Code A

Dr I Reid
Hampshire Primary Care Trust
Raebarn House
Hulbert Road
Waterlooville
PO7 7GP

4 December 2008

Dear Dr Reid

**Gosport Inquests (Joint Instruction)**

It was good meet you again last Thursday.

As you know, it has been agreed that at this stage I am happy to assist you in this matter and I am advising the NHS generally on the conduct of this inquest and I am arranging representation at the forthcoming hearing.

You should be aware that I have been contacted by Messrs Radcliffes le Brasseur who are instructed on behalf of the MPS. I understand your colleague, Dr Logan, has contacted the MPS for assistance and they are in touch with me to see whether or not I am happy to represent and assist Dr Logan at the forthcoming hearing. I do not anticipate any problems in that respect but if you have any views, kindly let me know.

It may be that you would want to contact the MDU simply to let them know what is happening and if you do so, it may be worth pointing out that Dr Logan has already contacted the MPS and that their lawyers are in contact with me so that they are fully aware of the situation.

In the meantime, I have received the witness statements from the coroner. They number 88 in total. Some of the witnesses will give evidence in person and some statements will be read out. The majority will be read out. I am aware that you have been called to give evidence. I assume that you have copies of your statements but let me know if that is not the case.

For your information, I attach expert evidence from Dr Andrew Wilcock (expert in palliative medicine and medical oncology) and Prof. David Black (consultant physician, geriatric medicine). These are the experts being called by the coroner. I attach a statement from each expert which he has prepared for each of the separate inquests. Perhaps you would care to have a quick look at these and let me have any points or issues that you feel are important and which should be raised. This will assist in our consideration of the matter in due course and especially when I instruct counsel.

Code A

The problem here is that these experts were instructed by the police essentially to advise on whether or not there were any criminal issues which needed to be considered. You will see that they say there are no criminal issues. There are however a number of recurring themes in these reports which you will no doubt see. In a couple of cases, you are criticised directly. You should be reassured however these are relatively minor criticisms when taken in the context of the whole case. Essentially, it appears there is some criticism of you for continuing or permitting this 'over prescription' of some patients and perhaps in failing to reduce the prescribed drugs far enough. Let me have your thoughts when you have had an opportunity to look at this.

If any questions arise out of the medical evidence, then you must not hesitate to contact me and I am happy to chat it through with you.

Interestingly, I do not believe there is any evidence that in fact these patients ever received 200mg of diamorphine. I know it was prescribed by Dr Barton but I don't find in the evidence that the patients ever received much more than 20 or 40mg. I accept that may still be 'too much' but I appreciate that Dr Barton was prescribing to allow drugs to be drawn down as and when, when she was off duty. Unfortunately, although understandable as that practice may be, am I right in thinking that the controlled drugs book would show that in fact no such high doses were ever supplied to patients?

Please do not worry unduly about this and if you have any questions, of course you must not hesitate to contact me.

Kind regards.

Yours sincerely

**Stuart Knowles**

**Code A**

**Code A**

Portsmouth Hospitals NHS
NHS Trust

Our Ref: RIR/ij
Your Ref: BSPK/4007152-0002/BJZM

Division of Medicine for Older People

Gosport War Memorial Hospital
Bury Road
GOSPORT
PO12 3PW

Tel: Code A

Mr Stuart Knowles

Code A


Date: 30th October 2008

Dear Mr Knowles Stuart

**Re: Gosport Inquests (Joint instruction) – Your letter dated 21st October 2008**

I would like to confirm that I have not involved my defence union in this matter and I am very pleased for you to offer support in respect of the Inquest.

I note that you have been supplied with a very old contact address!

For future communications it would be best to contact me at **Gosport War Memorial Hospital, Bury Road, Gosport, PO12 3PW.** My secretary can be contacted there on Code A

Code A

Yours sincerely

Code A

Dr R I Reid
Consultant Geriatrician

Code A

Dr I Reid
Hampshire Primary Care Trust
Raebarn House
Hulbert Road
Waterlooville
PO7 7GP

21 October 2008

Dear Dr Reid

**Gosport Inquests (Joint Instruction)**

Further to our recent meeting my apologies for not getting back to you.

As yet I have not received disclosure of documentation from the Coroner/Police and I have not had an opportunity of reviewing your statement. Hopefully I will be in a position to do this shortly. When I have read and reviewed the evidence then I will contact you again and it maybe that there will be some issues which I will be clarifying or want to go through with you.

I am assuming that you have not involved the MDU in this matter and I believe it is in order for the Trust and myself to continue to offer you assistance in this matter.

I do have this Inquest under active review and management and I will contact you again shortly. In the meantime if you have any questions or any issues arise you must not hesitate to contact me.

Kind regards

Yours sincerely

Code A

Stuart Knowles
Consultant
for Mills & Reeve LLP

cc: Jacqui Haines
Peter Mellor

Code A

X

Code A

**Subject:** FW: Inquests

**From:** Reid Ian - Consultant Code A
**Sent:** 06 October 2008 15:19
**To:** Stuart Knowles
**Subject:** RE: Inquests

Dear Stuart,

Thank you for responding so quickly.

I'd very much like to meet, but unfortunately, I'm based in Gosport which is about 30 mins drive from Queen Alexandra Hospital, where I presume you'll be meeting Lesley. I could possibly manage something very early on Friday, eg 8-8.30am (as I have to be back in Gosport for 9.30am), or at lunchtime, but the latter would be more difficult as I run a rapid access clinic on Fri am, and don't know how busy it'll be until Fri am!

I haven't been asked for my availability, although I understand fro Lesley that the inquests will start on 9th March and will last 4-6 weeks.

I look forward to meeting you, hopefully soon(!), as I have a number of (basic) questions about the processes.

Regards,

Ian.

**Stuart Knowles**

**Subject:** FW: Inquests

**From:** Stuart Knowles
**Sent:** 06 October 2008 14:52
**To:** 'Reid Ian - Consultant DMOP'
**Cc:** Code A
**Subject:** RE: Inquests

Dear Dr Reid

I am awaiting information from the Coroner on an urgent basis as to who is being called to give evidence. I would have thought that if you were to be called you would have heard by now - but I am checking the final list with the Coroner. I am afraid I am not at all confident that this matter is being well organised. It is listed for 6 weeks from 9th March ( I think) I would be surprised if the Coroner has set this date without getting availability of witnesses!

