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

Key points:-

Interview Y25Q.

Geoffrey PACKMAN was admitted to Queen Alexandra Hospital suffering from leg ulcers and following an incident at his home where he had become immobile.

He had subsequently been transferred to GWM Hospital for nursing care

He was described as being clinically obese, suffering from pressure sores and arthritis. His life expectancy was described as being poor, but there is nothing recorded to the effect that he was in a terminal phase of life.

In his position he was personally responsible for the care of Geoffrey PACKMAN whilst this patient was in Gosport War Memorial Hospital.

Interview Y25R.

When a patient was admitted to the hospital then that person would be asses by a doctor and nursing staff.

Mr PACKMAN was transferred to Gosport War Memorial Hospital from Queen Alexandra hospital because his major need was for nursing care, at that time he would appear to have been medically stable.

On his transfer to Gosport War Memorial Hospital Mr PACKMAN was prescribed DOXAZIN – 4 milligrams for high blood pressure, FRUSEMIDE (a diuretic) – 80 milligrams per day, CLEXANE – a blood thinning treatment, PARACETAMOL – one gram qds this was his only pain relief.

Mr PACKMAN needed a special bed (large) due to his size.

On a ward round, he would make an overall assessment of what he felt the main issues or patients problems were together with what could be done.

A patient's care plan would change if there was a change in the patient's condition.

Dr Barton was responsible for the treatment of Mr PACKMAN on a day to day basis.

The need arose for Mr Packman's condition to be investigated by means of tests etc. Haemoglobin urea electrolytes and liver function tests, the Haemoglobin tests were to detect any possible bleeding in the bowel.

Any decision making involving a patient should be recorded.

If a doctor was to see a patient then he would expect to see recorded in that patients notes, any interaction, symptoms which the patient may be experiencing together with a record of the results of any examination and treatment.

If a doctor had been called to see a patient for any reason and there had been any significant change in the patient's condition, then he would expect to see this noted in the patient's records.

Initiating any new treatment is significant and should, therefore be recorded

Found nothing in the records of Geoffrey PACKMAN to indicate that this patient was suffering pain.

Was aware of the 'analgesic ladder' and stated "you have to make a judgement about what steps of the ladder you take".

When asked, why Mr PACKMAN who had been on nothing more than one gram of paracetamol 4 times daily and who had no record of documented pain, why there was no record of the reasons for prescribing morphine or other strong opiod to that patient, replied that he was only able to speculate that Dr Barton had felt hat this patient was in sufficient distress caused by a condition which could be relieved by diamorphine.

Did not have any concerns about the care/treatment of Geoffrey PACKMAN.

Interview Y25S.

With regard to keeping up to date with pharmaceutical issues prescribing matters and the fact that he kept himself up to date. The BNF book was described as the 'Bible of Prescribing' and there was usually one on each ward. It was a constant source of information with regards to the possible side effects of drugs and a patient's reaction to new ones.

Had never seen either of the books, Palliative care Formulary or the Nurses Prescribing Formulary.

Mr PACKMAN had not been prescribed any drugs which were new or seldom used that Dr. REID was aware of; he was only ever given drugs which would be used regularly for a patient in Mr. Packman's condition.

Explained the layout of a prescription sheet and that one part is for the actual prescribing by a qualified person whilst the other part was for use by nurses etc. for administration of the drugs / medicines.

Referred to the notes of Geoffrey PACKMAN and listed the drugs prescribed to him as: - Aloperimide for Diarrhoea. On 26th August 1999 at 1800 hours. 10 milligrams of Diamorphine is muscularly prescribed on the basis of a verbal message from Dr. BARTON, with a similar dose on 27th or 28th. Alvine and mepitol dressings for skin wounds, Gaviscon for indigestion, Tempazepam 10 – 20 milligrams orally on 24th and 25th August. Doxazosin was given for high blood pressure, Frusemide 80 milligrams administered from 24th through to 31st Clexane (subcutaneous injection) twice daily on 25th and 25th August. Paracetamol 1 gram four times daily, a topical cream and Magnesium Hydroxide 10 mills twice daily.

