Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

FFW/115/01

WITNESS INFORMATION
(NURSES AND OTHER PROFESSIONALS)

X378090

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Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR JANE BARTON

WITNESS INFORMATION (NURSES AND OTHER PROFESSIONALS)

PHILIP BEED

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(05.03.2008)
(05.03.2008)

General Medical Council

Dr Jane Barton

Statement of Philip James Beed

I, **Philip James Beed,** will say as follows:

1. I make this statement in relation to the General Medical Council investigation into Dr Barton. I was previously interviewed by Hampshire Police on 24 July 2000 and I make this statement further to that interview.

2. Exhibited to this statement and marked "**PBI**" is a copy of the transcript of that interview. The transcript is broken down as follows:-

   (a) 1100 to 1145 hours (37 pages)

   (b) 1214 to 1250 hours (25 pages)

   (c) 1412 to 1452 hours (29 pages)

   (d) 1458 to 1541 hours (35 pages)

   (e) 1552 to 1604 hours (15 pages)

3. I am currently employed as a Senior Staff Nurse in the Multi-Disciplinary Response Team for Hampshire Primary Care Trust. Within this role I see patients in their own homes. It is quite a varied role and covers all of Fareham and Gosport. I have been employed in this position for the last 14 months.

4. I qualified in 1984 as a nurse whilst in the Navy. I worked in an ear, nose and throat ward for about a year and then specialised in ophthalmology whilst in the Navy. I left the Navy in 1989 and then worked for BUPA at Havant for five years. I then worked in Oxford at the Eye Hospital and also at Oxford Brookes University teaching and nursing at the same time.

5. In 1998 I took up a post at the Gosport War Memorial Hospital. I was employed as the Clinical Manager of Daedalus Ward.

6. I worked on Daedalus Ward until some time in 2004 and I then worked in intermediate care before commencing my current role.

7. Whilst I worked on Daedalus Ward I had 24-hour management responsibility.

8. I was the Clinical Manager of Daedalus Ward and I was supported by senior staff nurses. On days the Senior Staff Nurse post was held successively by; Yvonne Astridge, Pat Wilkinson and Rachel Ashton. There were usually six trained staff covering day shifts and about four trained staff covering night shifts, the exact numbers varied as staff left and new staff joined. There were also support workers giving us total of about 30 full time and part time staff. Dr Barton was the Clinical Assistant for Daedalus Ward and Dr Lord was the Consultant.

9. Dr Barton would attend Daedalus Ward every weekday morning to carry out a review of the patients. She would arrive at around 8 am. Dr Barton would return about midday to clerk any admissions. This occurred as and when we had admissions so could potentially be on any day of the week.

10. If we had any concerns within working hours then we would telephone Dr Barton or whoever was on call for her Practice.

11. Dr Lord would carry out a consultant ward once a week and Dr Barton would carry out a ward round on a daily basis as described above.

12. I did not have any concerns at the time I was working on Daedalus Ward about Dr Barton.

13. When I commenced working on Daedalus Ward in 1998 I had a lot of experience working variety of areas of nursing, and working with patients of all ages including the elderly, this provided me with a range of transferable skills and knowledge. I also had a comprehensive induction programme and was able to draw on guidance from other senior & therapy colleagues to assist me in adapting to the speciality. Standards of nursing practice on Daedalus Ward appeared to be consistent with other wards within the hospital and within the Department for Elderly Medicine and Queen Alexandra Hospital Cosham.

14. Of the wards in Gosport War Memorial Hospital Daedalus Ward was, in my opinion, busiest ward.

15. As with other community hospitals care is primarily carried out by nursing and therapy staff. Were a patients pain was not adequately controlled necessary increases in analgesia could be made in accordance with a medically prescribed range at the discretion of a qualified nurse.Gosport War Memorial Hospital is a community

hospital then the care was very much nursing and therapist led. This meant that there were occasions where a patient could be in distress or pain if we needed to increase their dosage of pain medication but we needed to get hold of the doctor first to do this.

16. In my interview of 24 July 2000 exhibited at **PB1** I have been asked a number of questions regarding the use of syringe drivers. I have nothing more to add at this stage regarding this matter.

17. I have been asked to expand upon my recollections of the treatment of the patient Gladys Richards.

18. I have detailed my recollection of the care of Mrs Richards from page 14 of exhibit **PB1(b)**.

19. I would like to add the following regarding my recollection of Mrs Richards.

20. Bearing in mind that I nursed Mrs Richards about ten years ago I cannot recall all aspects of her care, although there are a number of specific issues about her and her family which I do recall clearly. Mrs Richards presented with a fairly typical scenario of a fractured hip following a fall, and an existing history of dementia. This was not that uncommon for the patients that we treated on Daedalus Ward. I recall that her family were very involved in her care.

21. My recollection of Mrs Richards was that she was very confused. She could not communicate with the nursing staff at all. Her daughters said that they knew what their mother was saying. However, I observed one of the daughters, I think her name was Lesley Lack, talking to her mother. I could see no signs of any communication. Even at that time I noticed a disparity between what the daughters of Mrs Richards were saying about her communication abilities and what I and the other nursing staff had observed.

22. Mrs Richards was agitated and in my professional view this was because she was in pain. It is possible to discern if a patient's agitation is caused by pain by the way that they present. For example, if the agitation increases on movement this could be an indication of pain.

23. The term agitation can cover a lot of different behaviour. It can encompass at the highest levels shouting out and moving around but at the lowest level the term agitation can be used to describe a patient who is looking uncomfortable or picking at their clothes or bed sheets.

24. Mrs Richards was admitted to Gosport War Memorial Hospital on 11 August 1998. I detail her treatment on pages 14, 15 and 16 of exhibit **PB1(b)**.

25. On Friday 14 August 1998 I arrived on shift at about 7.30 am. Dr Barton arrived at 8 am. I had been informed that Mrs Richards had fallen on the ward on the previous day. I remember speaking to Mrs Richards' daughter Mrs Lesley Lack. She was very angry about the delay in her mother being xrayed and the fact that her mother had fallen in the first place. I would describe her as having been verbally angry with a kind of controlled anger.

26. As I was Clinical Manager of Daedalus Ward I got actively involved in all of the patients' care and I fitted in my administrative and managerial duties alongside caring for the patients. If a patient was a more complex case then I would actively engage with them. Because Mrs Richards' family were unhappy I paid particular attention to her care.

27. Mrs Richards was transferred to the Royal Haslar Hospital over the weekend from Friday to Monday. She was transferred back to us on Monday 17 August 1998. I detail what happened upon her arrival on pages 18 onwards of exhibit **PB1(b)**.

28. I can remember that Mrs Richards was screaming when she was transferred onto her bed on Daedalus Ward but she could not verbally communicate at all.

29. On page 20 of exhibit PB1(b) I have described Mrs Richards as "generally looking unwell". I mean, by this comment, that she was poorly perfused (her colour was poor), her facial expression and body reactions indicated that she was in pain, she was not responding at all to verbal stimuli and it was not possible to move her without aggravating her further.

30. It was difficult to nurse Mrs Richards at times because her daughters would constantly contradict each other. Mrs Lack would tell me that her sister had an issue with morphine and that she did not want her mother to be given that. However when I spoke to Mrs McKenzie she would say something different.

31. I got the impression that Mrs Richards' relatives did not get on with each other. I could pick up that there was some tension but I was not sure exactly what the problem was.

32. On page 22 of exhibit **PB1(b)** I refer to the likely cause of Mrs Richards' pain being a haematoma. This is caused by bleeding within the tissue surrounding the hip joint. A haematoma would cause a patient significant pain. In Mrs Richards' the haematoma was not visible from the surface of the skin as it was most likely in the wound site of the operation.

33. I was aware that Mrs Richards daughter, Mrs Lack, had concerns at the time regarding her mother's fall whilst she was on the ward, and as well as talking to her about her

concerns I ensured she knew how to make a formal complaint as I am required to do. I was surprised when Mrs McKenzie made her subsequent complaint to the police.

34. As I detail on page 22 of exhibit **PB1(b)** Mrs Richards' family agreed to her being put on a syringe driver to keep her pain free. If the family had said no then I would not have started the syringe driver. I would have gone back to the nurse manager and Dr Barton and/or Dr Lord and would have asked them to come and review the decision. All aspects of Mrs Richards care were communicated to her daughters and I ensured they were aware that her condition was expected to deteriorate.

35. Mrs Richards died on Friday 21 August 1998.

36. On exhibit **PB1(c)** I would like to correct on page 28 that it should read "lactulose" at the bottom of the page.

37. Subsequently to this complaint and the investigations that occurred at the hospital I would say that the record-keeping improved. The Primary Care Trust spoke to us all regarding records and introduced far more extensive paperwork for pain control. If we had had this paperwork at the time of Mrs Richards' care it would have provided a more effective means of demonstrating our decision making processes.

38. I have not discussed the case with Dr Barton subsequently except in very general terms.

39. I confirm that I have had the opportunity to re-read the transcripts of my interview with the police dated 24 July 2000 and I have nothing further that I wish to add or amend apart from my comments above.

40. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am have agreed to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true.

Signed: **Code A**

Philip James Beed

Dated: 14/7/08

General Medical Council

Dr. Jane Barton

Exhibit PB1(a)

This is the Exhibit marked "PB1" referred to in the statement of Philip Beed:-

- Interview of 24 July 2000

  11:00 – 11.45 (37 pages)

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y21

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1100 Time concluded: 1145

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

Interviewing Officer(s): Code A Code A

Other persons present: Mr GRAHAM -Saulet & Co Solicitors
Portsmouth Legal Advisor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

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

please and your date of birth for the tape?

BEED
Code A

Philip James BEED Code A

Right also present today is....

SOLICITOR

Mr GRAHAM from Saulet and Co Solicitors, Portsmouth - Legal Advisor.

Code A

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

BEED
Code A

Okay, yeah.

Right, before I start to question you at all, I have to go through and give you what we call a caution and that is, that you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court and anything you do say may be given in evidence. Do you understand the caution?

BEED — Yes.

Code A — What do you understand by that caution?

1.31 BEED — That I don't have to answer any questions but if I, if I choose not to erm and later erm say anything then that can be used against me.

Code A — Right, are you happy with that Mr GRAHAM?

SOLICITOR — That's pretty good for somebody who's never been questioned before.

Code A — That's pretty good and it's probably a better understanding than I had of it. One other thing I need to point out is that this interview room is capable of being monitored when the tape recorder is in the record mode only and with the tape running, and a warning light would indicate when monitoring is taking place. At no other time can our conversations be overheard. Now that red light there means that this interview is being monitored and it's by Code A the chap that you spoke to a few minutes ago. Right Philip, can you tell me what your job is and what you do?

BEED — Yeah I'm a Clinical Manager which is the Charge Nurse in charge of Daedalus ward at Gosport War Memorial Hospital.

Code A — Right and what are your day to day duties?

BEED — Er I've got erm over...24 hour accountability for the nursing care of the patients on the ward er and the management of the nursing team delivering that care. So I manage a team of

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

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

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

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

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

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

BEED Yeah.

Code A Right, what does a Ward Manager do?

BEED Erm responsible for nursing care of patients on a

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

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

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

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

BEED That was Doctor LORD.

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

BEED Yes she's cons...she's still consultant in charge now.

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

basis with Doctor LORD?

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

Code A — Right and when would you get in touch with Doctor LORD?

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

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

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

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

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

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

Code A — As in Doctor BARTON's practice?

7.14 BEED — Doctor BARTON's practice, yeah.

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

BEED — For ad..for admission?

Code A — ...Yeah.

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

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

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

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

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

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

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

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

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

Code A Right, is that adequate staffing then?

9.23 BEED For eighteen patients the ward gets very busy

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

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

BEED — Yeah, yeah.

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

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

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

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

BEED Doctor BARTON or Doctor LORD and also the other erm doctors in Doctor BARTON's practice if they come in, if we call them in.

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

BEED Yep.

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

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

Code A Right, are there occasions when the consultant or

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

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

Code A — Right

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

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

BEED — They should be, yep.

Code A — Okay. What paperwork accompanies a person?

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

Code A So and what is a T-T-O?

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

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

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

Code A Right, did you have a pharmacist?

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

Code A Okay, does she advise?

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

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

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

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

Code A (inaudible) Formary

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

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

BEED Yes.

Code A to keep an ongoing...

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

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

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

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

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

BEED — Yeah.

Code A — Who would they highlight that to?

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

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

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

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

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

BEED Yeah.

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

BEED Yeah, yeah.

Code A ...hard and fast rules?

BEED Yeah.

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

BEED Yep.

	Code A	...You can highlight it...
	BEED	Yep.
	Code A	...and as can the doctor highlight it but ultimately the consultant is...
	BEED	Overall responsible.
	Code A	...is overall responsible but there are a number of checks before we get there....
	BEED	Yeah, yeah.
	Code A	...and a number of opportunities for people to identify...?
	BEED	Yeah.
	Code A	Okay. Can you tell me about named nurses and what that's all about?
19.32	BEED	The named nurse is actually the nurse with the specific responsibility for individual patient and each patient has a named nurse erm and we allocate it so we each have usually about three or four patients erm and that nurse will be responsible for generally overseeing the patients care so any major change that takes place in, in..take effect in how we care for a patient er they will be involved in the decisions erm and also things like referral to Social Services, erm communicating with relatives and so on erm because we work a shift pattern, we also work in teams erm and other nurses can actually erm be involved in that patients care as well so erm if something is happening with the patient and the named nurse is off for two days then someone

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

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

20.47 BEED Yeah.

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

BEED Yeah, yeah.

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

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

Code A It almost picks itself?

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

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

21.41 Code A Right. What paperwork accompanies a patient?

BEED When they come to us?

Code A Yeah.

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

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

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

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

BEED Yeah.

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

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

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

Code A

Right and how many sort of separate plans are there?

BEED

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

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

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

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

BEED — ...Mobility is one, yeah.

Code A — Is it?

BEED — Yeah.

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

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

Code A — Right so the care plans are something that

develop...

BEED — Yeah.

Code A — ...over a period...

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

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

BEED — Yeah.

Code A — ...in the early stages...

BEED — Yeah.

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

BEED — Later on, yeah, yeah.

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

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

BEED — Yeah.

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

BEED — Clerking admissions?

Code A — Yes please.

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

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

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

BEED Yeah.

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

BEED Yeah.

Code A ...treatment...

BEED Yeah.

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

BEED Yeah, yeah.

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

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

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

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

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

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

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

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

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

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

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

Code A Right. What is Palliative Care?

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

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

is dying, who's we?

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

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

BEED — Yes, yeah.

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

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

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

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

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

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

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

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

BEED — Yeah.

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

BEED — Yeah.