I am pushing matters along and will do my best.

I am seeing Lesley on Thursday afternoon - possibly Friday morning if we need more time. Are you around on Friday morning - even if its just to say hello and I can fill you in as best I can

Stuart

**Stuart Knowles**
Consultant
for Mills & Reeve LLP

Code A

**Stuart Knowles**

**From:** Reid Ian - Consultant DMOP Code A
**Sent:** 06 October 2008 14:19
**To:** Code A
**Subject:** RE: Inquests

Dear Code A

I wasn't aware that you have been asked to assist NHS staff with the inquests, but am pleased that you have.

I haven't heard anything from the coroner about whether my presence will be required (or anything else for that matter).

I would be very pleased to meet you. I can be contacted either by e-mail, or through my secretary - Code A ext 2028. She's not here today, but is usually available Mon-Fri 9-5pm. Alternatively my mobile no. is Code A

Thank you,

Ian Reid.

---

**From:** Stuart Knowles Code A
**Sent:** 06 October 2008 13:02
**To:** Reid Ian - Consultant DMOP
**Cc:** Humphrey Lesley - Divisional General Manager; Code B
**Subject:** Inquests

Dear Dr Reid

As I believe you are aware from Lesley Humphries I have been instructed to assist the NHS and NHS staff with the inquest process into the Gosport cases.

Perhaps you would be kind enough to confirm I have your email address correctly. I am keen to speak to you as soon as possible. I assume you will be required to give evidence and wonder whether you have heard from the Coroner...

Perhaps you would be kind enough to call me or alternatively let me have your contact details and I will call you.

Many thanks in anticipation

**Stuart Knowles**
Consultant
for Mills & Reeve LLP

Code A

## Stuart Knowles

**From:** Stuart Knowles
**Sent:** 06 October 2008 13:02
**To:** Code A
**Cc:** Humphrey Lesley - Divisional General Manager'; Code A
**Subject:** Inquests

Dear Dr Reid

As I believe you are aware from Lesley Humphries I have been instructed to assist the NHS and NHS staff with the inquest process into the Gosport cases.

Perhaps you would be kind enough to confirm I have your email address correctly. I am keen to speak to you as soon as possible. I assume you will be required to give evidence and wonder whether you have heard from the Coroner...

Perhaps you would be kind enough to call me or alternatively let me have your contact details and I will call you.

Many thanks in anticipation

**Stuart Knowles**
Consultant
for Mills & Reeve LLP

Code A

**Stuart Knowles**

**From:** Humphrey Lesley - Divisional General Manager [lesley.humphrey@porthosp.nhs.uk]
**Sent:** 06 October 2008 12:32
**To:** Stuart Knowles
**Cc:** Reid Ian - Consultant DMOP
**Subject:** RE: Inquest

Hi Code A

Here is email address for Ian Reid. Ian was Medical Director for Portsmouth Healthcare Trust and then for East Hants and Fareham and Gosport PCTs for a while. During all that time he was also consultant geriatrician for DMOP - and still is.

Ian, Stuart is acting for the Trust on the GWMH inquests. He is meeting with me later this week and will also need to meet with you soonish I suspect and then perhaps other consultants involved.

Best wishes

*Lesley*

**Lesley Humphrey**
**Divisional General Manager - Medicine for Older People**
**Portsmouth Hospital's NHS Trust**
**South Block, QAH**

**Code A**

-----Original Message-----
**From:** Stuart Knowles Code A
**Sent:** 03 October 2008 17:14
**To:** Humphrey Lesley - Divisional General Manager
**Subject:** Inquest

Lesley

Just left a message for you.

I believe Dr Read (?Reid) may be an important witness and wonder whether you are in a position to put me in contact with him. I'm afraid I am a little 'stale' on the up to date whereabouts of personnel. Is he still with the Trust?

Many thanks for your help on this one.

Have a good weekend

Kind regards
Stuart

**Stuart Knowles**
Consultant

Portsmouth Hospitals NHS
NHS Trust

Our Ref: RIR/ij
Your Ref: Code B

Division of Medicine for Older People

Gosport War Memorial Hospital
Bury Road
GOSPORT
PO12 3PW

Code B

Mr Stuart Knowles
Consultant
Mills & Reeve LLP

Code A

Code A

Date: 16th January 2009

Dear Code B

**Re: Gosport Inquests (Joint instruction)**

Further to our telephone conversation I am writing to expand on the comments in my earlier letter in relation to one of the expert witnesses, Dr Andrew Wilcock, whom the coroner proposes to call to the inquest to give evidence.

In relation to the care of Code A on page 38 of his statement (first paragraph, first line) Dr Wilcock records that "in my view Code A was not anticipated to be dying ---".

Fractured neck of femur incurs a very high mortality (up to 25%). Mortality will be even higher in patients who are more elderly Code A was 92) and who develop complications following their operation (as Code A did), and who also have existing medical conditions as Code A Code A did – ischaemic heart disease, mild memory impairment. Continuing pain after an operation for fractured neck of femur is, in my view, a very poor prognostic fact for survival.

Dr Wilcock doubts the cause of death as laid out in the death certificate but offers no further opinion on cause of death.

In respect of Code A on page 47 (paragraph 2, line 11) of his statement Dr Wilcock records that Code A "--- had no known underlying life-threatening illness, death was not anticipated ---".

This view is grossly erroneous.

Marked obesity itself confers a significantly reduced life expectancy. Code A had gross arthritis of both knees and had become immobile. Immobility further reduces life expectancy. Very significantly he had extensive pressure sores which would put him at risk of sepsis (and increased mortality). In addition he was incontinent of urine and faeces. This would inevitably contaminate his pressure sores making sepsis and its complications stress peptic ulceration, gastrointestinal haemorrhage and death.

Continued/...

