Richard Ian REID (Consultant Geriatrician)

Series of tape recorded interviews with Dr REID in presence of legal representative Will CHILDS under caution 0921hrs – 11600hrs 4.7.06 in respect of Generic Matters Gosport War Memorial and Queen Alexandra Hospitals.

Keypoints:-
Interview Tape Y25.

Dr Reid qualified in 1974; his initial training was conducted in various hospitals in Scotland. After performing Senior Registrar duties in Portsmouth and Southampton Hospitals he was appointed as a Consultant in Geriatric Medicine in 1982.

In March 1998 he took up his current role as Consultant in Geriatric Medicine at Queen Alexandra Hospital, Cosham, he also had the additional responsibility of Medical Director.

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

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

Interview Tape Y25A.

Dryad Ward would take patients over 65 who were frail and/or had multiple medical problems, slow stream rehabilitation.

His leave entitlement was 6 weeks of which he would take all of it, nobody covered his ward rounds during his absence. Dr Lord, a consultant for Daedalus Ward would have been available should Dr Barton had needed her advice.

As the turnover of the ward (Dryad) was quite low locums were not used as cover.

DR REID performed a weekly ward round on Dryad Ward, on Monday afternoons. DR Barton accompanied him on alternate Mondays as she also attended Daedalus Ward for Dr Lord's round. If Dr Lord was away she would forego the Dryad round. His round lasted about 4 hours, he would spend approximately 12 minutes per patient depending on their conditions. New patients would take longer.

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

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

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

He did not sit down and have regular appraisals with Dr Barton.

In 1998/99 Dryad Ward was for continuing care, assessment for continuing care and Daedalus was for rehabilitation.

Interview tape Y25B.

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

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

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

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

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

Patients could be returned to the QA if they became unwell. However if they were unlikely to recover or they were too ill to transfer they would be looked after in a palliative way. Dr Barton usually made those decisions. QA was under huge pressure for beds at that time. It was almost "Well let's send the least suitable patients there" "Well there might be a chance that they might get back on their feet, but it doesn't really look very likely so we'll send them" It's difficult to understate how much pressure there was from QA to fill beds in community

hospitals. In an ideal world they would probably have gone to Daedalus Ward. Consequently the turnover of Dryad increased.

Interview Tape Y25C.

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

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

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

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

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

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

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

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

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

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

Interview Tape Y25D.

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

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

Dr REID had no supervisory responsibility for the nursing staff.

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

Though he and Dr Barton would be responsible for prescribing syringe drivers nurses might suggest it as an option.

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

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

Interview tape Y25E.

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

Described proactive prescribing as prescribing something in the absence of pain and variable where someone was in pain but the nurses are given discretion. He

had not seen any policy or guidance as to how large the variance could be. He said that Dr Barton had no authority as such, it was her decision, and she was free to do it though it was not good practice with regards to opiates. She did not speak to him about it.

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

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

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

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

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

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

<u>Interview Tape Y25F.</u>

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

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

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

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

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

Described Dr Barton's note keeping as brief but felt that she did record significant changes in condition and management. He said that his busy Mondays did not prevent him from properly writing notes.

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

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

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

Could not be specific but recalled that the nursing staff said that in Dr Barton's absence her partners could be reluctant to come in and see patients.

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

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

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

<u>Interview Tape Y25G.</u>

Didn't feel that DR Barton kept her notes to the letter of the GMC Guidelines.

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

There would always be a Consultant from Elderly Medicine available on call, but could not remember ever being called by Dr Barton.
Asked if Dr Barton met the standards of his note keeping he said that there were deficiencies.

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

It had come about at the same time as the SHIPMAN case and as a consequence of the Gladys Richard case. He felt it appropriate to develop a policy for the management of diamorphine by subcutaneous infusion. He did not relate it to any particular incident at GWMH.

First concerns on prescriptions came about with the Elsie Devine case in March 2000. This involved Fentanyl to Diamorphine prescribed by Dr BARTON. He would have prescribed a smaller dose. The protocol was already in an embryonic stage at this time.