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

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

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

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

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

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

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

BEED — That's unusual.

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

BEED — That's, that's nursing in general.

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

BEED — Yes, yeah, yeah.

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

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

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

BEED — Yeah.

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

BEED — Yeah.

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

BEED Yeah.

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

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

Code A So having that many opportunities to discuss the

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

38.50 BEED

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

Code A

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

BEED

Yeah.

Code A

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

BEED Right.

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

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

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

and when are you expected to write it?

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

Code A Right, but the key word is significant?

BEED Yep.

Code A It's not...

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

Code A Yeah.

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

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

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

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

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

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

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

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

Code A — Right.

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

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

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

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

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

General Medical Council

Dr. Jane Barton

Exhibit PB1(b)

This is the Exhibit marked "PB1" referred to in the statement of Philip Beed:-

- Interview of 24 July 2000

  12:14 – 12:50 (25 pages)

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21A

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1214 Time concluded: 1250

Duration of interview: 36 MINS Tape reference nos.

Interviewing Officer(s): Code A Code A

Other persons present: Mr GRAHAM - Solicitor Saulet & Co, Portsmouth

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

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

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

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

Code A — Would Dr BARTON ever assume that higher role?

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

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

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

BEED — In terms of consultant cover?

Code A — Yeah.

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

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

BEED — Right.

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

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

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

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

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

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

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

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

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

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

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

Code A — What would you use generally across the

board?

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

Code A — What other sizes do you use?

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

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

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

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

BEED — Yeah.

Code A — How long for?

BEED — Usually for about 20 to 30 minutes.

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

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

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

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

Code A — So the doctor relies on your judgement?

BEED — Yeah.

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

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

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

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

BEED From the information we supply to her.

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

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

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

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

BEED Yes.

Code A How long have you worked with Dr BARTON?

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

Code A Three years?

BEED Yeah.

Code A Is that a good sort of professional relationship?

BEED Yes.

Code A Is there a social element to it?

BEED No.

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

BEED Yes.

Code A Have you ever disagreed?

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

appropriate course of action is.

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

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

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

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

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

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

BEED

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

14.36 Code A

Can families influence that decision?

BEED

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

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

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

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

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

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

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

Code A

It's difficult ...

BEED

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

17.02 Code A

It's a skill that you develop over ...

BEED

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

Code A

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

Code A

Not at the moment no.

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

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

BEED Has this got the duty rotas in it as well?

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

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

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

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

18.07 BEED I think so yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BEED I don't mind.

GRAHAM It's all in your hands.

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

General Medical Council

Dr. Jane Barton

Exhibit PB1(c)

This is the Exhibit marked "PB1" referred to in the statement of Philip Beed:-

- Interview of 24 July 2000

  14:12 to 14:52 (29 pages)

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21B

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1412 Time concluded:

Duration of interview: Tape reference nos.
(🔊)

Interviewing Officer(s): Code A

Code A

Other persons present: Mr GRAHAM - Solicitor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

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

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

BEED Right.

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

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

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

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

BEED — Yes.

Code A — And I understand in the case of Mrs RICHARDS on that day it was a letter from Doctor REID.

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

Code A — Is it on the notes.

BEED — The letter from Doctor REID.

Code A — Yeah.

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

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

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

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

Code A Okay, so that letter arrives with you, on your ward before Mrs RICHARDS.

4.30 BEED Yeah.

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

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

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

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

BEED — Yeah.

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

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

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

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

Code A — Okay, Mrs RICHARDS arrives at the hospital, erm, what happens next.

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

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

6.34 Code A Would that have been out of choice.

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

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

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

Code A Okay, what's your first contact with Mrs RICHARDS.

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

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

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

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

Code A And what's your expectation of Doctor BARTON.

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

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

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

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

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

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

Code A Can you distinguish between pain and dementia.

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

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

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

	Code A	Does it present itself in difficult grades, different severities.
	BEED	Yes, yeah, you can have patients who've got mild dementia, erm, or dementia that's sort of worse at some time than others and are rational in between and patients who have dementia and are just quietly confused with it and you can have patients who are very noisy and very agitated and Mrs RICHARDS would come at the severe end of the scale.
	Code A	Right, is there any doubt that that could be confused with pain.
	BEED	It's difficult to differentiate but I, I, the sort of actions that I was seeing from Mrs RICHARDS and the difficulty with transferring her and so on indicated to me that as well dementia and confusion that she had pain.
11.06	Code A	Right, okay, does Doctor REID's letter give you any indication, he goes on about some drugs there, was it, how, Haloperidol and Trasadom, what do they do.
	BEED	Erm, Haloperidol is, is, erm, sedates people and helps the confusion, Trasadom does much the same things, it's a anti-depressant and, and helps with confusion.
	Code A	But they're (inaudible), the Trasadom anyway.
	BEED	Yeah, stopped the Trasadom, the family said that that, that they felt that had over sedated her, so, so he's actually discontinued that, and that

had been discontinued before she came to us.

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

BEED Yeah.

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

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

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

BEED Yeah, yep.

Code A That would be most likely.

BEED Yeah.

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

BEED Yeah.

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

BEED Confusion.

Code A The confusion and dementia.

BEED Yeah.

12.47 Code A So what do you do next.

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

	Code A	Okay, so what drugs did she take over the next couple of days, we're on the 11th.
	BEED	Yeah she had a further dose of Oramorph at 1145 at night on the the 11th, a further dose at 0615 in the morning on the 12th, erm.
	Code A	Had she been reviewed by any member of staff, had her pain lessened.
36.16	BEED	She'd, erm, what we'd have done was looked at her overall condition and, and erm, whether she was in pain and erm how the pain was, so whenever you go to give a dose of analgesia erm you look at the patient's pain and how well that's controlled and whether they, they need, so you always carry out a review before and when you're giving pain control.
	Code A	So what you said earlier was that the beauty of the syringe driver is the fact that you can ensure there's constant level.
	BEED	Yeah.
	Code A	But with Oramorph of course it's a quick fix.
	BEED	Yeah and then it would wear off.
	Code A	So is it recorded that on each and every occasion that the effects wore off that she needed more.
36.54	BEED	It wouldn't necessarily be recorded specifically.
	Code A	Is that unusual.
	BEED	Erm, it wouldn't give, if I look, what I need to do is look at the night care record cos that might, erm, we haven't actually made a specific

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

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

BEED I would have given her some more, yep.

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

BEED and again in the morning, yeah.

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

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

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

BEED No.

Code A ..for this lady.

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

General Medical Council

Dr. Jane Barton

Exhibit PB1(d)

This is the Exhibit marked "PB1" referred to in the statement of Philip Beed

- Interview of 24 July 2000

  14:58 to 15:41 (35 pages)

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21C

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1458 Time concluded: 1541

Duration of interview: Tape reference nos. (📼)

Interviewing Officer(s): Code A Code A

Other persons present: Mr GRAHAM - Solicitor Saulet & Co

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

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

RESTRICTED

Code A — Can you go through your duties and Gladys' notes.

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

Code A — Sorry what does PRN stand for.

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

Code A — This is Oramorph?

BEED — Yeah the Oramorph.

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

BEED — No.

Code A — On the 12th.

BEED — Yeah.

Code A — Right.

BEED — Yeah. Um I can't remember any other specific

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

	BEED	.....of everything that happened.
	Code A	Because you weren't on duty on that certain day.
	BEED	I wasn't on duty on that day.
	Code A	Okay, by making reference to the drugs.....
	BEED	Yeah, yeah.
	Code A	.....that were used on that day, what can you tell me about, you're off on the 13th.....
	BEED	Yeah.
	Code A	.....what drug regime.
	BEED	Um, was given er her normal regular drugs and at ten to nine in the evening er of the 13th er she was given some more Oramorph, that was after the hip had been dislocated so she didn't have any more Oramorph or other pain killers up until the point in which it was discovered that she had a dislocated hip.
	Code A	What time would she have had that fall, do you.....
4.06	BEED	The fall took place about one thirty um the nurse who examined her at that time didn't find anything abnormal um and a dislocated hip is fairly obvious so um going on the information I had the hip wasn't dislocated immediately after the fall, um, but once Mrs RICHARDS was helped into bed after she'd had her supper which was some time around eight, um, seven thirty, eight o'clock, that evening, um the hip was out of position and was obviously dislocated at that time.
	Code A	So, do you suggest that the dislocation could have

occurred at some other time rather than the fall.

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

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

BEED — Yeah.

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

BEED — No.

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

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

Code A — Okay. No I except that. What's your next contact with Gladys RICHARDS.

5.49 BEED — Er that was on the morning of the 14th when I was

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

Code A What does it look like a dislocation.

BEED Um.

Code A Can you tell.

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

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

BEED Yeah, yeah.

Code A When did you know there was a dislocation.

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

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

BEED That was done sometime around mid morning.

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

morning.

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

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

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

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

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

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

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

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

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

BEED — The hip is back in place yeah, yeah.

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

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

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

BEED — Yeah.

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

BEED — I was on duty from twelve fifteen on the 17th.

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

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

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

BEED Yeah.

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

BEED Yeah.

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

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

Code A Yeah.

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

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

BEED Yeah.

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

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

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

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

BEED Yeah.

Code A .....lifted up.

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

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

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

Code A Yeah sure.

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

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

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

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

Code A — So initially, uncomfortable.

BEED — Yeah.

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

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

20.02 Code A — So Doctor BARTON had been before that.

BEED — Yeah, yeah.

Code A — Because.....

BEED — Yeah.

Code A — Had she written another prescription at that point.

BEED — Um no as we still had the existing prescription so we used, that would have.....

Code A — How long's a prescription valid for.

BEED — Um it needs to be um reviewed, reviewed

regularly um, I'm, what the time limit is I don't know but I mean that would be well within it. If someone's written up for Oramorph that would be, be and remains on the ward or goes off a few days and comes back, be valid for a good number of weeks but needs to be reviewed during that period.

Code A — Ah ha. Okay she's in pain but she's able to take Oramorph.

BEED — Yeah.

Code A — So her swallow reflex is still there.

BEED — Yeah.

Code A — And up and running.

BEED — Yeah. She was refusing to eat lunch at that point in time um but she was swallowing.

Code A — Right is that significant do you think.

BEED — May have been because she was in pain and unsettled or it may have been just her general dementia and overall condition so you know it was just one of the things that we noted at that point in time that some food was prepared for her but she refused to eat it.

Code A — Okay. Right. How did she progress throughout the rest of the, the 17th.

BEED — Arranged an x-ray because the family was worried that the hip was dislocated although it didn't appear to be um and that took place.....

Code A — Didn't one of your nurses, have I read somewhere that the, the leg looked like it was a figure four.

BEED — The, yeah, one of the, Staff Nurse COUCHMAN

actually went in with the daughter and actually repositioned the leg because she thought it wasn't in er a very comfortable position but it wasn't in a position that looked like it was dislocated, um, so she made Mrs RICHARDS in a comfortable and appropriate position um and with her daughter, um, and generally examined her to check, because if she'd spotted an obvious dislocation at that time again we would have um, it's definitely x-rayed, it definitely needs x-raying.

22.14 Code A Yeah.

BEED But it looked in an odd position but not in a dislocated position.

Code A Right.

BEED Er. So really (inaudible) that afternoon was to give analgesia to try and make Mrs RICHARDS comfortable and to get her x-rayed to try and find out if it had dislocated again, um, or if it hadn't to find out if it was anything else we could do anything particular about.

Code A Okay. So what's the drug regime for the rest of the 17th.

BEED Um we carried on, we actually um, because we thought there was a sensitivity to the Oramorph we were giving a slightly lower dose so we were giving 5 milligrams, we gave that at one o'clock, we gave it attain at ten to seven, er sorry, gave it again, I can't read my own writing, looks, I think it was about quarter past three and then but that

wasn't, that obviously wasn't enough, so I gave a higher, a second dose of 5 milligrams at quarter to five and then we went back to giving the 10 milligram dose at eight thirty and then she had some in the early hours of the morning.

Code A — Are the family happy at this point that she's in pain as opposed to dementia.

BEED — Yeah, yeah, I had specific discussions with the daughter and Mrs LACK in particular was very concerned about how much pain um her mum was in and that we need to get that pain under control so I was working very much in conjunction with the family to um try and provide um what, the sort of care that they wanted for their mum.

Code A — So at this particular moment in time on the 17th you're all singing off the same hymn sheet.

BEED — Yeah, yeah.....

Code A — Everyone's quite happy with what's happening.

BEED — Yeah, um and that, that's one of the reasons I gave the second dose and I, I distinctly remember looking very carefully at how much can I give and when and what, and looking at the option of the syringe driver at that time should I need to proceed to it and saying to um Mrs RICHARDS' daughter that I wanted her mum to be comfortable before I went off duty that evening.

Code A — Was there a consideration to the use of a syringe driver then.

BEED — It would have been one of the options could we

not control the pain with the Oramorph.

Code A — Right, how, how high, or how far along that ladder were you prepared to go on Oramorph.

BEED — Because you're giving, because you're giving quite high doses and it's wearing off um the difficulty is you, you can't just give Oramorph and then say it hasn't worked you need to give it time to build up and I needed to give a second dose so, I think had I, had I gone for that um second dose which topped the Oramorph up to 10 milligrams at quarter to five, had she not been comfortable by the time I went off at eight thirty I would have, at that point been looking whether the use of a syringe driver was the next appropriate step because obviously if I'd gone to the full amount of Oramorph and that hadn't kept Mrs RICHARDS comfortable then the next logical step was whether a syringe driver would allow me to give um a more dose and a slightly stronger dose of pain killer.

25.28 Code A — Right and what's your objective behind that.

BEED — In going to a syringe driver.

Code A — Yeah.

BEED — To keep Mrs RICHARDS pain free.

Code A — Purely pain free and that.....

BEED — Yeah, yeah. Yeah.

Code A — Okay thanks for that. And then what happens next.

BEED — Um, she was cared for over night. I came, um, I was on duty again the following morning, the 18th

when she's reviewed by er Doctor BARTON.

Code A Had anything significant happened over night.

BEED Um she had another dose at, of Oramorph, I gave a dose at eight thirty, she needed another dose at twelve thirty which is, so she's only going 4 hours and another dose at four thirty, so she's going only the 4 hours between doses of Oramorph, um, so that's, we're giving the maximum amount we can, um, if I find the night (inaudible) records that might tell us how she was over night.....haven't got a specific record but I would have got handover from the night staff and obviously they would have told me that um they needed to give the Oramorph um every 4 hours and um that she hadn't been comfort, completely comfortable on that.

27.12 Code A The reasons for those being omitted from, from the record sheet is that an oversight or is.....

BEED An over, yeah.