The statements by Dr Wilcock would lead me to question how much experience he has in managing elderly patients who have sustained a fractured hip with complications and elderly patients with gross obesity, immobility and extensive pressure sores.

I note that his curriculum vitae states "---includes experience in health care of elderly (acute medicine and rehabilitation) ---". This would appear to have been at junior doctor level and is likely to have been four to six months at the most. He would not appear to have had any experience at consultant level in dealing with such patients.

This, and the statements above, which no doubt reflect his lack of experience in elderly medicine, would lead me to question his suitability as an expert witness at an inquest, the primary purpose of which is to determine cause of death.

Yours sincerely

**Code A**

Dr R I Reid
Consultant Geriatrician

Code A

**From:** Code A
**Sent:** 15 January 2009 10:44
**To:** Code B
**Subject:** Gosport

Dear Ian

Many thanks for your letter of 13 January the contents of which are noted.

I am putting this report in front of Counsel so that we can consider any issues at the forthcoming conference.

I am grateful to you for your assistance and if you have any further questions then of course you must not hesitate to contact me.

Kind regards

Yours sincerely

Sent on behalf of Stuart Knowles

Code A

Portsmouth Hospitals NHS
NHS Trust

Our Ref: RIR/lj
Your Ref: E Code A

Division of Medicine for Older People

Gosport War Memorial Hospital
Bury Road
GOSPORT
PO12 3PW

Mr Stuart Knowles
Consultant

Code A

Code A

Date: 13th January 2009

Dear Code A

Re: Gosport Inquests (Joint Instruction)

Thank you for your letters of the 4th December 2008 and 6th January 2009 and our subsequent telephone conversation.

You have asked me to make comments in relation to three areas. Firstly comments on the statements provided by the two expert witnesses, Dr Andrew Wilcock and Professor David Black. Secondly you have asked me to comment on the difference between prescribing practice now and in 1999 and thirdly you asked me to comment on Dr Barton's practice in 1999.

1. With regard to the comments of the expert witnesses it is notable that there are two main issues – inadequate note keeping and prescribing practice, particularly in relation to opiates.

Dr Wilcock also felt that in relation to two of the cases, Code A there was a case to be answered that the care was grossly negligent. This did not appear to be the view of Professor Black.

In relation to note keeping, best practice would dictate that every encounter with a patient is documented. A particular criticism is that on occasions opiates were prescribed or the dose increased without any apparent justification in the medical records. This is fair comment.

The second criticism is of prescribing practice, particularly opiates. Dr Wilcock's view would appear to be one of marked caution particularly in prescribing for the very elderly and would appear at times not to be set in context ie on some occasions his view would appear to be ensuring safe prescribing and not necessarily effective prescribing, given that in at least one of the patients the nursing documentation is littered with references to the patient being in pain.

Dr Wilcock specifically criticises me for not reducing the dose of Diamorphine enough (or stopping it). I can provide a detailed response to this if you wish.

Continued/...

**Gosport Inquests (Joint instruction) - continued**

Thirdly in relation to the case to be made for gross negligence I feel that in both patients, Code A Code A , Dr Wilcock has failed to take account of, or has not recognised the prognosis of both of these patients in his comments on their management. In my view both of these patients had an extremely poor prognosis which Dr Wilcock appears not to have recognised, ie his views on the management of these two patients have not been set in context. It is perhaps of note that he is a palliative care physician with an interest in medical oncology and I believe that one would have to question how much experience he has had in managing patients like Code A It is notable that Professor Black who practices in geriatric medicine, and who almost certainly has extensive experience of dealing with such patients, felt that both these patients had an (extremely) poor prognosis.

I also believe that Dr Wilcock's views on what would have been optimal management of these patients reflects academic palliative care practice and does not even reflect mainstream palliative/hospice practice today, eg Dr Wilcock refers to measuring respiratory rate and oxygen saturations. This would not be practised within the Rowans Hospice locally, according to the senior consultant there, Dr Huw Jones, to whom I spoke recently. Also Dr Wilcock refers to administering Naloxone to reverse the effects of opiates. This is not without problems, ie causing significant pain !!

2. Next you asked me to comment in the difference between prescribing practice then and now.

I think that medical and nursing staff within our department are now much better informed, about prescribing of opiates, in particular, than they were in 1999.

In 1999 I was not aware of the existence of the Wessex Palliative Care Protocols nor, would I suspect, were (most of) my consultant colleagues. I also suspect in 1999 there was low awareness of good prescribing practice of opiates within General Practice.

In 2009, while prescribing practice of opiates within the Department of Medicine for Older People is good, I do not believe that that knowledge extends far beyond our own department (and the Palliative Care Service). Many junior staff come into our department poorly educated in the prescribing of opiates. My local consultants in palliative care tell me that palliative care (opiate) prescribing in primary care (General Practice) is still poor.

As you are aware, Diamorphine and other drugs were prescribed with a (wide) dosage range in 1999. I do not believe that this would happen today, certainly within the Division of Medicine for Older Persons, but two of my colleagues in Portsmouth, Dr David Jarrett and Dr Jane Tandy have told me that they quite clearly remember opiates being prescribed in a variable dose in other hospitals within Portsmouth (including the acute hospital) when syringe drivers were first introduced (sometime before 1999).

It is also of note that even today the Wessex Palliative Care Protocols refer to the fact that it may be necessary to administer between 20mg and 200mg of Diamorphine to relieve pain and it may have been from this source that variable dose prescribing arose.

3. Lastly you asked me to comment on Dr Barton's practice. Was this common in 1999?

In relation to note keeping it has been my experience when visiting community hospitals where GP's provide day-to-day care that note keeping was of a standard not dissimilar to that of Dr Barton.

Continued/...

Gosport Inquests (Joint instruction) - continued

In 1999 I had recently moved to Portsmouth from Southampton and had experience of note keeping in Romsey Hospital and to a lesser extent Fenwick Hospital and Lymington Infirmary, where note keeping was of a similarly brief nature, much as would have been the case within GP records in primary care at that time.

I think it would be important to point out that on transfer to a community hospital one would not expect the same detail of clerking and note keeping as would be undertaken on admission to an acute hospital. (On occasions I have seen patients in community hospitals who have had nothing recorded in their notes on admission!!)