Was unable to explain the discrepancies in the administration, times and dates as shown on Geoffrey Packman's drugs chart, but said that the range of 40 – 200 milligrams of diamorphine allowed nursing staff discretion to increase the dose in the event of non availability of medical staff.

The range of 40 – 200 milligrams was too large a range at the time when the prescription was written,

Spoke of the side effects of diamorphine with one of them possibly being confusion and that a patient being drowsy may be an indication that the dose is too high.

Proactive prescribing was discussed together with variable dosage which allowed nursing staff flexibility in administering a drug to ease a patient's pain etc.

Agreed the reason for prescribing should always be recorded in the medical notes.

Telephone prescribing and verbal orders, where a nurse might telephone a doctor to explain a patient's current problem and the doctor would give an authority to administer a different drug or an increased dosage.

Nursing staff would prefer to have a written prescription rather than to rely of verbal orders, particularly diamorphine.

Mr PACKMAN was seen by Dr. REID on 1st September and at that time Mr. PACKMAN was on a dose of 40 milligrams of diamorphine, but within hours the dose had been increased, possibly by a nurse (Jill HAMBLIN) when the patient had already been noted as being drowsy on the smaller dose.

Interview Y25T

On 1st September it is recorded that sister Hamblin increased the diamorphine dose of Geoffrey Packman from 40 milligrams to 60 milligrams supposedly to control the patients symptoms, DR. REID was unable to say what these symptoms were because they had not been recorded, even though the patient had been seen by a doctor only hours previously and was noted to have been drowsy but comfortable, the diamorphine dose had been increased by half without explanation.

Relied upon Dr. Barton's knowledge and experience, he trusted her and the nursing staff to care for the patients

Acknowledged the fact that Dr. Barton and Sister Hamblin were more experienced than himself in the actual care of this particular type of patient and for whatever reason Sister Hamblin had seen fit to increase this dose, possibly because the patients condition had changed in the few hours since being seen by the doctor, but the reason for the increase had not been recorded.

Describes Dr Barton and Sister Hamblin as a formidable pair, who knew what they were doing and that they had an established practice of running the ward

Unable to say with any certainty that his clinical opinion was being ignored in this case, but admitted that on a previous occasion he had spoken to medical staff about the range of Diamorphine being too high for a patient.

With regard to the use of a syringe driver in the case of Mr Packman, he could only presume that it had taken that level of administration to control the patients symptoms, and because the patient was drowsy and possibly unable to take the drug orally. Was unable to explain why Mr Packman had not been given the drug orally even though he had accepted it orally in the recent past.

Gave no explanation as to why, when Mr Packman had been started on a syringe driver, that the matter had not been recorded or why it had been deemed necessary, even though he accepted that such a matter is a significant change in the patient's condition.

It was Dr. Barton who had prescribed the syringe driver on 26th when Mr Packman was seen and noted to be unwell. Dr Barton had finished the notes with 'keep Comfortable, I am happy for nursing staff to confirm death' but there was no mention at that stage of a syringe driver being commenced. There was a further visit by Dr Barton to Mr Packman but there is no note of the syringe driver commencing. It would then appear that on 30th August a syringe driver was commenced with 40 milligrams of Diamorphine and 20 milligrams of Midazolam and this entry would appear to have been signed by sister Hamblin.

Sister Hamblin would appear to have commenced the syringe driver, in respect of Mr Packman without discussing the matter with a doctor and when Mr Packman was apparently able to eat and drink a little i.e. he was able to swallow.

It was a 'big decision' to commence a syringe driver' but he was unable to say why sister Hamblin had apparently taken this decision herself, or why she had written in the clinical notes, as opposed to nursing notes.

Mr Packman had been seen by Dr Barton on 26th August, he was noted to be possibly suffering a heart attack and was sufficiently distressed that administration of Oramorph was necessary, therefore Oramorph had been prescribed in two dose strengths of 10 milligrams and up to 20 milligrams.

Mr Packman may have needed Midazolam because he had been stressed or agitated, and that this drug was mostly for mental agitation rather that physical pain.

Interview Y25U.