Code A Yeah, and nothing, nothing else.

BEED No.

Code A Just straight up oversight. What other drugs had she taken....

BEED Um.

Code A .....at the same time.

BEED That's on the um on the 18th, she actually hadn't, we've left off the Lactalose um, but she's had, she's having, no she did have Lactalose on the 17th and she had Haloperidol.

	Code A	Right, what did the Haloperidol do for her.
	BEED	Haloperidol is to help with her confusion and agitation.
	Code A	Right. I think you told me that once.
		Is that in an oral form at that time.
	BEED	Yes. Yeah.
	Code A	Okay so up until the 17th.....
	BEED	Yep.
	Code A	.....what's her condition, is she getting better, is she getting worse.
28.35	BEED	She's, she's really overall she's worse, her fluid and her diet intake is poor um she's, we're not really controlling the pain even with the regular dose of Oramorph um and she's quite agitated and uncomfortable and it's making it difficult for us to, to nurse her and look after her overall care.
	Code A	So generally the scenario is one of, it's becoming increasingly difficult.
	BEED	Yeah.
	Code A	Right, Doctor BARTON comes in.
	BEED	Yeah.
	Code A	Then what happens.
	BEED	Um, we'd have er reviewed her with myself, we'd have gone and seen the patient and looked at how she was um looked at the x-ray that was done the previous day and then um discussed Mrs RICHARDS care and what Doctor BARTON felt was this lady's overall condition was deteriorating er quite significantly, that we weren't controlling

the pain and the only way we would control the pain was by a syringe driver er and that she felt the lady's overall condition indicated that she was in, in such poor health that she was actually dying um and that we ought to keep her pain free and make sure we were meeting all her nursing needs but that, that we, that rehabilitation at this point wasn't going to be something that we were going to achieve and that we were likely to be looking at a patient that was going to die fairly shortly.

Code A Right and that's a decision that, that's not taken lightly.

BEED No.

Code A I would assume.

BEED No.

Code A And in conjunction with the family.

BEED I, the family weren't present at that point in time, so what I would then have done is discuss things with the family when they arrived um and try to do that in a sensitive and tactful way um, because you start building up a relationship with a family sometimes it can be just done er by nursing staff, sometimes you'd have to arrange for them to come back and see the doctor if you didn't think that their questions had been answered or you'd um answered all their concerns or they till had worries or whatever. Um but I met with them um sometime around mid morning when they came and discussed their mum's overall condition and

um the fact that we needed to use a syringe driver to control her pain um and that we didn't' think her, or we thought her prognosis was very poor and that she was actually going to die, sometimes.....

Code A — So it was cards on the table.

BEED — Yeah, oh yes, yeah.

Code A — Right, what was their reaction to that, can you recall.

BEED — Upset, as, as you would expect, the, I, I knew from previous discussions with them that they had worries about use of um strong analgesias, I believe Mrs MCKENZIE actually had experience of, of someone close actually um being in a hospice and having strong analgesia, er so I did in that sort of discussion which you try and make sense, tactful, allow them time to voice their fears and anxieties and to answer any questions they had. Um but overall my impressions was that they understood the situation and they agreed with, the, the kind of care which we were um wanted to proceed with.

Code A — Did they say at any stage, no we don't agree with this.

BEED — No, no, um if they had then I would have taken, I would, I wouldn't have proceeded and I would have taken advice from elsewhere, I would have go to a Nurse Manager or um a consultant to get their advice. So although I knew that was the care

		that Mrs RICHARDS needed I wouldn't have gone ahead with that sort, that care um if they were in direct opposition.
31.59	Code A	And what would have been the alternative to the syringe driver.
	BEED	Er carry on giving Oramorph, um could have given higher doses of Oramorph, so that would have been one alternative.
	Code A	Because she is still capable of taking it.
	BEED	Yeah. Yeah. Um the problem with that is it wasn't keeping her pain free for um the interval between the doses so it wasn't giving her adequate, it was giving her some level of pain control but it wasn't adequate pain control.
	Code A	But, was there still some way to go before you reached the maximum dose of Oramorph.
	BEED	Um we could have increased the dose, I think the, it's it's, it's more a matter of the interval inbetwen that, that Oramorph then wears off, um makes it difficult.
	Code A	Do people become immune to it, not immune to it but.....
	BEED	The effects of it do lessen over time yes.
	Code A	Do they.
	BEED	Yeah, yeah.
	Code A	(inaudible) with junkies you know they start off and they take more.....
	BEED	Yeah, yeah. Yeah. They, they, um the effect isn't heightened they get used to it.

Code A So it's likely that she becomes less resistant to, have I got that right.

BEED Yeah. She...

Code A I don't think I have, it has less of an effect.

BEED Has a less effect yeah, yeah.

Code A And for a lesser period of time.

BEED Yeah, yeah.

Code A Right.

BEED And the other thing we find when we're trying to control patient's pain it's easier with pain if you can stay on top of it all the time, so if you, if you allow someone to become in pain it's then harder to control, get that pain back under control when if you don't allow someone to get in pain in the first place.

Code A Okay.

BEED So if you give a continuous dose that, that never lets that pain come through or if it does come through it just keeps it at a controlled level um then it's much, you don't actually need so much of the medication to keep it under control.

Code A Right, where's this pain coming from.

BEED It's obviously from the hip, there's no doubt she was getting pain from the hip but she also gave the impression of someone who was in general discomfort and agitation because anything you tried to do with her was causing her to get upset and distressed. And again that's something that's quite common with people who are very poorly

and dying that, that they have specific pain somewhere but they've also got very generalised pain and discomfort.

Code A — Yeah okay I'm, I'm with you there. Right, so we, a team decision is referred to .

BEED — Yeah.

Code A — And that team, who's in that team.

BEED — Um, that's um Doctor BARTON reviewing the patient, myself as one of the nurses looking after the patient and Staff Nurse COUCHMAN who's the named nurse er of Mrs RICHARDS and was on duty um at morning, um, who, so together we reached that decision and, and the family of course, er so we make that decision and then um at.....

Code A — That's fairly comprehensive in the, the interested parties.

BEED — Yeah, yeah, yeah.

Code A — And there's no dissent there from anyone.

BEED — No.

Code A — Okay. Who, who fixes up the syringe driver.

BEED — That was myself and Staff Nurse COUCHMAN um and we started that at eleven forty-five.

Code A — And what was the contents of that.

35.38 BEED — Um that was Diamorphine, 40 milligrams, Haloperidol, 5 milligrams, and Midazolam, 20 milligrams.

Code A — Right, how does 40 milligrams of Diamorphine compare to the idiot with 10 milligrams of.....

BEED

It, it's calculated on the basis of um the amount of um Oramorph that's been needed in the previous 24 hours so what Doctor BARTON would have done would have been total up the amount, the total amount of Oramorph we'd given really since um one o'clock the previous day um and then there's a, you can look in the, the formulary book BNF or we've got a booklet produced by the local Hospice which then gives you a conversation for how much Diamorphine to give over 24 hours bearing in mind whether the Oramorph had actually kept someone comfortable or not, so if that Oramorph had kept Mrs RICHARDS completely comfortable we would have gone for a lower dose but she wasn't, she was still getting periods of discomfort so we wanted to go slightly higher to make sure that she was pain free.

Code A

Right just to make absolutely sure.

BEED

Yeah.

36.54 Code A

Okay, and the other drugs, Midazolam that's a new one.

BEED

Yeah, the Midazolam's um a, a hypnotic and that basically deals with agitation and relaxes um patient, keeps them calm, um and the Haloperidol she's already on and that's, that has a similar effect and that's kept because it's actually something Mrs RICHARDS is on already um and Doctor BARTON felt that if that was omitted from the driver we'd, it's something you can give

		through a driver um and giving it through a driver would make sure that she didn't get withdrawal symptoms from the Haloperidol.
	Code A	Cos that could have had a knock on detrimental effect.
	BEED	Yeah.
	Code A	Okay I understand that, and was there one other drug in there.
	BEED	Um not at that point, we used, we started Hyoscine, but we didn't' start using Hyoscine um, may be we didn't use Hyoscine at all, yes we did, yeah, we didn't start using Hyoscine until the 19th of August which was the um the Wednesday.....
	Code A	(inaudible) and that's, Hyoscine, correct if I'm wrong is for secretions.
	BEED	Yeah, yeah.
38.05	Code A	(inaudible).
	BEED	Yeah, yeah.
	Code A	I've read somewhere there's a potential problem using Midazolam and Haloperidol in respiratory function. Are you aware of that.
	BEED	Er well, all, all the drugs we are using with the driver can, are known to cause some degree of depression of respiration, so that's a known side effect um and something you'd watch for, when someone's poorly their respiration becomes depressed as they start to pass away anyway so that's one of the difficulties knowing whether the medication you're giving is causing depression of

respiration or whether it's the patient's overall condition.

Code A — Right.

BEED — So, but the key thing we're looking at is how comfortable is the patient and comfortable is their breathing.

Code A — Okay if they do go into arrest or their respiratory function slows down to a stop, do you have any equipment to use to bring that back.

BEED — We, the doses we're sort, we're using would depress respiration but I've never know it to actually to stop the respiration so in fact and you wouldn't um, so we wouldn't, shouldn't be using doses that actually cause that to happen and if you're, if you're giving Palliative care um you don't, and you help the patient, relatives come to terms with the fact that someone's dying you wouldn't want to put yourself in a position where you're suddenly having to take resusative measures because that would be very confusing and upsetting for the family.

Code A — So it's a conscious decision that if, if, if it's a natural by-product of that, that they stop breathing then that's death and...

BEED — Yeah, yeah.

Code A — .....that's inevitable.

BEED — Mmm, yeah.

Code A — Right, Midazolam used subcutaneously, is it.

BEED — That's, that's very common, we usually use that

in, it's the Haloperidol is the one that we don't usually use but we usually use Midazolam because the relaxes, quite a lot of patients if they're in a lot of pain, they're also, and very well, there's a lot of fear and anxiety going on as well, so it just relaxes them and calms them down, takes away some of the, some of the fear that's associated with their condition.

40.27 Code A Right, that's not a product that's licensed for subcutaneous use. Were you aware of that.

BEED Um, I'm, um, the information we work on is produced by um the local hospice and they do say in that, that the doses that are used and the medication that are used are sometimes being used outside of their er normal dosage range and where they'd be used but it's established, well established practices in Palliative care.

Code A It's common practice.....

BEED So yeah. Yeah.

Code A .....so the although the fact that it isn't licensed.....

BEED That's it.

Code A .....for the use is not a bar to using it.

BEED No, no.

Code A Because experience tells you.

BEED Because it's being, it is being used in a lot of cancers in that way.

Code A Right, so you're, we've reached that point where we're on the syringe driver with the, the

combination of drugs, how long does that continue.

41.29 BEED Given that we're recognising that Mrs RICHARDS is in Palliative care we would expect that to continue up until the time she passes away um because if anything sensitivity to the pain killers is going to (inaudible) or, or the pain, level of pain may increase, so you may need to increase the pain killers. If you withdrew um the analgesia then the patient would again be in the level of pain they were before you started it um, so it's expected to continue but it's constantly under review to check the level that you're giving is appropriate to the patient's needs, so really every time you go into the patient and every time you go to change the driver, every 24 hours, um you'll be monitoring how the patient is whether they're comfortable or uncomfortable and how they are over all.

Code A What, what steps are taken to insure that she remains hydrated.

BEED Our, our practice um with hydration is, is the patients are conscious and able to take food and fluids then we encourage them and help them, make sure they're not thirsty, um if patients become unconscious and we're delivering Palliative care um we base our work on studies that show that giving patients by alternative means actually doesn't do anything to effect the outcome,

	um the fluids aren't likely to absorbed and they become uncomfortable so we don't usually hydrate patients when we're delivering Palliative care, um, unless there was a partic, a specific indication that it was the appropriate thing to do.
Code A	Right. When did we stop actively treating Gladys and move on to Palliative care.
BEED	Um, that was on the morning of the 17th.
Code A	Right, then on the morning of the 17th .....
BEED	Sorry, that was on the morning of the 18th. Tuesday the 18th.
Code A	And at that point, did her death become a matter of time.
BEED	Yes.
Code A	Right were any steps taken in the ensuing 3 days by yourself, Doctor BARTON or any of the nursing staff to ensure her level of pain hadn't decreased to enable her to come off of that drug regime.
BEED	We would have monitored that when we, every time we looked after her so when you, when you go to wash someone, check there clean and so on that's when you start getting pain if you're going to get any so you could see that if you were, um, cos you have to roll and turn people to get them clean and to change their bedclothes and their night clothes and so on, so if she was showing, showing no signs of pain whatsoever then that would say right you might need slightly less, far

more normal that someone shows some indication of being in pain when you start to move them and you have to judge is that a lot of pain that we're, you know we're, we're putting them through agony and we need to increase things or is it just the normal amount that you would associate with moving someone in which case level of pain killers you're giving is about right.

44.36 Code A Right, is it recorded anywhere in the notes that those checks were undertaken on Gladys.

BEED It's, it's not specific but it's integral with um the nursing care plan so um on the 18th um for her night care but she's comfortable and the daughter stayed. Um on the, on the hygiene that she's had, she's had bed bathes and she's had oral care. Um, on the 19th she's had a night change and wash, repositioned, apparently pain free during care.

Code A So if she's pain free during that period, is it not then a proper consideration to reduce.....

(the tape buzzer rings)

Code A I think we've got two minutes left, but don't, don't rush your answer because of that.

BEED Right, okay. Right, okay. The difficulty was if you start then reducing the pain, reducing the analgesia and the pain breaks through um you're then right back to square one where you've not got the pain controlled um and you're having to go in with high doses again, so if the patient is, recognising that the patient's condition is deteriorating and

		dying anyway, if they're pain free then you continue at the dose you're at.
	Code A	But that doesn't give them the opportunity to recover.
	BEED	But we're all, we're recognising that this lady, we didn't feel this lady was likely to recover anyway at this point in time.
	Code A	Right, but she was never given the opportunity to recover was she.
	BEED	(inaudible).
46.36	Code A	Had, had someone said hold on she's not in pain let's.....
	BEED	Yeah, right.
	Code A	.....reduce this to half the dose.
	BEED	Yeah.
	Code A	And see what happens.
	BEED	Yeah.
	Code A	Because if she was in pain from a broken hip.....
	BEED	Yeah.
	Code A	.....that may have well subsided over the 2 or 3 days. Is there a straight forward answer.
	BEED	We, well, we, we didn't' expect that the pain would have resided, we would have expected if we'd reduced, reduced the analgesia that the pain would have came back at the same level.
	Code A	Right and that decision is based on experience.....
	BEED	Yeah.
	Code A	.....in.....