My impression was that while Dr Barton's notes were usually brief, she had usually captured the essence of the reason for transfer in her notes and recorded important changes in patients' condition.

In relation to prescribing in GP community hospitals and in primary care, my experience and that palliative care consultant colleagues in Southampton, was that it was generally poor in 1999 and remains poor today.

I hope these comments are helpful. If you would like me to elaborate further should be very happy to do so.

Yours sincerely

Code A

Dr R I Reid
Consultant Geriatrician

| | |
|---|---|
| Client: | Hampshire Primary Care Trust - 4007152-0002 |
| Matter: | Gosport Inquests (Joint Instruction) |
| Date of Attendance: | 9 January 2009 |
| Fee Earner: | Stuart Knowles |

---

Dr Ian Reid telephoning in. He had a 3 preliminary comments on the experts reports.

1. He agreed with the comments on nursing and note keeping which were generally poor. .

2. He doesn't agree with Dr Wilcox's comments about "test doses of Diamorphine" to be used on palliative care. Dr Reid suggested that that would not be common knowledge in 1998 and he would not expect Dr Barton to be aware of this.

3. He referred to Dr Wilcox's comments with regard to gross negligence. He referred particularly to the 2 cases where he is criticised. He said that Dr Wilcox has looked at both patients as though they were people without pre-existent problems. Here we had a case of a Code B who was 92 years of age with a fractured neck of femur and a 62 year old Code B with serious comorbidities. He questioned what experience Dr Wilcox had in dealing with these types of patients. From his comments he thought that it might be outside his expertise.

Other points Dr Reid confirmed.

1. Dr Logan was only prolifarily involved and doesn't really have much to contribute.

2. I can contact Dr Logan at the Department of Medicine for Elderly People at the QEH.

3. He confirmed that Dr Lord was now in New Zeland.

4. I confirmed that the Inquest would be at the Combined Court Centre in Portsmouth and I said that we will discuss how to handle the Inquest and deal with any questions and issues well before the attendance.

5. I asked Dr Reid to consider a further question. I asked him to comment on the prescribing practices as they were in 1998 and as they are now and also to consider Dr Barton's practice of prescribing a range and to consider whether or not that was "accepted" practice at the time. Was it accepted "on the nod" or was it something which was common practice and encouraged? I pointed out the experts were critical of this and didn't seem to be able to support this practice so it appears that it might not have been generally "acceptable". I wonder whether he could say what the position was in other Trusts in the 1990s and whether or not it was generally accepted "on the ground" that this practice went on.

SPK

Time taken: 3 units

Code A

Dr I Reid
Hampshire Primary Care Trust
Raebarn House
Hulbert Road
Waterlooville
PO7 7GP

6 January 2009

Code A

Dear Dr Reid

**Gosport Inquests (Joint Instruction)**

I am writing further to my letter of 4 December and to our subsequent telephone conversation.

I wonder whether you have had an opportunity of reviewing the expert evidence in this matter? I certainly wwould be interested in discussing this matter with you further and any comments that you may have.

You will be contacted (indeed you may already have been) by my assistant Code B She is helping me to set up a conference with our Barrister in this matter and I am keen that your dates of availability are taken into account so that you can attend if possible.

I appreciate that you are criticised in many respects (only in the periphery) by the experts but I do appreciate that that may be causing you some concern. If this is the case, I am happy to assist you in any way that I can.

I am not sure whether you have contacted the MDU but I would be happy to discuss matters further with you if you wish. I look forward to hearing from you and of course you must hesitate to contact me at any time.

Kind regards

Yours sincerely

**Stuart Knowles**
Consultant
for Mills & Reeve LLP

Code A

## Stuart Knowles

**From:** Stuart Knowles
**Sent:** 19 March 2009 12:16
**To:** Reid Ian - Consultant DMOP
**Cc:** Code A

**Importance:** High

Dear Ian

I have now returned to Birmingham following the first day of the Inquest. I expect you watched it on telly and read all about it in the papers.

One of the issues that became clear was that the timetable originally produced by the Coroner was no longer going to work. As a consequence the Coroner has tried to re- jig the timetable. I think you might hear from him shortly. In the meantime he is suggesting that you give evidence on March 31 and April 1. I think this is about a week earlier than was originally envisaged.

In order that we can make appropriate representations to the Coroner perhaps you would be kind enough to look at your diary and let me know what the situation is with those dates.

If you have any questions then of course you mustn't hesitate to contact me at any time and I will do my best to assist.

Kind regards

Stuart Knowles

**Stuart Knowles**
Consultant
for Mills & Reeve LLP

Code A

## Stuart Knowles

**From:** Stuart Knowles
**Sent:**
**To:** Code A
**Cc:**
**Subject:**

**Attachments:** Summaries of Ian Reid's Interviews with Police.pdf; Letter from HM Coroner dated 26.02.09.pdf; Letters from Dr Ian Reid dated 13 + 16 Jan 09.pdf; CHI Response Table.pdf; Pharmacy Report.pdf


Summaries of Ian Reid's Interv...


Letter from HM Coroner dated 2...


Letters from Dr Ian Reid dated...


CHI Response Table.pdf (2 MB)


Pharmacy Report.pdf (32 KB)

Dear Code A

In advance of the meeting on Friday I attach the following in case you have not received them:-

1. Summaries of Ian Reid's interviews with the Police. These have been prepared by the Police and sent to the Coroner for his consideration. Ian is not entirely happy with the summaries but I have reassured him that they are not the basis of any evidence which he may provide to the Coroner.

2. Letter from the Coroner dated 26 February the contents of which are self explanatory and no doubt we can discuss on Friday.

3. Letters from Ian Reid of 13 January 2009 and 16 January 2009.

4. Update to CHI Response Table.

5. Pharmacy Report.

As you are aware Dr Ann Dowd the current clinical lead in the hospital is reviewing the "expert" reports and will be with us on Friday to discuss and advise. If I receive anything from her prior to the meeting I will let you know.

I assume that you have got the original Police interviews. It is not my intention to bring these with me on Friday since they are so bulky and I hope that you will be able to work from your documents. If there is a problem please do let me know.