Diamorphine is an analgesic and included in a group of drugs called opiates which are strong painkillers.

Prior to taking Diamorphine, by referring to the 'analgesic ladder' one would start with Paracetamol and then move up to Coedine and then to extra Coedine and Paracetamol before arriving at drugs which are Opiate related, such as Tramadol. Finally there are the strong Opiates which are known as Morphine and Diamorphine.

Within the analgesic ladder, Diamorphine fits into stage three, which is at the top of the ladder, being the strongest level of painkiller.

Mr Packman had been prescribed Diamorphine in a range of 40 – 200, and this gap / range had been to allow for nursing staff to use their discretion if the starting dose had not been able to control the patient's symptoms.

Midazolam could be used in conjunction with Diamorphine to be administered via a syringe driver and the same range of dosage would be applied in accordance with the analgesic ladder.

Would not expect a nurse to administer the highest range of a drug from the outset, he said that the lower range would be the starting point.

The Diamorphine was prescribed to Mr Packman on 26th August but it had not been actually administered until 30th August, a gap of four days, this was pro-active prescribing.

Mr Packman had originally been prescribed Oramorph as a regular prescription, and the Diamorphine prescription was pro-active in the sense that if the patient was no longer able to take medication orally or that the pain was not controlled then this situation would allow the Diamorphine to be introduced.

Was unable to comment with regard to what circumstances had arisen whereby the patient had been administered the Diamorphine i.e. whether the patient was unable to take oral medication or that the pain was not controlled. Mr Packman was eating small quantities.

Pro-active prescribing policy was not required if a doctor was going to see the patient once a day or was available.

There was nothing in place at that time, as a guide to nursing staff regarding what increase should be made within the prescribed range of 40-200 milligrams. There were no checks or safeguards on this issue other than it was a requirement for two nurses to carry out the procedure of administration of controlled drugs such as diamorphine.

It was difficult to say whether or not Mr Packman was in the terminal phase of his life by the time he was receiving Diamorphine because Dr Barton had written on the notes, 'remains poorly but comfortable, continue with opiates over the weekend' which implied to him that this patient was seriously ill.

A person could be seriously ill but treatable.

In the case of Mr Packman, it was difficult to say from the notes that he was terminally ill at that stage.

He would expect to see written justification for the use of Diamorphine because it was a switch from oral medication to Diamorphine.

An excessive dose of Diamorphine, would vary from patient to patient. Also the fact that a patient may be opiate-naïve but the best answer to this lay with an expert in Pharmacology.

60 milligrams of oramorph converted to a dose of 20 Milligrams of Diamorphine.

Had not advised Dr Barton about her prescribing regime because he had never been asked to. Had not noticed the variance of doses in this case, but said that if he had noticed the variable dosage the he should have said something.

Saw Mr Packman on 1st and noted that he was drowsy but did not feel that he had been overdosed with Diamorphine.

There was no justification in Mr Packman's notes regarding the use of Midazolam.

When he saw Mr. PACKMAN on 1st September he was in the terminal phase of his life, because Mr Packman was taking a fair amount of opiate for pain control, he was passing 'melina stool' and bleeding from the gut, the overall picture was one in a terminal phase of life. Therefore, despite the apparent symptoms of the patient, he was not referred to another consultant.

Mr Packman was unlikely to have suffered a heart attack and that the main cause of his deterioration was due to the internal bleeding.

Explained the policy of 'not for 555' (not for resuscitation) which was the case for Mr Packman but stated that this did not mean that the patient was not to be diagnosed, treated and possibly cured of the presenting complaints.

Interview Y25V.

Mr Packman is recorded as having died of Myocardial Infarction, and that there is no reference to a heart problem when seen by Dr REID two days earlier.

There was a discussion about the availability of supervision, guidance and study leave for staff, including Dr. Barton if ever that person thought it useful.

It didn't take long to write out patient notes and that to the best of his recollection, there had not been a time when Dr Barton had complained to him about the her work load being too great.

If there was sufficient interaction with a patient then it should be noted.

Had there been any adverse reports with regards to Dr Barton then he would have tackled her on any relevant issues, but from his understandings, she was regularly on the wards in accordance with her contract and more, sometimes two or three times a day.