BEED	Yeah.
Code A	Between yourself and Doctor BARTON.
BEED	Yeah, yeah.
Code A	Right. With hindsight, was it not considered, was it not appropriate that.....
BEED	No wouldn't have.....

Tape ends as BEED is talking, at 1541 hours.

General Medical Council

Dr. Jane Barton

Exhibit PB1(e)

This is the Exhibit marked "PB1" referred to in the statement of Philip Beed

- Interview of 24 July 2000

  15:52 to 16:04 (15 pages)

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21D

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: Fareham Police Station

Date of interview: 24/07/2000

Time commenced: 1552 Time concluded: 1604

Duration of interview: 12 mins Tape reference nos. (◆)

Interviewing Officer(s): Code A Code A

Other persons present: Mr. GRAHAM (Solicitor)

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(◆)	Person speaking	Text
Code A		This is a continuation of our interview with Philip BEED. The same people still present, Philip. The time by my watch is three fifty-two p.m. You can leave at any time if you want or speak to Mr. GRAHAM get your legal advice. We got to the point at the end of the last tape

RESTRICTED

where we were speaking about the drug regime over the last three/four days of Mrs RICHARDS's life and my question was that, having settled on a particular drug regime, why was no consideration given to, to reducing that dose, just to see?

BEED At, I've just erm, come to, there's an entry in the contact record by Staff Nurse JOYCE at eight o'clock on the 18th, which was the, so that was 24, that's 36 hours after we had started that drug regime, er that she is sleeping in peace, that Mrs RICHARDS is peacefully sleeping but she reacted to pain when she was moved and that pain appeared to be in both the legs. So that's 36 hours in and we, we actually know that Mrs RICHARDS is in pain when we are moving her.

Code A Is, is that right? If that was on the 18th, it only started..

BEED That, we started at er eleven forty-five on the Monday so that was, and that was, this is eight o'clock on ..

Code A No, on the Tuesday you started didn't you? She came to you on the 17th.

BEED Sorry, started on a Tuesday, yeah, er sorry eight o'clock on the Tuesday night, yeah, that's right. So that, that's been assessed em..

Code A So twelve hours into ..

BEED Twelve, twelve hours in, yeah, yeah.

Code A Are you aware at that time how that pain

manifested itself, how..

BEED — As Staff Nurse JOYCE has said its er, it appears to be in both legs when Mrs RICHARDS was moved, but she's, she's obviously comfortable when she is not being moved.

Code A — Right. She is not given any other hydration?

BEED — No.

Code A — So, is it safe to assume that is an inevitability?

BEED — Yeah.

Code A — At one point she's going to die?

BEED — Yeah, yeah.

Code A — On the drug doses, right, is that a particularly high....

BEED — No, that, that's er the bottom end of the scale really, erm, we, we sometimes up patient, patients on lower doses but we, we could, on the prescription here we could have gone up to two hundred milligrammes of diamorphine and eight hun...and eighty milligrammes of er midazalam. I've known patients go up to even higher doses than that, so five hundred milligrammes of diamorphine would not be er, an uncommon dose to give to someone who was in that much pain.

Code A — Right. Was there any other evidence of, of other illness?

BEED — Er, it was, it was more a general overview of the patient's condition, a combination of er, the severe pain, the, the er reluctance to eat and

drink, the appearing frail, er and difficulty moving, so it wasn't one specific thing but (inaudible) the overall picture that she presented of being a very poorly lady.

Code A — Right. What did she die of?

BEED — Er, Doctor BARTON had er, er, stated she died of Bronchopneumonia and certainly on the, on the 19th she was getting a very rattley chest er, which is caused when you have got actual secretions in your chest and we had started er Hyocine at that point.

Code A — Right, Did, did the sisters agree with that?

BEED — Er, in the statements that I have seen then they haven't but of course if Mrs RICHARDS had developed a chest infection then the, the drugs which we are using to control her pain, keep her comfortable, would have masked a lot of the symptoms of a chest infection. So...

Code A — Can I just ask a question? So, I mean the decision is made on the 18th, bearing in mind her condition and that pain, that, that she is dying?

BEED — Yeah.

Code A — So, the decision to go down the road of palliative care is taken then?

BEED — Yeah, yeah.

Code A — So, but she is dying then

BEED — Yeah.

Code A — But she is not dying of..

BEED — A chest infection at that point.

Code A at that stage?

BEED At that point, no.

Code A But later on, which is, I mean is that caused by the drugs she's on? The, the chest infection?

BEED No, but, but when the, its er really to do with being, being very frail and very susceptible and her respiration not being so good and of course the, the drugs she's on do have an effect on respiration, depressed respiration but her overall condition would have affected the respiration as well.

Code A Right. In terms of the 18th at the time, the, the consultation occurs and a decision is taken, what was she dying of then? Or what was you impression of what she was dying of then?

BEED Just a combination of factors. There wasn't one specific factor.

Code A Yeah.

BEED Er that she was dying of.

Code A Can you, can you just go over those?

BEED Just that she was very frail, that she wasn't eating, she had been very reluctant to eat and drink, she was in pain which wasn't controllable er and that she wasn't able to mobilize or, or doing anything to meet her own needs.

Code A Okay.

If I went into hospital, as fit and healthy as I hope to be, and were put immediately on a syringe-driver, with that combination of drugs,

would I die?

BEED — No. I don't think so. Er but you wouldn't, you wouldn't go on that if you were fit and healthy.

Code A — (Laughter) I know. But, if I were to put another ninety-one year old woman without any, I mean would that kill her?

BEED — No. Patients have been on this, these levels of sort of pain control and sedation er we've upped conditions and have gone on to recover so, no, not necessarily.

Code A — In your experience, that's, that's happened.

BEED — Yeah, yeah.

Code A — In terms of ..

In terms of recovery process for other patients, and this may be a hypothetical question, how do they come out of that? How was that accessed that they could, they can come out of that situation? If in particular they are sedated as a result of what they are on?

BEED — Um. You probably wouldn't be (inaudible). If someone was going to er recover you wouldn't see, er and given that levels of sedation um, so its a bit difficult to answer really.

Code A — Right. So really those four...

BEED — Are.....

Code A — .....taken together....

BEED — ... are appropriate to palliative care, they wouldn't, I don't know that, that those, that combination would be appropriate to anyone in

anything other than a palliative situation.

Code A — So someone who there, there's a consideration that they may well recover that would not be a combination?

BEED — No, you, you would, may use one or more of those drugs but probably not the entire combination.

Code A — But all taken together. So if you were to look at some notes, you've never seen the patient but you've seen they're on a driver and on those sort...

BEED — Yeah.

Code A — .....of drugs, would your impression be well this is someone who, who may well be, be dying..

BEED — Yeah.

Code A — ..and try and assist in giving her a comfortable, painfree death?

BEED — Yeah, yeah.

Code A — Okay.

I was just going through Mrs LACK's statement at the end of the day. She, she mentions a conversation about euthanasia - do you recall that?

BEED — Does...does she say what day that was on? Was that on the, Monday the 17th?

Code A — Yeah.

BEED — Yeah, yeah she, I, I remember. Was that Mrs LACK or Mrs MacKENZIE?

Code A — My sister, so, Mrs MacKENZIE.

BEED — Yeah, I remember Mrs MacKENZIE um, asking about euthanasia um and of course I advised her that that's not something what we would ever contemplate or consider. Its, its not er something we can do and not something we would do.

Code A — What's the difference between euthanasia and palliative care?

BEED — Palliative care is when we recognize that someone's dying um and the care we are providing is to make that death um a comfortable and dignified experience and meet someone's nursing needs. Um, euthanasia is, euthanasia as I understand it is actually actively um assisting someone in dying.

Code A — Yeah. One thing we haven't covered. I am drawing to a close now, is a suggestion of a massive haematoma. Do you recall this or..

BEED — Dr. PETERS, who was the G.P. who looked at the xray um said that he felt the cause of the pain was a massive haematoma. Um, as I understand it that's um, bruising as a result of the dislocation and the manipulation to put it back in. Um and, and that could be quite painful. I think Mrs RICHARDS' level of pain, to me seemed to be much more than just a haematoma, she, she was in a awful lot of uncontrollable pain, and distressed from the pain as well, but, but cos I expect anyone, and we have seen

patients have dislocations put back it and they do have bruising and some discomfort but not on the level that Mrs RICHARDS was experiencing yeah.

Code A

Okay. Just somebody has written down a question here which I am not quite sure is appropriate is why was Mrs RICHARDS not given fluids subcutaneously during the period 18th, 19th and 20th?

Well then.. it wasn't...

BEED

That's, that's because we, we don't feel that's an appropriate course of action with palliative care and that it doesn't make anyone any, it doesn't change the outcome. Um, it makes them uncomfortable cos the fluids don't get absorbed properly, they, they collect under the skin and don't get absorbed and um, you're just, just adding another intervention which is making a patient uncomfortable um and isn't changing what's actually happening.

Code A

Am I right in saying that, at that time, the hospital wasn't licensed to, or authorize to, provide fluids through a subcutaneous route?

BEED

We, we, no we could give fluids subcutaneously. What we couldn't do is give fluids intravenously and um that's cos we haven't got a doctor on site who could re..re-establish an intravenous line.

Code A

Right.

BEED Subcutaneously is, is an alternative route at giving fluids and that's, that's what we can ...

Code A And you always been, as far as you are aware..

BEED Always been able to give subcutaneous fluids and that doesn't need a doctor to set it up, the nursing staff can actually establish subcutaneous fluids, so we could have, if, if, if it had been appropriate to Mrs RICHARDS care we could have established subcutaneous fluids er and run them.

Code A Phil, what I intend to do in a second is, is to, to kill the tape, run upstairs just to see if there is any other points that I may have missed that they feel need covering, but I am getting to the point now where I think we've had a fairly thorough going over of, of your actions throughout that period, is there anything that, that you wanna, we want to add to your account so far? Is there anything that you feel that either myself or Lee have missed or misunderstood. Just so you can leave here saying well I, I've told them everything that they wanted to know.

BEED Yeah. The only thing really is, is that some of, is that I spent an awful lot of time with, with er Mrs LACK and Mrs MacKENZIE talking to them and answering all sorts of questions and I, I just find it strange that they're now asking questions which they had lots of opportunity to ask at the time and didn't, and I, I find that, that

puzzling.

Code A

I think, I think that's explained if, if explanation is the right word, with the fact that they perhaps found it difficult to deal with what they termed as the early stages of the loss, dealing with the loss of their mother, and perhaps with the benefit of hindsight, that they felt that some things weren't addressed properly and perhaps there was a case. With hindsight, would Philip BEED have done anything differently at all?

BEED

There, there were things that happened with Mrs RICHARDS when I wasn't on the ward, um, when she fell, which um it would have been better if Mrs RICHARDS had been transferred earlier than she was for the dislocation to look at - I don't know whether that would have changed, I don't believe that would have actually changed anything but it would have um answered one of the big questions that the family had, er more than anything. In terms of Mrs RICHARDS' care when she returned to us, then no, we, we, we looked at Mrs RICHARDS um and examined her thoroughly and made decisions appropriate to her and we discussed things with the, the family and tried to get, keep them involved um in what was happening and make sure that, that they were understanding the care we were giving and in agreement. So um I can't see that um, in terms of the overall care of Mrs RICHARDS, er

there was anything er that we'd have done differently now if we were in the same situation again.

Code A

One last thing for me, is, is a point that is raised by Mrs LACK in her statement where, and if I read the paragraph out it is on Page 13, she says I told Dr. BARTON and the Ward Manager that I'd been to Haslar that morning and explained what happened and told them that Haslar would be prepared to re-admit my mother. I considered that this was essential so that the cause of my mother's pain could be treated and sim..not simply the pain itself. Dr. BARTON said that it was inappropriate for a ninety-one year old who had been through two operations to go back to Haslar where she would not survive further surgery.

(inaudible) ... contact this has been at some point on the 17th..

Was it ever a consideration to return?

BEED

Yeah, that was after Mrs RICHARDS been x-rayed and Dr. BARTON had come back in, um Dr. PETERS had looked at the xray and Dr. BARTON had then come back in so DR. BARTON looked at results of the xray on Mrs RICHARDS, um and discussed it with Mrs LACK, the daughter, um. I, I can't remember Mrs LACK um saying those particular words to Dr. BARTON but know, I know it was, that was

in looking at Mrs RICHARDS' care we consider the options what do we, what do we do here um and Dr. BARTON's view was the...there was nothing specifically wrong that Haslar would be able to treat um and heal and thought that transfer would be more traumatic. That, that Mrs RICHARDS might not even survive the transfer er, cos we know the transfer itself is quite traumatic, and that they wouldn't be able to do anything when she arrived there so the most appropriate thing to do was to keep Mrs RICHARDS in our care er and she discussed that with the daughter at that time.

Code A — So it would have been to the detriment of her health had she been transferred....

BEED — If we had transferred her back.

Code A — ..cos, and there was nothing wrong with her to look at

BEED — (inaudible) cos, when she got there, if there was an obvious, if the hip dislocated again then yeah that would have been an obvious indication or if there was something else that, that Haslar could have er done that we couldn't have done, then it would have been appropriate to transfer.

Code A — Great. I am ever so grateful you are taking (inaudible)...no, there's someone with a finger up in the corner (laughter)

Just one .there is more. Just a, just to go over,

back to the 11th and a very quick question on the care plans and the letter in relation to consideration being given to the immobilization. Now it's not docu...there is no care plan for the mobilization. Is there any particular reason for that?

BEED — Um, what we, we were working on mobilize...we didn't have a care plan but we were trans ..trying to transfer Mrs RICHARDS where we could and, had things not gone in the direction they'd gone in, we would have got a physiotherapist involved in looking at transfers over the, the next few days, er but the fact that she fell and dislocated really overtook the plan to mobilize because obviously once she had re-dislocated we couldn't do anything but we would, at that point in time we were assessing well what sort of level of mobilization er was Mrs RICHARDS actually capable of.

Code A — In terms of instructing the physio, who, who does that fall down to on the ward to, to do that.

BEED — Er, nurse in charge of any particular shift, cos the physiotherapist comes on ev...we've got our own physiotherapist and we're saying we've got a patient here that we want you to, to look at please and, and see how they are

Code A — Great. Anything else that you would like to say at this point? Right, I will run upstairs to make sure there isn't any points but I am sure if we

have missed anything we'd better resolve those quickly, but thanks for taking the time and trouble to answer the questions so fully. All things being equal, the time is eight minutes past four.....

Mr. GRAHAM?? I am quite happy for you to leave those tapes in there while you run upstairs (inaudible)

Code A That' very kind of you, you are all heart. (inaudible) etc.....