I wonder whether it would be possible for me to have a chat prior to the meeting at 10:00 on Friday possibly at 09:15 or 09:30. There are one or two housekeeper items which I need to discuss with you but it shouldn't take too long. I assume that Kiran on behalf of the PCT would wish to be present and the housekeeping items are nothing confidential to PHT.

If any of the issues arise then please don't hesitate to call me prior to the meeting on Friday and I will be happy to chat.

Yours

Stuart
**Stuart Knowles**
Consultant
for Mills & Reeve LLP

Code A

## Stuart Knowles

**Subject:** FW: Summaraies of evidence produced by the police

-----Original Message-----
From: Stuart Knowles
Sent: 12 February 2009 16:54
To: 'Reid Ian - Consultant DMOP'
Cc: Mellor Peter - Company Secretary; Code A Code B Code A
Subject: Summaraies of evidence produced by the police

Ian

Thank you for getting back to me and for looking at the summaries. I have also sent the summaries to counsel.

It is my understanding from the police that these have been recently completed by Code A and sent to the Coroner - presumably to save him the trouble of reading through the complete set! Of course you and we will have to do that at some time!

The purpose, I believe, is to give the Coroner a 'flavour' of the contents and to guide him in his decision whether to call you on these additional inquests. If you believe they are materially inaccurate we could point this out to the Coroner if you let me have details. They are not documents which can be put in evidence - they are not signed or approved by you. They should not go to the families. They will not go before the jury because that would be highly prejudicial.

The rule of evidence here is that it is the oral evidence which you give on oath that counts and not any documents prepared by third parties.

As far as your summons is concerned:

3rd April - Evidence on E. Devine (which involves you)

9th April - Evidence on S Gregory (which involves you)

From my list the Coroner has listed a second day for possible evidence on the matter of Devine for the 8th April. I am not sure why - it appears to me that you are early in his list to hear from with this patient but I suppose he might change around the order of witnesses from that suggested in his list. Is the 8th a problem? If it is insurmountable I will contact the Coroner. I would be hopeful that you would not be needed on both days and that the day for your attendance could be agreed nearer the time.

Now that the Coroner has the report from the police I assume he now realises you were involved in Code A Code A Whether he knew this before I can not say. If not then to some extent it beggars belief! However at the hearing before the Coroner last month he admitted that he was unable to remember all the people from whom he had read reports!

My advice on this is not to worry about the summary and we will go through the evidence when we meet counsel. I will press the Coroner before then for a decision as to whether you are needed to give evidence on Code A

Kind regards,

Stuart

Stuart Knowles
Consultant
for Mills & Reeve LLP

Code A

-----Original Message-----
From: Reid Ian - Consultant DMOP Code A
Sent: 11 February 2009 13:26
To: Stuart Knowles
Subject: RE: Gosport Inquest

Dear Code A

Thank you for the summary. There are one or two things in it which don't, I feel, represent what I meant, and one which I definitely think is wrong. Do I need to be concerned about that? Are these statements made available to the families?

When I git home last night, a summons was awaiting me from the coroner asking me to attend the inquest on 3rd April, and also stating that I'd probably be required on 8th and 9th April. I was aware of the 3rd and 9th from our meeting with counsel on 26th Jan, but not 8th April.

As the only consultant who appears to be being called, is the coroner aware that only 4 of the cases were mine. Is he aware now that Code A are my cases, and not just Code A

Ian.

## Stuart Knowles

**From:** Stuart Knowles
**Sent:** 10 February 2009 12:23
**To:** 'ian.reid@porthosp.nhs.uk'
**Cc:** Code A Mellor Peter - Company Secretary; Martin Neil - Operational Manager DMOP
**Subject:** Gosport - urgent

**Importance:** High

Ian,

I refer to my email of 30th Jan.

The transcripts of evidence have been sent to Counsel.

I have not heard from the Coroner yet but I am chasing.

As a matter of urgency we need to get the date of your meeting with counsel in our diaries. I propose we meet Counsel in London - It might be a bit of a trek for you but it will be more cost effective for the NHS. Can you let me have some dates today? I think we will need half a day.

I spoke to Anne Dowd last week who seemed quite sensible as far as the expert evidence of Black and Wilcock is concerned. Her view seemed to be that their evidence was based on academic views and betrayed some lack of experience in dealing with end of life care on the ward situation. I think we would both agree with that. I asked her if she would help us with our thoughts and response to the reports of Black and Wilcock and she seemed quite happy to do that. I suspect it would be easier to use her rather than try and engage the assistance of an external expert who might be able to offer us little more support. We won't be calling any experts - we would only be suing them to provide 'ammunition for our counsel'.

Do you agree? If so I want to 'get her on the job' immediately. Would you be happy for Dr Dowd to come to con with you to discuss with counsel? If you would prefer to see counsel on your own - please say so it would not be a problem and I will sort out Dr Dowd separately. If you are happy for her to attend then we can have a wide ranging discussion and take this matter significantly forward.

Don't hesitate to call if you want to chat. I look forward to hearing from you.

Kind regards

Stuart
**Stuart Knowles**
Consultant
for Mills & Reeve LLP

Code A

**Theresa Roberts**

**From:** Theresa Roberts
**Sent:** 05 February 2009 10:48
**To:** Code A
**Subject:** FW: Y25a

Dear Code A

As agreed here are the transcripts. Happy reading!

Code A

**From:** roy.stephenson@hampshire.pnn.police.uk Code A
**Sent:** 28 January 2009 13:08
**To:** Code B
**Subject:** Y25a

## RESTRICTED .

## RECORD OF INTERVIEW

**Number:** Y25A

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

Person interviewed: **REID, RICHARD IAN**

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 1002 Time concluded: 1042

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

Interviewer(s): Code A

Other persons present: Mr CHILDS - Solicitor

Police Exhibit No: Number of Pages: 25

Signature of interviewer producing exhibit

Person speaking Text

**Code A** This is a continuation of the interview of Doctor Richard Ian REID. Doctor can you just confirm that we just stopped briefly just to change the tapes over?

REID Yes.

