardial infarction possibility didn't you?

No comment.

Can you tell me even now, through this prepared statement, your evidence that indicates that he had a myocardial infarction?

Code A

(Silence).

Can you?

No comment.

And can you, through this prepared statement, justify your entry on the Death Certificate?

No comment.

(Pause) So poor old Code A he came into hospital and his ongoing problems were obesity, arthritis, immobility, pressure sores and constipation. So to put it bluntly he was a fat man with arthritis in his knees, his immobility was possibly due to his size, pressure sores

because he wasn't getting about and he was constipated and he's died of what you consider to be a myocardial infarction. Now forget the drugs at the moment, forget the Diamorphine and the Midazolam and all the other drugs, there was two diagnoses that you made on the 26th of August, two possible diagnoses myocardial infarction or a GI bleed, now forget which one was right, but what did you do about either?

Code A

No comment.

What basic tests did you put in place?

No comment.

If you were unable to treat or look after Code A why didn't you move him somewhere where he could be?

No comment.

We mentioned before that Code A seemed to be hampered by being in hospital, he was disadvantaged by being in hospital, he could have just as easily have been at home except then somebody could have called an ambulance couldn't they doctor?

(Silent)

Did you consider anything, I mean of all the options that were open to you ECGs, all the different tests etcetera,

didn't you consider anything that could have been done for

Code A

Code A

No comment.

Had he been suffering from a GI bleed or a heart attack on the 26th of August, was the terminal?

No comment.

Could that have been treated?

No comment.

And could his life have been saved?

No comment.

Now if you bring the drugs back into it the Diamorphine and that, was the proactive prescribing done in order that you didn't have to be bothered with nighttime call out?

No comment.

But why such a range?

No comment.

And with what eventually becomes, it could be either I suppose, but I would say quite high doses of Diamorphine

etcetera, was that a way of covering up the inadequate care and the treatment Code A received?

Code A

No comment.

Just keep him quiet, out of pain and he would just eventually die of whatever was wrong with him?

No comment.

Code A

(Pause) Doctor a GI bleed is consider, you tell me if I'm wrong, is considered as a serious and life threatening medical emergency is it not?

No comment.

And as such it should require urgent and appropriate care?

No comment.

On the 25th of August Code A was called wasn't he?

No comment.

And for out-of-hours and that was because Code A was passing fresh blood per rectum wasn't he?

Code A

No comment.

Now (pause) Code A as a consequence what did he do? He ordered that the Clexane should be stopped didn't he?

No comment.

Now was the Clexane, that was to stop DVT wasn't it, deep vein thrombosis wasn't it?

No comment.

So it's an anti coagulum isn't it for blood?

No comment.

It stops the blood from clotting doesn't it?

No comment.

So what Code A did was quit reasonable wasn't it stopping that?

No comment.

Now we mentioned this GI bleeding before and if we get a lower bowel GI bleeding it comes out as red doesn't it?

No comment.

Code A

Or it can do. And why is that doctor?

No comment.

That's because the blood hasn't had the time, has it, to be digested from stomach to rectum (somebody coughs) and turn it into that horrible black smelly melaena. Is that right?

No comment.

(Pause) So coupled with that and the fact that he had vomited, he was unwell, wasn't he at lunchtime? You were called to see him at lunchtime, then indigestion and he was becoming more unwell and that's why Code A was called and we know that the HB was 7.7 from that day, but that came through later. We're pointing there, aren't we, that it was quite reasonable for you to have known that he had the GI bleed (pause) and you already knew that Code A had asked for that haemoglobin to be chased up on the 13/08 because she suspected it. You knew that Code A had request HB to be reviewed later on in the week when he looked at him on the 23rd (pause), so it's all pointing that was isn't it?

Code A

No comment.

So why didn't you investigate that further yourself?

Code A

No comment.

Neither of those were properly investigated were they? Neither the myocardial infarction nor the GI bleed.

No comment.

(Pause) Was that done (inaudible)?

Sorry?

Was that done (inaudible)?

No you put...

None of that?

No.

(Inaudible). There's just a couple more things I want to ask you then, it's general things really doctor. What was your duty of care towards Code A

No comment.

Was it to treat him with his medical condition to make sure everything's done to treat his illnesses and things like that?

No comment.

Code A

Isn't that what the public would assume the role of a doctor to be?

No comment.

To diagnose, to treat, to make better, and guidance is provided, isn't it, by things like your Job Description of what you've got to do, the extensive training you must have gone through to become a doctor in the first place, there's all sorts of other guides and policies, there's the BNF to assist you in providing that duty of care isn't there doctor?

No comment.

So is it reasonable to say that a person going into hospital would think: "I'm going to hospital, a doctor will try and make me better." Is that a reasonable assumption for a member of the public?

No comment.

Right well if you have a duty of care such at that, what would you consider then doctor to be a breach of that duty?

No comment.

Would you consider failing to examine Code A a breach?

No comment.

Code A

Would you consider failing to keep records a breach?

No comment.

Well how about not following drug prescription guidelines?

No comment.

What about the failure to follow up those blood results?

No comment.

What about thinking he may have a GI bleed, but doing nothing about it?

No comment.

What about thinking he may have been having a heart attack, but not doing anything about that?

No comment.

What about not carrying out an ECG when the machine's available?

No comment.

There's a handful of things. Would you consider any one of those to be a breach of duty of care doctor?

Code A

No comment.

Or all of them?

No comment.

(Pause) I mean people at times of negligent aren't they for any number of reasons. Were you negligent?

No comment.

Well what is negligence? Is it any of those things I mentioned before failing to examine Code A

No comment.

Failing to keep the records?

No comment.

Need I go through them all again?

No comment.

Can you explain why you failed to conduct any of the above, any of the things I've mentioned?

No comment.

Code A

You see sometimes negligence can have tragic consequences can't it doctor? Is this what happened here?

No comment.

You see on top of all the breaches that I've mentioned about duty care and care of Code A there was no referral to another hospital was there, or a doctor, or transferring Code A to another hospital?

No comment.

(Pause) How many single deviations doctor would you say, or devious good practice would you say was acceptable?

No comment.

Do you think could the failure to treat his GI bleed have contributed to his death?

No comment.

Could failure to identify whether he was suffering from myocardial infarction or a heart attack have contributed to his death?

No comment.

Code A

Could the failure to seek help or assistance from more experienced doctors or a consultant have contributed to his death?

No comment.

(Coughs) Could the rapid increase in Morphine based drugs have contributed to his death?

No comment.

Could the combined failure of all of the ones I've just mentioned, all the things I've just mentioned, including the rapid increase in Morphine based drugs, have contributed to the death of Code A

No comment.

So then what doctor, as a doctor with over thirty years' experience, what would you consider to be an act of medical negligence?

No comment.

Let's turn that round then, how would you deal with one act of negligence that you saw in either a junior or senior doctor?

No comment.

Code A

How would you deal with repeated breaches of good practice in the medical treatment of one patient?

No comment.

When would you consider a doctor to be grossly negligence in carrying out their duties doctor?

No comment.

Code A

(Pause) I don't have anymore.

No. Is there anything you wish to clarify doctor?

No thank you.

Is there anything you wish to add?

All right. We'll give you a notice explaining what will happen to the tapes and the tape recording procedure. The time is 1605 hours and I am going to turn the recorder off.

THE INTERVIEW CONCLUDED – THE TAPE MACHINE WAS SWITCHED OFF.