FILE COPY

Strictly Private & Confidential

Mr Philip Beed

Code A

Our ref: TET/GML/00492-15579/7872598 v1
Your ref:

Tamsin Hall

Code A

14 July 2008

Dear Mr Beed

Dr Barton - Interim Orders Panel

As you will be aware from my previous correspondence with you the GMC Fitness to Practise Hearing previously scheduled to start in September 2008 has been postponed pending the outcome of the proposed Inquest.

The GMC therefore referred the matter to be considered by the Interim Orders Panel (IOP). Cases are referred to the Interim Orders Panel (IOP) where the doctor faces allegations of such a nature that it may be necessary for the doctor's registration to be restricted whilst the allegations are resolved, for the protection of members of the public or in the public interest or in the interests of the doctor.

As well as the protection of the public, the "public interest" includes preserving public trust in the profession and maintaining good standards of conduct and performance.

The IOP may make an order suspending a doctor's registration or imposing conditions upon a doctor's registration for a maximum period of 18 months. Alternatively, they may decide to take no action.

The IOP hearing in Dr Barton's case was heard on Friday 11 July 2008. The IOP decided to impose conditions on Dr Barton's registration. Details can be found on the internet at http://www.gmc-uk.org/concerns/hearings_and_decisions/fitness_to_practise_decisions.asp

In summary, the IOP placed a condition on Dr Barton that she 'must not prescribe diamorphine and must restrict her prescribing of diazepam in line with BNF guidance'. She must provide evidence that she has complied with this condition to the GMC. Her employers and any prospective employers will be informed of the restriction. The condition will be imposed on her registration for 18 months and will be reviewed within the next 6 months.

If you have any further queries then please do not hesitate to contact me.

Yours sincerely

Tamsin Hall
for **Field Fisher Waterhouse LLP**

Hall, Tamsin

From: Hall, Tamsin
Sent: 11 July 2008 15:00
To: Beed Philip - Senior Staff Nurse
Cc: Watson, Adele
Subject: RE: Barton statement

Thanks very much, I look forward to receiving it.

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
dd Code A

Mobile Code A

From: Beed Philip - Senior Staff Nurse Code A
Sent: Friday, July 11, 2008 2:31 PM
To: Hall, Tamsin
Subject: RE: Barton statement

Dear Tamsin

RCN soliciter has checked my statement and is posting it back to me today, so I expect to be able to forward it to you early next week.

regards

Phil

From: Hall, Tamsin Code A
Sent: 11 July 2008 11:01
To: Beed Philip - Senior Staff Nurse
Cc: Watson, Adele
Subject: Barton statement
Importance: High

Hi Philip

I wonder if you are now in a position to send us your signed statement? If you need any amendments to be made then please let either Adele or I know.

This has now become urgent as it must be disclosed to Dr Barton's solicitors in order that they may prepare their defence.

Regards

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP

Code A

Consider the environment, think before you print!

Field Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
Tel+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
Web www.ffw.com **CDE**823

Hall, Tamsin

From: Hall, Tamsin
Sent: 11 July 2008 11:01
To: 'Beed Philip - Senior Staff Nurse'
Cc: Watson, Adele
Subject: Barton statement
Importance: High

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This has now become urgent as it must be disclosed to Dr Barton's solicitors in order that they may prepare their defence.

Regards

Tamsin

Tamsin Hall | Solicitor

Code A

Watson, Adele

From: Watson, Adele
Sent: 02 July 2008 17:00
To: Beed Philip - Senior Staff Nurse
Subject: RE: Dr Barton - return of witness statement

That would be much appreciated - we are waiting to disclose all signed statements to the defence at present so as soon as possible please.

Thank you.

Adele

From: Beed Philip - Senior Staff Nurse [Code A]
Sent: Wednesday, July 02, 2008 4:27 PM
To: Watson, Adele
Cc: Woodland Betty - PCT Trainer
Subject: RE: Dr Barton - return of witness statement

Dear Ms Watson

My statement is currently with our RCN legal representative who needs to review it before I can return it to you

I will email them and ask if they know when it might be ready

regards

Phil Beed

From: Watson, Adele [Code A]
Sent: 02 July 2008 15:05
To: Beed Philip - Senior Staff Nurse
Subject: Dr Barton - return of witness statement

Dear Mr Beed

Further to our earlier communication I still do not appear to have received a copy of your signed witness statement in relation to this matter.

I would be grateful if you could return your completed statement to me by **Monday 7 July 2008**. If you feel this will not be possible please telephone me to let me know.

Many thanks

Adele Watson | Paralegal

Code A

Consider the environment, think before you print!

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Tel+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
Web www.ffw.com **CDE**823

Watson, Adele

From: Watson, Adele
Sent: 02 July 2008 17:00
To: 'Beed Philip - Senior Staff Nurse'
Subject: RE: Dr Barton - return of witness statement

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From: Watson, Adele Code A
Sent: 02 July 2008 15:05
To: Beed Philip - Senior Staff Nurse
Subject: Dr Barton - return of witness statement

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Many thanks

Adele Watson | Paralegal
for Field Fisher Waterhouse LLP

Code A

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Web www.ffw.com **CDE**823

Watson, Adele

From: Watson, Adele

Sent: 02 July 2008 15:05

To: 'philip.beed Code A

Subject: Dr Barton - return of witness statement

Dear Mr Beed

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I would be grateful if you could return your completed statement to me by **Monday 7 July 2008**. If you feel this will not be possible please telephone me to let me know.

Many thanks

Adele Watson | Paralegal
for Field Fisher Waterhouse LLP

Code A

FILE COPY

Strictly Private & Confidential

Mr Philip Beed

Code A

Our ref: TET/GML/00492-15579/7753423 v1
Your ref:

Tamsin Hall

Code A

26 June 2008

Dear Mr Beed

General Medical Council - Dr Jane Barton

I write further to our previous correspondence to update you on the current position of the GMC Fitness to Practise investigation.

You may be aware that recently the Portsmouth and South East Hampshire Coroner has announced his intention to open Inquests into the deaths of ten people who died at Gosport War Memorial Hospital.

After careful consideration, and upon the receipt of legal advice, the GMC has decided to postpone the Fitness to Practise Panel Hearing regarding Dr Jane Barton until the Inquest has been held into the deaths of the ten patients at the Gosport War Memorial Hospital. Eight of these patients were amongst those due to be considered at the Fitness to Practise Panel Hearing. The GMC has taken legal advice and has decided that on balance it is preferable to await the outcome of the Inquest. The outcome of the Inquest could give rise to further fitness to practise allegations or could lead to the GMC revising the charges that they are proposing to bring and so could be highly relevant to the GMC proceedings. Given the Inquest primacy will also allow Dr Barton to deal with that inquiry and evidence for that process, ahead of her having to finalise her response to the Fitness to Practise Panel.

The GMC Fitness to Practise Hearing will be relisted once we have been informed by the Coroner of the date of the Inquest. At present I do not know when this will be, but will of course keep you fully informed.

In the meantime I am continuing with my preparation for the Hearing, which includes finalising any outstanding witness evidence. This will ensure that once I have further information from the Coroner the GMC will be ready to re-list the Hearing without any further delays.

I appreciate that you may be disappointed by this news but hope that you understand the reasons above. If you would like to discuss this matter then please do not hesitate to contact either myself or Sarah Ellson.

The Coroner may contact you directly regarding the Inquest. Any queries regarding the Inquest should be directed to him. For your information his details are:

Mr Horsley
Her Majesty's Coroner for Portsmouth and East Hampshire
Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

May I take this opportunity to thank you again for your ongoing assistance. My colleagues and I appreciate your co-operation.

Yours sincerely

Tamsin Hall
for **Field Fisher Waterhouse LLP**

Hall, Tamsin

From: Hall, Tamsin
Sent: 05 March 2008 16:51
To: 'Beed Philip - Senior Staff Nurse'
Subject: General Medical Council - your statement
Attachments: DOCS_6887866_1.DOC

Dear Philip

Further to our meeting a couple of weeks ago please find attached to this e-mail the draft witness statement I have prepared upon your behalf based upon our discussions.

I am sorry that it has taken me a while to get this over to you.

Please read the statement carefully, as I explained to you it is your statement and it is very important that you are happy with the contents. If you would like to make any amendments then either do so on the document and e-mail it back to me or give me a call.

Please also re-read the transcripts of your interviews with the Police and if there is anything else you would like to add or clarify then please let me know and I will amend your statement accordingly.

If you would like me to send you hard copies of any of the documents in the post then let me know.

Thank you for your ongoing assistance.

Regards

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP

Code A

(05.03.2008)
(05.03.2008)

General Medical Council

Dr Jane Barton

Statement of Philip James Beed

I, **Philip James Beed**, will say as follows:

1. I make this statement in relation to the General Medical Council investigation into Dr Barton. I was previously interviewed by Hampshire Police on 24 July 2000 and I make this statement further to that interview.

2. Exhibited to this statement and marked "**PB1**" is a copy of the transcript of that interview. The transcript is broken down as follows:-

   (a) 1100 to 1145 hours (37 pages)

   (b) 1214 to 1250 hours (25 pages)

   (c) 1412 to 1452 hours (29 pages)

   (d) 1458 to 1541 hours (35 pages)

   (e) 1552 to 1604 hours (15 pages)

3. I am currently employed as a Senior Staff Nurse in the Multi-Disciplinary Response Team for Hampshire Primary Care Trust. Within this role I see patients in their own homes. It is quite a varied role and covers all of Fareham and Gosport. I have been employed in this position for the last 14 months.

4. I qualified in 1984 as a nurse whilst in the Navy. I worked in an ear, nose and throat ward for about a year and then specialised in ophthalmology whilst in the Navy. I left the Navy in 1989 and then worked for BUPA at Havant for five years. I then worked in Oxford at the Eye Hospital and also at Oxford Brookes University teaching and nursing at the same time.

5. In 1998 I took up a post at the Gosport War Memorial Hospital. I was employed as the Clinical Manager of Daedalus Ward.

6. I worked on Daedalus Ward until some time in 2004 and I then worked in intermediate care before commencing my current role.

7. Whilst I worked on Daedalus Ward I had 24-hour management responsibility.

8. I was the Clinical Manager of Daedalus Ward and I was supported by senior staff nurses. On days this was Yvonne Astridge, Pat Wilkinson and Rachel Ashton. There would be approximately six trained staff on day shifts and about four trained staff on night shift. There were also support workers and there were about 30 staff in total. Dr Barton was the Clinical Assistant for Daedalus Ward and Dr Lord was the Consultant.

9. Dr Barton would attend Daedalus Ward every weekday morning to carry out a review of the patients. She would arrive at around 8 am. Dr Barton would return about midday to clerk any admissions. This occurred as and when we had admissions so could potentially be on any day of the week.

10. If we had any concerns within working hours then we would telephone Dr Barton or whoever was on call for her Practice.

11. Dr Lord would carry out a weekly consultant ward once a week and Dr Barton would carry out a ward round on a daily basis as described above.

12. I did not have any concerns at the time I was working on Daedalus Ward about Dr Barton.

13. When I commenced working on Daedalus Ward in 1998 I was a very experienced nurse. I had, however, not worked in the speciality of stroke rehabilitation or continuing care previously. At the time I was new to that speciality but I was working with very experienced people within the ward. I also looked at practises in other areas of the hospital's departments for the elderly and the levels of care on Daedalus Ward seemed standard.

14. Of the wards in Gosport War Memorial Hospital Daedalus Ward was the busiest ward.

15. As Gosport War Memorial Hospital is a community hospital then the care was very much nursing and therapist led. This meant that there were occasions where a patient could be in distress or pain if we needed to increase their dosage of pain medication but we needed to get hold of the doctor first to do this.

16. In my interview of 24 July 2000 exhibited at **PB1** I have been asked a number of questions regarding the use of syringe drivers. I have nothing more to add at this stage regarding this matter.

17. I have been asked to expand upon my recollections of the treatment of the patient Gladys Richards.

18. I have detailed my recollection of the care of Mrs Richards from page 14 of exhibit **PB1(b).**

19. I would like to add the following regarding my recollection of Mrs Richards.

20. Bearing in mind that I treated her about ten years ago now I can remember most things about her. Mrs Richards stuck in my mind and I can recall her and her family. She presented with a fairly typical fractured hip and dementia. This was not that uncommon for the patients that we treated on Daedalus Ward. I recall that her family were very involved in her care.

21. My recollection of Mrs Richards was that she was very confused. She could not communicate with the nursing staff at all. Her daughters said that they knew what their mother was saying. However, I observed one of the daughters, I think her name was Lesley Lack, talking to her mother. I could see no signs of any communication. Even at that time I noticed a disparity between what the daughters of Mrs Richards were saying about her communication abilities and what I and the other nursing staff had observed.

22. Mrs Richards was agitated and in my professional view this was because she was in pain. It is possible to discern if a patient's agitation is caused by pain by the way that they present. For example, if the agitation increases on movement this could be an indication of pain.

23. The term agitation can cover a lot of different behaviour. It can encompass at the highest levels shouting out and moving around but at the lowest level the term agitation can be used to describe a patient who is looking uncomfortable or picking at their clothes or bed sheets.

24. Mrs Richards was admitted to Gosport War Memorial Hospital on 11 August 1998. I detail her treatment on pages 14, 15 and 16 of exhibit **PB1(b)**.

25. On Friday 14 August 1998 I arrived on shift at about 7.30 am. Dr Barton arrived at 8 am. I had been informed that Mrs Richards had fallen on the ward on the previous day. I remember speaking to Mrs Richards' daughter Mrs Lesley Lack. She was very angry about the delay and the fact that her mother had fallen in the first place. I would describe her as having been verbally angry with a kind of controlled anger.

26. As I was Clinical Manager of Daedalus Ward I got actively involved in all of the patients' care and I fitted in my administrative duties on top of caring for the patients.

If a patient was a more complex case then I would actively engage with them. Because Mrs Richards' family were unhappy I paid particular attention to her care.

27. Mrs Richards was transferred to the Royal Haslar Hospital over the weekend from Friday to Monday. She was transferred back to us on Monday 17 August 1998. I detail what happened upon her arrival on pages 18 onwards of exhibit **PB1(b)**.

28. I can remember that Mrs Richards was screaming when she was transferred onto her bed on Daedalus Ward but she could not verbally communicate at all.

29. On page 20 of exhibit PB1(b) I have described Mrs Richards as "generally looking unwell". I mean, by this comment, that she was poorly perfused (her colour was poor), her facial expression and body reactions indicated that she was in pain, she was not responding at all to verbal stimuli and it was not possible to move her without aggravating her further.