Code A Yeah. And the personnel in the room still stayed the same?

REID The same, yes.

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

REID No.

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

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

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

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

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

REID Six weeks.

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

REID No. I certainly took my full quota.

Code A Sorry?

REID I would have taken the full quota.

Code A Yeah, okay.

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

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

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

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

REID About a week or two weeks.

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

REID Yeah.

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

REID Yeah.

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

REID Smoothly.

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

REID None.

Code A None at all?

REID No.

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

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

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

Code A Yes please go on.

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

Code A Yeah.

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

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

REID I've no recollection of there being a locum in Gosport in the time I was there I couldn't, you

know,...

Code A No.

REID ... say absolutely not but I have no recollection of it.

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

REID Yes...

Code A Yeah.

REID ...at the same time.

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

REID At least twice a week.

Code A And what wards would they have been?

REID There was an Ann ward.

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

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

Code A Yeah.

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

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

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

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

REID Once a week.

Code A Once a week.

REID On a Monday afternoon.

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

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

Code A Obviously I was talking about in the absence of Doctor LORD.

REID Yes, yeah, yeah.

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

REID Yeah, yeah.

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

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

Code A So it's quite recent, yeah.

REID But not at that time.

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

REID There's no cover.

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

REID No.

Code A No. Presumably, say for arguments sake something untoward had occurred to you and you had a forced lay off with a broken leg or something and you're off work for four months

REID That, that...

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

REID That would have been different.

Code A Yeah.

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

Code A Yeah.

REID ...and, um, I mean it usually would have been sort of, Doctor JARRETT would have made the decision.

Code A Uh-huh.

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

REID Yes.

Code A So would that be if you were away for two weeks and let's say for arguments sake whoever was doing the ward rounds whether it be Doctor BARTON or somebody else, there was someone that they, when you weren't there there was someone they could contact?

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

Code A Yeah.

REID ...so that sort of thing would happen.

Code A Okay. So no local cover was arranged at all?

REID No.

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

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

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

REID Yes.

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

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

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

REID Yes.

Code A Yeah.

REID Yeah.

Code A Have you got any questions Code A

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

REID Yeah.

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

REID Yes.

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

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

Code A Uh-huh.

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

Code A Right.

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

Code A Yes.

REID ...the new development of policies, that sort of thing.

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

REID Yeah.

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

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

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

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

Code A Yeah.

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

Code A Yeah.

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

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

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

Code A Yeah.

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

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

REID No it's just completely, it's completely different really...

Code A Right. I understand the Registrars...

REID ...and the Senior Registrars are still in training.

Code A Training yeah.

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

Code A Yeah.

REID ...or would be covering say St. Christopher's Hospital...

Code A So they've got a good standing?

REID Yes.

Code A They've got an equal...

REID Yes.

Code A ...standing so to speak?

REID Yeah. They're not Doctors in training,...

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

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

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

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

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

REID Yeah.

Code A ...what was that about?

REID It was about, um, and I can't remember what it was entitled, um, it was called 'A Senior Management Programme' and it was at Keele University and it wasn't for Doctors, there were a couple of Doctors on the course, but it was for, you know,...

Code A General management?

REID Yes.

Code A Non-specific?

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

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

REID Right.

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

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

Code A Yeah.

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

Code A Uh-huh, yeah.

REID ...about that time, so.

Code A Thanks.

Code A Finished with that Code A

Code A Yeah.

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

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

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

REID Yeah.

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

REID Um yes on, on Ann Ward I did,...

Code A Yeah.

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

Code A Yeah.

REID ...person on the ward but first job.

Code A Pardon?

REID The first or second job out of medical school.

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

REID Yes.

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

REID Yes.

Code A Yeah. Regarding the patients, yeah?

REID Yeah.

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

REID Yeah there's three of us.

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

REID Yes.

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

REID No. There was just Doctor BARTON.

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

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

Code A Evolution.

REID Yeah history really.

Code A Yeah.

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

Code A Yeah.

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

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

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

Code A Yeah.

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

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

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

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

REID Yeah.

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

REID No.

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

REID Yes.

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

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

Code A Yeah.

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

Code A Yeah.

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

Code A Right.

REID ...because there's a sort of...

Code A Yeah.

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

Code A During that time?

REID Yeah.

Code A Uh-huh.

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

Code A Yeah.

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

Code A Yeah.

REID ...and support the Junior Doctors there.

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

REID At Q.A.

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

REID Yeah.

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

REID Yes.

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

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

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

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

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

REID Yes.

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

REID Yeah.

Code A I've got you.

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

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

REID Yes and more really.

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

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

Code A Yeah.

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

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

REID No.

Code A No?

REID No. That was, that was decided by, by a Doctor JARRETT,...

Code A Yeah.

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

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

REID Yeah.

**Code A** How it,...

REID Yes.

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

REID Yeah and by responsibilities.

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

REID Yeah he was the person who made the decision.

**Code A** ...where you worked?

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

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

REID Yes, yes.

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

REID No.

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

REID Oh nine o'clock.

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

REID One, one probably (1300).

**Code A** And would you see everybody on the ward?

REID Oh yeah.

**Code A** You'd see all the patients?

REID Yes.

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

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

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

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

Code A Yeah.

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

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

REID And I had to go down to Gosport.

Code A And what time would you be down there?

REID I usually go down for about two (1400).

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

REID Yes.

Code A Yeah and go through the same...

REID Yes.

Code A Yeah. And finishing at what time then?

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

Code A Yeah.

REID ...so you'd be there after that.

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

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

Code A Yeah.

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

Gosport, you know, wasn't a major time consideration say compared to writing the notes at Q.A.

Code A And why was that because?

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

Code A Yeah.

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

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

REID Usually.

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

REID They do yeah.

Code A Yeah, yeah.

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

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

REID Yeah.

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

REID Yes.

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

REID See relatives...

Code A Yeah.

REID ...and do other things.

Code A Yeah and then you go.

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

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

down there?

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

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

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

Code A Yeah,

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

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

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

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

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

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

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

REID Uh-huh.

Code A ...within both hospitals obviously?

REID Yeah.