Explained his personal method of ward rounds and days it was carried out.

When he saw Mr Packman on 1st September, he was dying and was suffering a GI bleed for which he would not be treated for. The patient was to be made comfortable and allowed to pass away peacefully.

Mr Packman was suffering a GI Bleed as opposed to MI because of the huge drop in haemoglobin in a short time. Also the patient was passing black stools caused by bleeding in the upper gut.

Interview Y25W.

On 23rd August, the day Mr Packman arrived at Gosport War Memorial Hospital, he is seen by Dr. Ravindrane and assessed. It is noted that, as on previous occasions, Mr Packman may be suffering a GI bleed. Dr. REID stated that a GI bleed is a life threatening medical emergency, which is treatable but with difficulty, explained some treatments.

The symptoms of being pale, clammy and unwell are very consistent with GI bleeding, and he was sure of this by 1st September following the results of the check. Nothing further was done because a decision had to be made as to whether or not it was in the patient's best interest to transfer to another hospital for the necessary treatment / blood transfusion etc. and whether or not a patient in this condition would even survive the transfer.

There was no evidence, other than Dr Barton's note entry to support the fact that Mr Packman was not fit for transfer, but Dr. REID stated that it was a judgement which had to be made at the time.

When Mr Packman arrived at Gosport War Memorial Hospital, he was not in immediate expectation of death, despite his obesity and presenting complaints. He may well have been 'on the slippery slope' but he could not tell at that time if Mr. PACKMAN would survive one week or six months.

There was anything in the medical notes where Mr Packman's wife was made aware of his condition and the decision not to transfer him for further treatment or blood transfusion.

Persons charged with looking after MR. PACKMAN had a duty of care to him and his wife, but on looking at the notes, it would seem that little was done in respect of either.

Did speak with Dr Barton about variable dose prescribing but he was unable to recall as to what particular patient it was regarding.

There were no set safeguards to prevent a patient being administered an unintentional dose other than the expectation of nursing staff to start with the lowest dose.

Interview Y25X.

Agreed that on 27th August the patient's condition would appear to have stabilised, and that there should have been sufficient time to obtain the haemoglobin results from the check on the previous day.

Unable to give an explanation as to why Mr Packman had not been transferred for treatment to another hospital when his condition would appear to have improved.

Mr Packman's condition was not discussed with a gastroenterologist or the on-call medical team.

Mr Packman had complained of left sided abdominal pain on 29th August. It would be unusual for the cause of such pain to be Myocardial Infarction.

Mr Packman was started on a syringe driver on 30th, when he is noted to have slept for long periods the previous night. He would appear to have complained of left abdominal pain and there is a 'query' indigestion'. Unable to give an explanation as to why Sister Hamblin started this patient on a syringe driver at that time.

He was not certain if the syringe driver was appropriate at that time, because there is no record of it being required for use at that particular time.

Agreed it appeared, that a nurse had made a decision to start Mr Packman on a syringe driver, but there is no record of that nurse having discussed it with Dr Barton, so was not able to say as to whether or not it was a satisfactory situation.

There was some discussion regarding the haemoglobin test and the fact that the result, although available, was not received for some time, and whether or not there would have been an alternative route for the treatment of Geoffrey PACKMAN, either through his verbal wishes or the requirements of his wife and the ethics of it all.

Didn't know if Dr Barton had at any stage made the correct diagnosis of Mr Packman.

Not able to say as to whether or not Dr Barton had ever acted on the results of the haemoglobin check results, even though she had seen them.

As far as he was concerned he had fulfilled his duty of care in respect of Mr Packman, he was aware that discussion had taken place between medical staff and Mrs Packman about her husbands condition and the management of it, he had to take some things on trust, such as what others had recorded, and these factors would influence him in his decision with regards to the treatment of this patient.

In hindsight, there should have been better documentation in the case of Mr Packman. In his opinion Mr Packman died from a Gastro-Intestinal bleed and if he was to certify Mr Packman's death today he would put the cause of death as being a Gastro-Intestinal bleed.