30. It was difficult to nurse Mrs Richards at times because her daughters would constantly contradict each other. Mrs Lack would tell me that her sister had an issue with morphine and that she did not want her mother to be given that. However when I spoke to Mrs McKenzie she would say something different.

31. I got the impression that Mrs Richards' relatives did not get on with each other. I could pick up that there was some tension but I was not sure exactly what the problem was.

32. On page 22 of exhibit **PB1(b)** I refer to the likely cause of Mrs Richards' pain being a haematoma. This is caused by bleeding within the tissue surrounding the hip joint. A haematoma would cause a patient significant pain. In Mrs Richards' the haematoma was not visible from the surface of the skin as it was most likely in the wound site of the operation.

33. Subsequently to Mrs Richards' death the family complained. I was surprised at their final complaint. I was aware that they had concerns at the time regarding their mother's fall whilst she was on the ward.

34. As I detail on page 22 of exhibit **PB1(b)** Mrs Richards' family agreed to her being put on a syringe driver to keep her pain free. If the family had said no then I would not have started the syringe driver. I would have gone back to the nurse manager and Dr Barton and/or Dr Lord and would have asked them to come and review the decision. I explained to Mrs Richards' daughters that Mrs Richards would deteriorate once she was put on a syringe driver.

35. Mrs Richards died on Friday 21 August 1998.

36. On exhibit **PB1(c)** I would like to correct on page 28 that it should read "lactulose" at the bottom of the page.

37. Subsequently to this complaint and the investigations that occurred at the hospital I would say that the record-keeping improved. The Primary Care Trust spoke to us all regarding records and introduced far more extensive paperwork for pain control. If we have had the paperwork at the time of Mrs Richards' care then it would have been a lot better. The documentation that came in was a lot better.

38. I have not discussed the case with Dr Barton subsequently except in very general terms.

39. I confirm that I have had the opportunity to re-read the transcripts of my interview with the police dated 24 July 2000 and I have nothing further that I wish to add or amend apart from my comments above.

40. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true.

Signed: .....

Philip James Beed

Dated: .....

Philip Beed. 15:09.

24/7/00 - interviewed.
never had a statement.

name correct.

* Senior Staff nurse, Multi-Disc Response Team. nurses / therapists see pt. in own home
GP seen them, unwell, manage at home falls / infections.
All of Fareham / Gosport. v. varied.

* 14 months.

Qual in 1984 as a nurse, in Navy at time. worked ENT ward for yr., spec opthalmology in navy
left navy 1989. BUPA at Havant
5 years. Oxford eye hospital
Oxf Brookes Uni. teaching + nursing
* 1998 Daedalus clinical mgr.
@ 2004 left there.
intermediate care then current role.

- 24 hr mgr responsibility.

- Senior staff nurse — days — Yvonne Astridge / — Pat Wilkins / — Rachel Ashton
  nights
- Approx 6 trained staff on days + me
  4 " nights
- Support workers 30 staff in total.
- Dr Barton clinical assistant.
  Dr Lord consultant.

- Dr B every weekday morning review
  @ 8.00
  midday to clerk admissions
  as + when potentially any day of the week.
- in working hours either her or whoever on call for practice.

- No concerns at time re Dr Barton.
- v. experienced nurse stroke rehab/ continuing care not in that speciality before.
- at time new to speciality but working w/ experienced people looking at practice in other areas of hosp. dept for elderly seemed standard.

- of wards in hospital it was the busiest ward.

- weekly consultant ward once per week Dr Barton daily.

- community hospital nursing + therapist led.
- would have been occasions where pt in distress / pain if needed to ↑ dose + get hold of a Dr.

- Can remember most things about her 10 years ago. She stuck in my mind + her family.
- fairly typical fractured hip / dementia not uncommon.
- family v. involved in care.

My recollection - v. confused. couldn't communicate with nursing staff at all.
Daughter. I conversed with her - Lesley - she said knows what mother
I'd be in room talking to them
ever at time noted a disparity.
- prob her agitated because in pain way someone presents, if increase agitation on movement. type of response.
- behaviour unsettled. agitation can cover a lot.
encompass highest shouting out, moving round

later used leaving uncomfortable pacing at times between.

I started at 7.30 Dr B arrived at 8.
Same up been up an.

can't remember if both, spoke to Mrs Lock.

Angry about delay. It happened at all. Verbally angry. Continued after.

I as clinical mgr for activity involved in pt care + fitted in admin as hap.
If more complex pt I would activity engage. Depending on which staff an.

can't remember if discussed specifically with JB.

Hospital over weekend Friday to Monday.

Screaming when transferred onto bed but calmer verbally communicate.

We couldn't auth an x-ray, need a signature of a Dr to do so.
Can't remember sequence of events.

'generally looking unwell'
- poorly perfused (colour)
- facial expression body reactions indicating pain.
- Not responding at all to verbal stimuli
- couldn't move her w/out aggravating further.

Times when only in room, would talk about other one. contradict.
Mrs Lack. sister had a thing about morphine didn't want.
Mrs McKenzie - saying diff.
Relatives didn't get on.
Could pick up but not exactly what.

Haem - bleeding w'in tissues surrounding hip joint.
Would cause pain.
In Mrs R couldn't tell, (if nr surface would seem like a bruise).

Reduced consc. not automatic, depends on starting point.

At this point expect death
poss days, not eating /drinking
Agreed with t'ment. family.
Didn't raise concerns w/ me at
time.

I was aware of concerns.

was surprised at formal complaint

if family said no
- wouldn't start SD myself
go back to nurse mgr / Dr Barton
Dr Lord.
- ask them to come + review
decision

I explained she would deteriorate
once on SD.

Died on Friday.

p 28 / 29 Lack of law,

Haloperidol - anti-psychotic
Records
PCT spoke to us all re records
More extensive paperwork for
pain control
if we'd had at time then
would have been helpful

Documentation must come in was a lot better.

? Discussed case JB
- any in v. general terms.

Incident report form for the fall should be available.

NOT an incident Review form.
four triggered events e-g. dual W'in 24 hours.

partic known to be a faller. Multiple falls in rest home.

Send notes to Pickup's office.
Trust will hand deliver
room P+C.

Hall, Tamsin

From: Hall, Tamsin
Sent: 06 February 2008 11:58
To: 'Beed Philip - Senior Staff Nurse'
Subject: RE: GMC hearing

Great, thanks. I look forward to meeting with you then.

Regards

Tamsin

Tamsin Hall | Solicitor

Code A

From: Beed Philip - Senior Staff Nurse Code A
Sent: Wednesday, February 06, 2008 9:42 AM
To: Hall, Tamsin
Cc: Woodland Betty - PCT Trainer
Subject: RE: GMC hearing

15:00 Mon is fine with me

Philip

From: Hall, Tamsin Code A
Sent: 05 February 2008 17:08
To: Beed Philip - Senior Staff Nurse
Cc: Woodland Betty - PCT Trainer
Subject: RE: GMC hearing

Dear Mr Beed

Thank you for getting back to me, I apologise for the delay in getting back to you. Unfortunately I have been out of the office unwell.

I am coming to Hampshire next week - 11 to 14 February.

I have arranged to meet Betty (hence copying her in to my response) at Fareham Reach on Monday 11 Feb at 14:00. Would you be free to meet with me and Betty at 15:00?

I look forward to hearing from you.

Tamsin

Tamsin Hall | Solicitor

for Field Fisher Waterhouse LLP

Code A

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Tel+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
Web www.ffw.com **CDE**823

From: Beed Philip - Senior Staff Nurse Code A
Sent: Friday, January 25, 2008 8:21 AM
To: Hall, Tamsin
Cc: Woodland Betty - PCT Trainer
Subject: GMC hearing

Dear Ms Hall

I acknowledge receipt of your letter

I can make myself available at anytime on 29th-31st Jan, I understand this will be co-ordinated by our RCN representative, Betty Woodland.

At the present time I am available for any dates from 8th Sept - 31st Oct.

The information I gave to the Commission for Health Improvement will be contained within their report, which I imagine you have a copy of.

The home address you have for me is correct.

My email is Code A (as per this email)

My work tel numbers are listed below. You should note that I community based so am not always available to answer my phone, but messages can be left on my mobile or at our office base.

Yours Sincerely

Phil Beed
Senior Staff Nurse
Multidisciplinary Response Team
Code A

Code A

FILE COPY

Strictly Private & Confidential

Philip Beed

Code A

Our ref: TET/00492-15579/6627726 v1
Your ref:

Tamsin Hall

Code A

16 January 2008

Dear Mr Beed

General Medical Council - Dr J Barton

I apologise for contacting you out of the blue. I am a solicitor instructed by the General Medical Council, the governing body of the medical profession.

As you may be aware the General Medical Council, as a result of the outcome of the investigations carried out by Hampshire Constabulary, has now decided to refer Dr Barton for a hearing before its Fitness to Practise Panel. The Panel will consider whether her fitness to practise is impaired.

I have been instructed to prepare the case for hearing and I note that you assisted Hampshire Constabulary with their investigations. I have been provided with all of the investigation material from Hampshire Constabulary, including witness statements, which will be used as evidence by the General Medical Council at the hearing.

If you made statements to any other body, for example the Commission for Health Improvement, then I would be grateful for your further information in this regard. In particular, if you could forward me copies of any additional information that you may have then this would be exceedingly helpful.

I anticipate that I will need to call you as a witness for the GMC Fitness to Practise hearing. I would therefore like to meet with you to discuss your evidence further. I will be visiting Hampshire with regard to this case between 29 and 31 January 2008. Please contact me in order that we may arrange a mutually convenient time to meet.

My contact details are Code A or alternatively via email at Code A

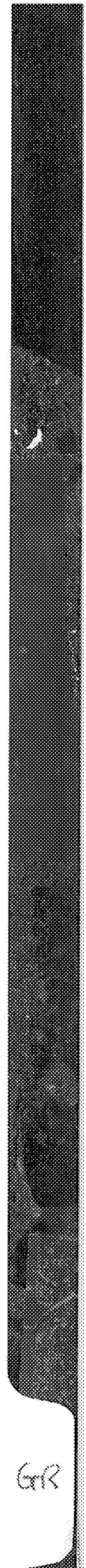
In order that you may refresh your memory I have enclosed copies of transcripts of your police interviews dated 24 July 2000.

I would also like to take this opportunity to let you know in advance that you will be required to give evidence at the General Medical Council hearing in London. The hearing has been provisionally listed for **8 September – 31 October 2008**. It is likely that your attendance will be required during September and I would therefore be grateful if you could provide me with details of any dates that you will be unavailable during that month for example if you have any holidays booked. Further, it would be helpful if you could confirm that I have the correct correspondence address for you, and if you could also provide a contact telephone number and email address to me.

Thank you for your assistance in this matter. I look forward to hearing from you.

Yours sincerely

Tamsin Hall
for **Field Fisher Waterhouse LLP**



GR

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y21

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1100 Time concluded: 1145

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

Interviewing Officer(s): Code A Code A

Other persons present: Mr GRAHAM -Saulet & Co Solicitors
Portsmouth Legal Advisor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

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

please and your date of birth for the tape?

BEED — Philip James BEED, 21st of March '63.

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

SOLICITOR — Mr GRAHAM from Saulet and Co Solicitors, Portsmouth - Legal Advisor.

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

BEED — Okay, yeah.

Code A — Right, before I start to question you at all, I have to go through and give you what we call a caution and that is, that you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court and anything you do say may be given in evidence. Do you understand the caution?

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

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

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

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

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

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

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

BEED Yeah.

Code A Right, what does a Ward Manager do?

BEED Erm responsible for nursing care of patients on a

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

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

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

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

BEED — That was Doctor LORD.

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

BEED — Yes she's cons...she's still consultant in charge now.

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

basis with Doctor LORD?

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

Code A — Right and when would you get in touch with Doctor LORD?

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

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

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

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

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

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

Code A As in Doctor BARTON's practice?

7.14 BEED Doctor BARTON's practice, yeah.

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

BEED For ad..for admission?

Code A ...Yeah.

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

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

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

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

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

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

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

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

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

Code A Right, is that adequate staffing then?

9.23 BEED For eighteen patients the ward gets very busy

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

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

BEED Yeah, yeah.

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

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

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

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

BEED Doctor BARTON or Doctor LORD and also the other erm doctors in Doctor BARTON's practice if they come in, if we call them in.

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

BEED Yep.

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

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

Code A Right, are there occasions when the consultant or

		in your experience says no this person's not fit to come to us?
	BEED	There might be but we wouldn't know because they wouldn't get as far as us...
	Code A	Right
	BEED	...if that had happened because they would, they would, like they would...that information would be directly between the consultant and the particular ward. I do know that does happen from time to time, either the patient is too well to come to us and doesn't need rehabilitation or the patient isn't well enough erm the other thing that happens is patient...is that conditions on the patients progress are made before transfer so the same patient can come to us but these things, these tests or these things must be sorted first before they come over to the War Memorial.
13.46	Code A	So generally speaking a patient arriving at the War Memorial is stable and able to be nursed?
	BEED	They should be, yep.
	Code A	Okay. What paperwork accompanies a person?
	BEED	Erm if they come...at that point in time if they came from QA they would come with their notes, if they came from Haslar they would come with their Haslar notes and we would obtain the Portsmouth notes and there should be a transfer letter as well and they should have any medications which they're required to be on, what we call T-T-O's.

Code A So and what is a T-T-O?

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

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

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

Code A Right, did you have a pharmacist?

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

Code A Okay, does she advise?

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

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

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

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

Code A (inaudible) Formary

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

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

BEED Yes.

Code A to keep an ongoing...

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

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

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

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

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

BEED — Yeah.

Code A — Who would they highlight that to?

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

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

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

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

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

BEED Yeah.

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

BEED Yeah, yeah.

Code A ...hard and fast rules?

BEED Yeah.

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

BEED Yep.

	Code A	...You can highlight it...
	BEED	Yep.
	Code A	...and as can the doctor highlight it but ultimately the consultant is...
	BEED	Overall responsible.
	Code A	...is overall responsible but there are a number of checks before we get there....
	BEED	Yeah, yeah.
	Code A	...and a number of opportunities for people to identify...?
	BEED	Yeah.
	Code A	Okay. Can you tell me about named nurses and what that's all about?
19.32	BEED	The named nurse is actually the nurse with the specific responsibility for individual patient and each patient has a named nurse erm and we allocate it so we each have usually about three or four patients erm and that nurse will be responsible for generally overseeing the patients care so any major change that takes place in, in..take effect in how we care for a patient er they will be involved in the decisions erm and also things like referral to Social Services, erm communicating with relatives and so on erm because we work a shift pattern, we also work in teams erm and other nurses can actually erm be involved in that patients care as well so erm if something is happening with the patient and the named nurse is off for two days then someone

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

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

20.47 BEED — Yeah.

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

BEED — Yeah, yeah.