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

REID Yes.

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

REID Yeah.

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

REID Oh yeah, oh, (laughs) I mean I could produce a list…

Code A Yeah.

REID …but it's huge.

Code A Huge yeah.

REID Um I was, um, there was a small executive team which met, I think we met weekly in the Chief Executive's office, um, but you know thqat I was just a tiny bit of it. As I say I can produce a list of all the committees I was either chairing, or being involved in.

Code A And I think…

Code A Then was that as a Medical Director?

REID Yes.

Code A Yeah.

Code A Or more as a Consultant?

REID Most of them were as a Medical Director, some were as a Consultant.

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

REID Yes. Most as a Medical Director though.

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

REID (Laughs)

Code A …with those roles. …

REID Yes.

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

REID Nominally,…

Code A Yeah.

REID …but in practice it worked out probably I was spending a third of my time clinically and, and two-thirds being Medical Director.

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

REID Yeah. I was working far in excess of that.

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

Code A No.

No. Right the next role Doctor REID is, again it's an opportunity to explain about the Clinical Assistant…

REID Yeah.

Code A …involving this, how people become appointed and how this would impact on their role as a G.P. and that sort of thing through their experience. What was the role of the Gosport War Memorial Hospital within the local community?

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

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

REID Sorry just start again?

Code A Before you started…

REID Yes.

Code A …working there,…

REID Uh-huh.

Code A …were there any great changes…

REID Not at all no.

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

REID Yeah.

Code A taking those...

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

Code A What are the 'bed fund holders'?

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

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

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

Code A Yeah and...

REID ...and someone would apply for it.

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

REID If they're very, very, experienced yeah,...

Code A Yeah, yeah.

REID ...but that would be exceptional.

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

REID Um, I...

Code A Or is it?

REID I think all Doctors can be yeah.

Code A Yeah.

REID Um I mean most Clinical Assistants are probably G.P.'s who are working either in a Dermatology Clinic, or under sort of the supervision of a Consultant, or in an Ear, Nose and Throat Clinic, or sometimes it's orthopaedics. So they're probably people who have had a little bit more experience of that, um, during their Junior Doctor training so they might have happened, because to be a G.P. you've got to go through training and do jobs in hospital, so you might have spent three months doing ENT and decided you'd quite like to continue doing a couple of clinics in ENT.

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

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

Code A Yeah.

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

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

REID Click on?

Code A Yeah sure.

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

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

Code A Yeah.

REID Okay.

Code A What's the time?

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

INTERVIEW CONCLUDES – TAPE MACHINE IS SWITCHED OFF.

Code A

Dr I Reid
Hampshire Primary Care Trust
Raebarn House
Hulbert Road
Waterlooville
PO7 7GP

27 January 2009

Dear Ian

**Gosport Inquests (Joint Instruction)**

Further to our conference perhaps you would be kind enough to let me have a copy set of your 2 additional witness statements which do not appear to have been released to the Coroner. I have no idea whether or not he has seen them and whether the Police made them available to him but I will check. I will then take this opportunity of reviewing them and conform the discussion with our next meeting with Counsel.

Perhaps you would be kind enough to look at your diary and let me have dates in February that you are available to attend a meeting with Counsel to go through your evidence. I suspect it will be easier and perhaps more cost effective on this occasion if the conference is held in London.

As always if you have any questions you must not hesitate to contact me.

Yours sincerely

Code A

Code A

| | |
|---|---|
| Client: | Portsmouth Hospitals NHS Trust - 3000019-1201 |
| Matter: | Gosport Inquests (Joint Instruction) |
| Date of Attendance: | 31 March 2009 |
| Fee Earner: | Stuart Knowles |

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**Pre- Inquest Conference- Morning**

In Attendance

**Code A**

Peter Mellor, Company Secretary (PM)
Mary Deeks, Project Officer (MD)
Ian Reid, Consultant Geriatrician (IR)

PM informed those in attendance that Richard Samuel had informed him that Dr Reid was extremely nervous and broke down when he attended the inquest the day before he was to give evidence (Note that IR was not in attendance at this time).

BB noted that questions had been raised which related to bed transfer. PM stated that he had spoken Graham and that it was impossible for patients to be transferred from QA to Gosport when there was a problem with beds. Graham was adamant that this was not the case as there was a delineation between the two organisations.

BB stated that IR would be best placed to answer questions in relation to 'bed blocking'.

*IR joined us at this point.*

IR explained that there was a waiting list for each ward and the patient at the top of the list would get a bed at Gosport when it became available. PM asked if this was with the permission of the trust health board. IR replied that it was established practice.

BB asked IR to explain the service at that time. IR stated that there had been a decision to maintain NHS continuing care beds. Around 1999, they started discharging patients who had been in hospital for a long time; this created empty beds as well as pressure to fill them.

BB also asked IR to explain his understanding of bed blocking. IR stated that this relates to patients who are medically fit for discharge who cannot be removed for social and other reasons. BB also inquired as to whether IR had any concerns about Dr Barton and he stated that he had no concerns and that he would have raised it with her if that had been the case.

BB asked if patients had been transferred too early. IR stated that if a patient had been reviewed by an orthopaedic surgeon for instance and they were satisfied that the patient could be transferred, then this would suffice.

IR also explained that TLC means tender loving care; when this was written, they would not consider life saving treatment. BB asked if this was palliative care and he confirmed that it was.

**Lunch break conference**

BB informed IR that she proposed to request a 'strike out' in reference to IR's opinion on Elsie Devine's treatment.

BB also told IR that she had spoken to the other barristers in order to try and "ease his passage" in the witness box.

BB stated that bed-blocking issues may be raised during the inquest as Jeanette Bean had referred to Mrs Devine as a bed-blocker.

**Evening Conference**

PM stated that Nephrologist, Judith Stevens, was in agreement with the family. Judith stated that chronic renal failure had been changed to chronic renal disease because the previous name had been distressing. Essentially, it remained the same thing.

PM stated that Judith explained that people would normally have creatinine ranging between 50 to 60. Although Mrs Devine's creatinine level was at 200, Judith stated that this was not a problem. It would become problematic when it reached 800; dialysis would then become necessary.