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

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

Code A — It almost picks itself?

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

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

21.41 Code A Right. What paperwork accompanies a patient?

BEED When they come to us?

Code A Yeah.

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

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

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

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

BEED Yeah.

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

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

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

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

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

	Code A	Up to twelve things, I mean it's not an exam, I wouldn't want to...could you sort of as many of those as you can name for me?
	BEED	Er so nutrition, erm breathing, erm feeding, erm elimination which is continence er hygiene erm relationships, communication, erm sexuality, erm religious needs, sleeping so that's the and there's another two there somewhere but I'm not sure but we would...not all of those would be applicable to all patients so...
	Code A	No so I mean is there a mobility?
	BEED	...Mobility is one, yeah.
	Code A	Is it?
	BEED	Yeah.
	Code A	So and when a person comes in who assesses how many of these plans are applicable to a patient?
25.10	BEED	That would usually be the named nurse and if not someone acting on their behalf so it would be a qualified nurse and we would assess and initiate as many care plans as we could initially the patient came in but it might...but that doesn't have to be done immediately, we usually...I would expect all our patients to have a full set of care plans within 48 hours of admission for some of the things it may take a day or two to assess what their needs are and to actually erm introduce the care plans properly.
	Code A	Right so the care plans are something that

develop...

BEED Yeah.

Code A ...over a period...

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

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

BEED Yeah.

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

BEED Yeah.

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

BEED Later on, yeah, yeah.

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

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

BEED Yeah.

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

BEED Clerking admissions?

Code A Yes please.

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

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

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

BEED Yeah.

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

BEED Yeah.

Code A ...treatment...

BEED Yeah.

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

BEED Yeah, yeah.

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

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

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

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

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

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

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

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

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

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

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

Code A Right. What is Palliative Care?

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

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

is dying, who's we?

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

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

BEED Yes, yeah.

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

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

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

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

		do it with the medical staff in making decisions about care.
	Code A	So initially if the patient reaches that point, I mean that may be 20 odd hours away from seeing a doctor but are you empowered to move to palliative care without reference to the doctor?
	BEED	Yeah, I mean we could, we could call a doctor if we needed to erm but we would have discussed the patients ongoing care and prognosis and outlook on each occasion we saw the doctor so we are empowered to initiate a syringe driver erm because what would have happened is on a previous occasion when they've been reviewed by the doctor where the patient hasn't been looking good erm we think their condition may deteriorate erm and the syringe driver would be written up or have been written up and the instruction would be if this patient condition worsens and you can utilise the syringe driver er to keep that patient pain free.
34.33	Code A	Right so it's once again you're empowered to make that and the doctor says that you know this is perhaps a natural route to go down...
	BEED	Yeah.
	Code A	...and it's an individual decision for you that we've reached that point now and perhaps...
	BEED	Yeah.
	Code A	...and you're empowered to initiate a syringe driver on...

	BEED	Yeah, yeah, yeah because the controlled drugs have to be checked by erm two nurs...two qualified nurses erm then actually the decision is a team decision erm and you'd make it in discussion with erm a nursing colleague before actually initiating that so we're empowered to but it's usually done by two people rather than just the one.
	Code A	Okay, to the untrained mind, is the onset of using a syringe driver normally a signal to all concerned that...?
	BEED	It normally is but not, that's not absolute and I, I've not say for the majority of patients that we initiate a syringe driver then we're going down the palliative care route but I have seen syringe drivers used and discontinued on erm some occasions when a patients made an improvement.
35.46	Code A	Okay so that is a decision that's reversible?
	BEED	If, yes certainly if the patient no longer needed to be on a syringe driver they could come off it.
	Code A	Right but in your experience it's unusual?
	BEED	That's unusual.
	Code A	Is that peculiar to that hospital or is that peculiar to nursing in general?
	BEED	That's, that's nursing in general.
	Code A	Okay so and I guess the doctor would invariably agree with your decision because it's all part of the plan?

BEED — Yes, yeah, yeah.

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

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

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

BEED — Yeah.

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

BEED — Yeah.

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

BEED Yeah.

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

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

Code A So having that many opportunities to discuss the

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

38.50 BEED

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

Code A

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

BEED

Yeah.

Code A

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

BEED Right.

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

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

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

and when are you expected to write it?

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

Code A Right, but the key word is significant?

BEED Yep.

Code A It's not...

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

Code A Yeah.

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

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

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

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

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

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

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

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

Code A — Right.

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

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

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

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

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

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21A

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1214 Time concluded: 1250

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

Interviewing Officer(s): Code A Code A

Other persons present: Mr GRAHAM - Solicitor Saulet & Co, Portsmouth

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

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

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

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

Code A — Would Dr BARTON ever assume that higher role?

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

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

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

BEED — In terms of consultant cover?

Code A — Yeah.

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

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

BEED — Right.

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

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

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

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

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

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

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

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

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

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

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

Code A — What would you use generally across the

board?

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

Code A — What other sizes do you use?

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

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

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

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

BEED — Yeah.

Code A How long for?

BEED Usually for about 20 to 30 minutes.

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

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

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

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

Code A So the doctor relies on your judgement?

BEED Yeah.

Code A In an ideal world is that common practice?

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

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

Code A

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

BEED

From the information we supply to her.

Code A

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

BEED

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

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

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

BEED Yes.

Code A How long have you worked with Dr BARTON?

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

Code A Three years?

BEED Yeah.

Code A Is that a good sort of professional relationship?

BEED Yes.

Code A Is there a social element to it?

BEED No.

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

BEED Yes.

Code A Have you ever disagreed?

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

appropriate course of action is.

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

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

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

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

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

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

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

14.36 Code A Can families influence that decision?

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

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

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

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

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

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

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

Code A It's difficult ...

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

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

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

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

Code A Not at the moment no.

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

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

BEED Has this got the duty rotas in it as well?

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

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

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

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

18.07 BEED I think so yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BEED I don't mind.

GRAHAM It's all in your hands.

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

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21B

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1412 Time concluded:

Duration of interview: Tape reference nos.
(🎞)

Interviewing Officer(s): Code A Code A

Other persons present: Mr GRAHAM - Solicitor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

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

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

BEED Right.

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

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

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

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

BEED Yes.

Code A And I understand in the case of Mrs RICHARDS on that day it was a letter from Doctor REID.

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

Code A Is it on the notes.

BEED The letter from Doctor REID.

Code A Yeah.

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

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

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

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

Code A

Okay, so that letter arrives with you, on your ward before Mrs RICHARDS.

4.30 BEED

Yeah.

Code A

So you're , so what's your expectation.

BEED

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

		eye on all of our patients all the time but the rooms closest to the office and the nursing stations are the ones that we can most easily observe on the most frequent basis, er, in fact the room that we got ready for this lady was room 3, which is immediately adjacent to the ward office and the nursing station.
	Code A	Right, so your expectation was for a lady who was stable enough to be transferred and therefore you could make plans about.
	BEED	Yeah.
	Code A	And were any plans made on that occasion.
5.43	BEED	Well we were still need to wait and see the actual person theirself to see exactly what we could do, and it usually takes the patients 2 to 3 days minimum to sort of settle into the ward so you can't really make any firm progress on rehabilitation until the patient's had a chance to settle into the ward.
	Code A	So it wouldn't be upmost on your list of priorities to, to think of a plan for the future, immediately.
	BEED	No, no, not until we've actually met the patient and had a few days to assess them and see how they are.
	Code A	Okay, Mrs RICHARDS arrives at the hospital, erm, what happens next.
	BEED	The ambulance crew would take her to room and pop her into either bed or chair depending

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

6.34 Code A Would that have been out of choice.

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

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

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

Code A Okay, what's your first contact with Mrs RICHARDS.

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

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

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

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

Code A And what's your expectation of Doctor BARTON.

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

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

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

		couldn't have given that without the chart being written up.
9.03	Code A	Okay, so relying on your notes there and message, tell me about Gladys RICHARDS, when you did see her.
	BEED	Very anxious, very confused, and appeared to be in pain from the hip that she'd had operated on, erm, difficult to tell exactly, what, what was going on because she was so confused but I, I felt that she was in pain and certainly very difficult to communicate with.
	Code A	Can you distinguish between pain and dementia.
	BEED	It's, it's, sometimes very difficult, erm, one of the things that would tell us is if that, erm, the shouting got worse when we went to transfer the patient, and we would have had to do that at some point in the afternoon to pop her on a commode, if she wanted to spend a penny and, erm, daughter was actually saying that when she's agitated she want to use the toilet, so that would be one indication, erm, sometimes it's very difficult to distinguish.
	Code A	Did you have much experience of, of, erm, patients who have dementia.
	BEED	Yeah, I have, I, all my previous posts I've look after patients with dementia so I've seen lots of patients with dementia and it presenting in all sorts of different ways.

	Code A	Does it present itself in difficult grades, different severities.
	BEED	Yes, yeah, you can have patients who've got mild dementia, erm, or dementia that's sort of worse at some time than others and are rational in between and patients who have dementia and are just quietly confused with it and you can have patients who are very noisy and very agitated and Mrs RICHARDS would come at the severe end of the scale.
	Code A	Right, is there any doubt that that could be confused with pain.
	BEED	It's difficult to differentiate but I, I, the sort of actions that I was seeing from Mrs RICHARDS and the difficulty with transferring her and so on indicated to me that as well dementia and confusion that she had pain.
11.06	Code A	Right, okay, does Doctor REID's letter give you any indication, he goes on about some drugs there, was it, how, Haloperidol and Trasadom, what do they do.
	BEED	Erm, Haloperidol is, is, erm, sedates people and helps the confusion, Trasadom does much the same things, it's a anti-depressant and, and helps with confusion.
	Code A	But they're (inaudible), the Trasadom anyway.
	BEED	Yeah, stopped the Trasadom, the family said that that, that they felt that had over sedated her, so, so he's actually discontinued that, and that

had been discontinued before she came to us.

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

BEED — Yeah.

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

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

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

BEED — Yeah, yep.

Code A — That would be most likely.

BEED — Yeah.

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

BEED — Yeah.

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

BEED — Confusion.

Code A — The confusion and dementia.

BEED — Yeah.

12.47 Code A — So what do you do next.

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

	Code A	Okay, so what drugs did she take over the next couple of days, we're on the 11th.
	BEED	Yeah she had a further dose of Oramorph at 1145 at night on the the 11th, a further dose at 0615 in the morning on the 12th, erm.
	Code A	Had she been reviewed by any member of staff, had her pain lessened.
36.16	BEED	She'd, erm, what we'd have done was looked at her overall condition and, and erm, whether she was in pain and erm how the pain was, so whenever you go to give a dose of analgesia erm you look at the patient's pain and how well that's controlled and whether they, they need, so you always carry out a review before and when you're giving pain control.
	Code A	So what you said earlier was that the beauty of the syringe driver is the fact that you can ensure there's constant level.
	BEED	Yeah.
	Code A	But with Oramorph of course it's a quick fix.
	BEED	Yeah and then it would wear off.
	Code A	So is it recorded that on each and every occasion that the effects wore off that she needed more.
36.54	BEED	It wouldn't necessarily be recorded specifically.
	Code A	Is that unusual.
	BEED	Erm, it wouldn't give, if I look, what I need to do is look at the night care record cos that might, erm, we haven't actually made a specific

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

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

BEED I would have given her some more, yep.

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

BEED and again in the morning, yeah.

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

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

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

BEED No.

Code A ..for this lady.

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

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21C

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: FAREHAM POLICE STATION

Date of interview: 24/07/2000

Time commenced: 1458 Time concluded: 1541

Duration of interview: Tape reference nos. (📼)

Interviewing Officer(s): Code A Code A

Other persons present: Mr GRAHAM - Solicitor Saulet & Co

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

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

Code A — Can you go through your duties and Gladys' notes.

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

Code A — Sorry what does PRN stand for.

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

Code A — This is Oramorph?

BEED — Yeah the Oramorph.

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

BEED — No.

Code A — On the 12th.

BEED — Yeah.

Code A — Right.

BEED — Yeah. Um I can't remember any other specific

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

BEED .....of everything that happened.

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

BEED I wasn't on duty on that day.

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

BEED Yeah, yeah.

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

BEED Yeah.

Code A .....what drug regime.

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

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

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

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

occurred at some other time rather than the fall.

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

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

BEED — Yeah.

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

BEED — No.

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

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

Code A — Okay. No I except that. What's your next contact with Gladys RICHARDS.

5.49 BEED — Er that was on the morning of the 14th when I was

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

Code A What does it look like a dislocation.

BEED Um.

Code A Can you tell.

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

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

BEED Yeah, yeah.

Code A When did you know there was a dislocation.

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

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

BEED That was done sometime around mid morning.

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

morning.

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

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

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

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

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

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

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

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

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

BEED The hip is back in place yeah, yeah.

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

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

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

BEED Yeah.

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

BEED I was on duty from twelve fifteen on the 17th.

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

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

14.54	Code A	Now there are some issues around that transfer which I'm not really fully au fait with, and I don't, something to do with the stretcher, a sheet.....
	BEED	Yeah.
	Code A	.....what is a street. Can you just explain to the, to the uninitiated.....
	BEED	Yeah.
	Code A	.....exactly what went on.
	BEED	Usual, usually if some one comes on a stretcher they'll be on what we call a canvas, which is a er, which literally is a length of canvas with holes up either side and you can slide poles into those holes and it then becomes a stretcher which you can lift from the stretcher, one person either end.....
	Code A	Yeah.
15.26	BEED	.....over onto the bed so the patient comes up nice and easily, and over um Mrs RICHARDS came to us on a sheet instead of a canvas and I'm given to understand that they couldn't find a canvas and that they'd phoned to say sorry she's not on a canvas um and therefore the ambulance crew when they arrived picked her up on the sheet which doesn't give the same level of support because they're just sort of grabbing the sheet which is going to sag and be uncomfortable and transfer you in that way.
	Code A	So it's a sheet before it has the poles inside.....
	BEED	Yeah.
	Code A	.....and then it's a canvas.

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

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

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

BEED Yeah.

Code A .....lifted up.

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

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

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

Code A Yeah sure.

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

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

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

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

Code A So initially, uncomfortable.

BEED Yeah.

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

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

20.02 Code A So Doctor BARTON had been before that.

BEED Yeah, yeah.

Code A Because.....

BEED Yeah.

Code A Had she written another prescription at that point.

BEED Um no as we still had the existing prescription so we used, that would have.....

Code A How long's a prescription valid for.