Judith Stevens was of the opinion that something had caused Mrs Devine's creatinine levels to go from 200 to 360 . She stated that lack of water was a possible cause and not diamorphine. If Mrs Devine was dehydrated, this could have caused damage to her kidneys.

According to Judith Stevens, Mrs Devine had multiple myeloma but this conflicted with the opinion of Dr Cranfield who stated that she did not.

PM stated that he was considering making Ann Dowd the spokesperson for the PHT as opposed to Graham.

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|---|---|
| Client: | Portsmouth Hospitals NHS Trust - 3000019-1201 |
| Matter: | Gosport Inquests (Joint Instruction) |
| Date of Attendance: | 20 March 2009 |
| Fee Earner: | Stuart Knowles |

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SPK receiving a return call from Ian Reid.

I explained the situation to him in respect of the additional statement from Nurse Hamblin and some documentation with regard to prescribing practices in the 1990s.

I indicated their appeared to be some confusion with regard to anticipatory prescribing and prescribing with a range and that there may be some policies and procedures from the 1990s which needed careful consideration.

It was agreed that an appointment would be made for him to discuss this with Counsel and with Peter Mellor on Monday morning. It was agreed that I would give his number to **Code B** **Code A** so that they could make arrangements on Monday morning.

Ian also indicated that he had a copy of the statement that he gave to Field Fisher Water House and he would bring this to the meeting on Monday so that we could consider it.

I indicated that we would need a conference with him later in the week.

In subsequent discussions during the day with Peter Mellor and **Code A** it was agreed that they would meet at 08.00 in Peter Mellor's office.

## Stuart Knowles

**From:** Reid Ian - Consultant DMOP [ian.reid@porthosp.nhs.uk]
**Sent:** 19 March 2009 14:32
**To:** Code A
**Subject:** RE:

Dear Code A

I can attend on the 31st March. I'm supposed to be going to a study day in London on 1st April, but I'm happy to cancel that to get the inquests over with. However, I'd like to know asap so that I can get as much of a refund as possible? Am I also to attend on 3rd, 8th and 9th April, or is this instead of? Also, am I still only giving evidence on Code A now included?

Ian.

**From:** Stuart Knowles [Code A
**Sent:** 19 March 2009 12:16
**To:** Reid Ian - Consultant DMOP
**Cc:** Jill Mason; Code A Mellor Peter - Company Secretary
**Subject:**
**Importance:** High

Dear Ian

I have now returned to Birmingham following the first day of the Inquest. I expect you watched it on telly and read all about it in the papers.

One of the issues that became clear was that the timetable originally produced by the Coroner was no longer going to work. As a consequence the Coroner has tried to re- jig the timetable. I think you might hear from him shortly. In the meantime he is suggesting that you give evidence on March 31 and April 1. I think this is about a week earlier than was originally envisaged.

In order that we can make appropriate representations to the Coroner perhaps you would be kind enough to look at your diary and let me know what the situation is with those dates.

If you have any questions then of course you mustn't hesitate to contact me at any time and I will do my best to assist.

Kind regards

Stuart Knowles

**Stuart Knowles**
Consultant
for Mills & Reeve LLP

Code A

Code A

Please consider the environment - do you really need to print this email?

Code A

| | |
|---|---|
| Client: | Portsmouth Hospitals NHS Trust - 3000019-1201 |
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Notes of a statement of Dr Ian Reid dated 17 June 2008 provided to the GMC.

SPK considering this statement and making notes during the Hearing of the Inquest. The following points are noted from the witness statement.

- IR indicates that he saw Dr B about once a fortnight during the ward round.
- He believes that Dr B is a good Doctor.
- He refers to his interview to the Police on 4 July 2006 page 45 "I remember on one occasion speaking to Dr Barton…".
- He now says that he cannot remember exactly when he has had discussions with Dr Barton about particular patients.
- IR does indicate that he can remember a conversation with Dr B when she said that over the bank holiday period it had been hard to get cover from her GP partners and therefore had prescribed a range of drugs so patients wouldn't have to wait.
- He does not recollect Dr B frequently prescribing drugs in advance.
- IR explained that he would not look at the reverse side of the drug charts. He indicates that during his ward round he would look at the front of the drug chart and would see which drugs the patient was on. (SPK by implications accepts that he would not know a particular amount or prescription of each drug).
- He does not remember seeing any prescriptions written in advance.
- He says that if he was prescribing to patients he would use the analgesic ladder. He does indicate however that anticipatory prescribing can be good practice in certain circumstances. He indicates this could be for post operative pain control or if a patient was terminally ill and needed drug relief pain/distress if there was no medical cover.
- He accepts that notes of Dr B were poor and brief and were as a consequence of the pressures of work.
- He does remember a conversation in early 2000 with Dr B in connection with the pressures of the job. At this stage it appears that IR was undertaking a risk assessment of the role.
- At about this time IR indicated that the nature of the patients changed and GWMH. They were more poorly with acute problems and there was an increase in discharges to GWMH from the acute sector.

- He remembers discussions at this time with Dr Barton but this was not a reflection as a result of any complaints and he had no concerns over Dr Barton's practice.

- He indicates that Dr Barton and Nurse Hamblai worked closely together and he found that it was difficult for them to be flexible.

- His main concern was over Dr B's work clothes.

- IR indicates that patients were transferred from the acute sector once acute problems no longer needed to be dealt with and medics on the acute ward were to give an "over optimistic view" of the prognosis. Quotes like "a patient will be upon their feet in no time".

- His view was that they wanted to get them, off the acute ward as soon as possible.

- A patient's relatives were told that their patient has been transferred for "rehabilitation". In his view IR felt that there was little prospect or benefit. He said that this was an issue that was hard for staff at GWMH (both nursing and clinical) to deal with at to handle their expectations.

- IR said that he will do his to rehabilitate patients but often their prospects were very poor.

- He indicates that missing records would be a "theme of transfer to GWMH". Notes from Haslar/QA/St Mary's were not always present with the patient.

- There were some further paragraphs which I did not have time to read fully and there were also several exhibits which I believe were Police statements.