BEED Um it needs to be um reviewed, reviewed

regularly um, I'm, what the time limit is I don't know but I mean that would be well within it. If someone's written up for Oramorph that would be, be and remains on the ward or goes off a few days and comes back, be valid for a good number of weeks but needs to be reviewed during that period.

Code A — Ah ha. Okay she's in pain but she's able to take Oramorph.

BEED — Yeah.

Code A — So her swallow reflex is still there.

BEED — Yeah.

Code A — And up and running.

BEED — Yeah. She was refusing to eat lunch at that point in time um but she was swallowing.

Code A — Right is that significant do you think.

BEED — May have been because she was in pain and unsettled or it may have been just her general dementia and overall condition so you know it was just one of the things that we noted at that point in time that some food was prepared for her but she refused to eat it.

Code A — Okay. Right. How did she progress throughout the rest of the, the 17th.

BEED — Arranged an x-ray because the family was worried that the hip was dislocated although it didn't appear to be um and that took place.....

Code A — Didn't one of your nurses, have I read somewhere that the, the leg looked like it was a figure four.

BEED — The, yeah, one of the, Staff Nurse COUCHMAN

actually went in with the daughter and actually repositioned the leg because she thought it wasn't in er a very comfortable position but it wasn't in a position that looked like it was dislocated, um, so she made Mrs RICHARDS in a comfortable and appropriate position um and with her daughter, um, and generally examined her to check, because if she'd spotted an obvious dislocation at that time again we would have um, it's definitely x-rayed, it definitely needs x-raying.

22.14 Code A Yeah.

BEED But it looked in an odd position but not in a dislocated position.

Code A Right.

BEED Er. So really (inaudible) that afternoon was to give analgesia to try and make Mrs RICHARDS comfortable and to get her x-rayed to try and find out if it had dislocated again, um, or if it hadn't to find out if it was anything else we could do anything particular about.

Code A Okay. So what's the drug regime for the rest of the 17th.

BEED Um we carried on, we actually um, because we thought there was a sensitivity to the Oramorph we were giving a slightly lower dose so we were giving 5 milligrams, we gave that at one o'clock, we gave it attain at ten to seven, er sorry, gave it again, I can't read my own writing, looks, I think it was about quarter past three and then but that

wasn't, that obviously wasn't enough, so I gave a higher, a second dose of 5 milligrams at quarter to five and then we went back to giving the ·10 milligram dose at eight thirty and then she had some in the early hours of the morning.

Code A — Are the family happy at this point that she's in pain as opposed to dementia.

BEED — Yeah, yeah, I had specific discussions with the daughter and Mrs LACK in particular was very concerned about how much pain um her mum was in and that we need to get that pain under control so I was working very much in conjunction with the family to um try and provide um what, the sort of care that they wanted for their mum.

Code A — So at this particular moment in time on the 17th you're all singing off the same hymn sheet.

BEED — Yeah, yeah.....

Code A — Everyone's quite happy with what's happening.

BEED — Yeah, um and that, that's one of the reasons I gave the second dose and I, I distinctly remember looking very carefully at how much can 1 give and when and what, and looking at the option of the syringe driver at that time should I need to proceed to it and saying to um Mrs RICHARDS' daughter that I wanted her mum to be comfortable before I went off duty that evening.

Code A — Was there a consideration to the use of a syringe driver then.

BEED — It would have been one of the options could we

not control the pain with the Oramorph.

Code A — Right, how, how high, or how far along that ladder were you prepared to go on Oramorph.

BEED — Because you're giving, because you're giving quite high doses and it's wearing off um the difficulty is you, you can't just give Oramorph and then say it hasn't worked you need to give it time to build up and I needed to give a second dose so, I think had I, had I gone for that um second dose which topped the Oramorph up to 10 milligrams at quarter to five, had she not been comfortable by the time I went off at eight thirty I would have, at that point been looking whether the use of a syringe driver was the next appropriate step because obviously if I'd gone to the full amount of Oramorph and that hadn't kept Mrs RICHARDS comfortable then the next logical step was whether a syringe driver would allow me to give um a more dose and a slightly stronger dose of pain killer.

25.28 Code A — Right and what's your objective behind that.

BEED — In going to a syringe driver.

Code A — Yeah.

BEED — To keep Mrs RICHARDS pain free.

Code A — Purely pain free and that.....

BEED — Yeah, yeah. Yeah.

Code A — Okay thanks for that. And then what happens next.

BEED — Um, she was cared for over night. I came, um, I was on duty again the following morning, the 18th

		when she's reviewed by er Doctor BARTON.
	Code A	Had anything significant happened over night.
	BEED	Um she had another dose at, of Oramorph, I gave a dose at eight thirty, she needed another dose at twelve thirty which is, so she's only going 4 hours and another dose at four thirty, so she's going only the 4 hours between doses of Oramorph, um, so that's, we're giving the maximum amount we can, um, if I find the night (inaudible) records that might tell us how she was over night.....haven't got a specific record but I would have got handover from the night staff and obviously they would have told me that um they needed to give the Oramorph um every 4 hours and um that she hadn't been comfort, completely comfortable on that.
27.12	Code A	The reasons for those being omitted from, from the record sheet is that an oversight or is.....
	BEED	An over, yeah.
	Code A	Yeah, and nothing, nothing else.
	BEED	No.
	Code A	Just straight up oversight. What other drugs had she taken....
	BEED	Um.
	Code A	.....at the same time.
	BEED	That's on the um on the 18th, she actually hadn't, we've left off the Lactalose um, but she's had, she's having, no she did have Lactalose on the 17th and she had Haloperidol.

	Code A	Right, what did the Haloperidol do for her.
	BEED	Haloperidol is to help with her confusion and agitation.
	Code A	Right. I think you told me that once. Is that in an oral form at that time.
	BEED	Yes. Yeah.
	Code A	Okay so up until the 17th.....
	BEED	Yep.
	Code A	.....what's her condition, is she getting better, is she getting worse.
28.35	BEED	She's, she's really overall she's worse, her fluid and her diet intake is poor um she's, we're not really controlling the pain even with the regular dose of Oramorph um and she's quite agitated and uncomfortable and it's making it difficult for us to, to nurse her and look after her overall care.
	Code A	So generally the scenario is one of, it's becoming increasingly difficult.
	BEED	Yeah.
	Code A	Right, Doctor BARTON comes in.
	BEED	Yeah.
	Code A	Then what happens.
	BEED	Um, we'd have er reviewed her with myself, we'd have gone and seen the patient and looked at how she was um looked at the x-ray that was done the previous day and then um discussed Mrs RICHARDS care and what Doctor BARTON felt was this lady's overall condition was deteriorating er quite significantly, that we weren't controlling

the pain and the only way we would control the pain was by a syringe driver er and that she felt the lady's overall condition indicated that she was in, in such poor health that she was actually dying um and that we ought to keep her pain free and make sure we were meeting all her nursing needs but that, that we, that rehabilitation at this point wasn't going to be something that we were going to achieve and that we were likely to be looking at a patient that was going to die fairly shortly.

Code A Right and that's a decision that, that's not taken lightly.

BEED No.

Code A I would assume.

BEED No.

Code A And in conjunction with the family.

BEED I, the family weren't present at that point in time, so what I would then have done is discuss things with the family when they arrived um and try to do that in a sensitive and tactful way um, because you start building up a relationship with a family sometimes it can be just done er by nursing staff, sometimes you'd have to arrange for them to come back and see the doctor if you didn't think that their questions had been answered or you'd um answered all their concerns or they till had worries or whatever. Um but I met with them um sometime around mid morning when they came and discussed their mum's overall condition and

um the fact that we needed to use a syringe driver to control her pain um and that we didn't' think her, or we thought her prognosis was very poor and that she was actually going to die, sometimes.....

Code A So it was cards on the table.

BEED Yeah, oh yes, yeah.

Code A Right, what was their reaction to that, can you recall.

BEED Upset, as, as you would expect, the, I, I knew from previous discussions with them that they had worries about use of um strong analgesias, I believe Mrs MCKENZIE actually had experience of, of someone close actually um being in a hospice and having strong analgesia, er so I did in that sort of discussion which you try and make sense, tactful, allow them time to voice their fears and anxieties and to answer any questions they had. Um but overall my impressions was that they understood the situation and they agreed with, the, the kind of care which we were um wanted to proceed with.

Code A Did they say at any stage, no we don't agree with this.

BEED No, no, um if they had then I would have taken, I would, I wouldn't have proceeded and I would have taken advice from elsewhere, I would have go to a Nurse Manager or um a consultant to get their advice. So although I knew that was the care

that Mrs RICHARDS needed I wouldn't have gone ahead with that sort, that care um if they were in direct opposition.

31.59 Code A And what would have been the alternative to the syringe driver.

BEED Er carry on giving Oramorph, um could have given higher doses of Oramorph, so that would have been one alternative.

Code A Because she is still capable of taking it.

BEED Yeah. Yeah. Um the problem with that is it wasn't keeping her pain free for um the interval between the doses so it wasn't giving her adequate, it was giving her some level of pain control but it wasn't adequate pain control.

Code A But, was there still some way to go before you reached the maximum dose of Oramorph.

BEED Um we could have increased the dose, I think the, it's it's, it's more a matter of the interval inbetwen that, that Oramorph then wears off, um makes it difficult.

Code A Do people become immune to it, not immune to it but.....

BEED The effects of it do lessen over time yes.

Code A Do they.

BEED Yeah, yeah.

Code A (inaudible) with junkies you know they start off and they take more.....

BEED Yeah, yeah. Yeah. They, they, um the effect isn't heightened they get used to it.

Code A	So it's likely that she becomes less resistant to, have I got that right.
BEED	Yeah. She...
Code A	I don't think I have, it has less of an effect.
BEED	Has a less effect yeah, yeah.
Code A	And for a lesser period of time.
BEED	Yeah, yeah.
Code A	Right.
BEED	And the other thing we find when we're trying to control patient's pain it's easier with pain if you can stay on top of it all the time, so if you, if you allow someone to become in pain it's then harder to control, get that pain back under control when if you don't allow someone to get in pain in the first place.
Code A	Okay.
BEED	So if you give a continuous dose that, that never lets that pain come through or if it does come through it just keeps it at a controlled level um then it's much, you don't actually need so much of the medication to keep it under control.
Code A	Right, where's this pain coming from.
BEED	It's obviously from the hip, there's no doubt she was getting pain from the hip but she also gave the impression of someone who was in general discomfort and agitation because anything you tried to do with her was causing her to get upset and distressed. And again that's something that's quite common with people who are very poorly

and dying that, that they have specific pain somewhere but they've also got very generalised pain and discomfort.

Code A — Yeah okay I'm, I'm with you there. Right, so we, a team decision is referred to .

BEED — Yeah.

Code A — And that team, who's in that team.

BEED — Um, that's um Doctor BARTON reviewing the patient, myself as one of the nurses looking after the patient and Staff Nurse COUCHMAN who's the named nurse er of Mrs RICHARDS and was on duty um at morning, um, who, so together we reached that decision and, and the family of course, er so we make that decision and then um at.....

Code A — That's fairly comprehensive in the, the interested parties.

BEED — Yeah, yeah, yeah.

Code A — And there's no dissent there from anyone.

BEED — No.

Code A — Okay. Who, who fixes up the syringe driver.

BEED — That was myself and Staff Nurse COUCHMAN um and we started that at eleven forty-five.

Code A — And what was the contents of that.

35.38 BEED — Um that was Diamorphine, 40 milligrams, Haloperidol, 5 milligrams, and Midazolam, 20 milligrams.

Code A — Right, how does 40 milligrams of Diamorphine compare to the idiot with 10 milligrams of.....

BEED — It, it's calculated on the basis of um the amount of um Oramorph that's been needed in the previous 24 hours so what Doctor BARTON would have done would have been total up the amount, the total amount of Oramorph we'd given really since um one o'clock the previous day um and then there's a, you can look in the, the formulary book BNF or we've got a booklet produced by the local Hospice which then gives you a conversation for how much Diamorphine to give over 24 hours bearing in mind whether the Oramorph had actually kept someone comfortable or not, so if that Oramorph had kept Mrs RICHARDS completely comfortable we would have gone for a lower dose but she wasn't, she was still getting periods of discomfort so we wanted to go slightly higher to make sure that she was pain free.

Code A — Right just to make absolutely sure.

BEED — Yeah.

36.54 Code A — Okay, and the other drugs, Midazolam that's a new one.

BEED — Yeah, the Midazolam's um a, a hypnotic and that basically deals with agitation and relaxes um patient, keeps them calm, um and the Haloperidol she's already on and that's, that has a similar effect and that's kept because it's actually something Mrs RICHARDS is on already um and Doctor BARTON felt that if that was omitted from the driver we'd, it's something you can give

		through a driver um and giving it through a driver would make sure that she didn't get withdrawal symptoms from the Haloperidol.
	Code A	Cos that could have had a knock on detrimental effect.
	BEED	Yeah.
	Code A	Okay I understand that, and was there one other drug in there.
	BEED	Um not at that point, we used, we started Hyoscine, but we didn't' start using Hyoscine um, may be we didn't use Hyoscine at all, yes we did, yeah, we didn't start using Hyoscine until the 19th of August which was the um the Wednesday.....
	Code A	(inaudible) and that's, Hyoscine, correct if I'm wrong is for secretions.
	BEED	Yeah, yeah.
38.05	Code A	(inaudible).
	BEED	Yeah, yeah.
	Code A	I've read somewhere there's a potential problem using Midazolam and Haloperidol in respiratory function. Are you aware of that.
	BEED	Er well, all, all the drugs we are using with the driver can, are known to cause some degree of depression of respiration, so that's a known side effect um and something you'd watch for, when someone's poorly their respiration becomes depressed as they start to pass away anyway so that's one of the difficulties knowing whether the medication you're giving is causing depression of

respiration or whether it's the patient's overall condition.

Code A — Right.

BEED — So, but the key thing we're looking at is how comfortable is the patient and comfortable is their breathing.

Code A — Okay if they do go into arrest or their respiratory function slows down to a stop, do you have any equipment to use to bring that back.

BEED — We, the doses we're sort, we're using would depress respiration but I've never know it to actually to stop the respiration so in fact and you wouldn't um, so we wouldn't, shouldn't be using doses that actually cause that to happen and if you're, if you're giving Palliative care um you don't, and you help the patient, relatives come to terms with the fact that someone's dying you wouldn't want to put yourself in a position where you're suddenly having to take resusative measures because that would be very confusing and upsetting for the family.

Code A — So it's a conscious decision that if, if, if it's a natural by-product of that, that they stop breathing then that's death and...

BEED — Yeah, yeah.

Code A — .....that's inevitable.

BEED — Mmm, yeah.

Code A — Right, Midazolam used subcutaneously, is it.

BEED — That's, that's very common, we usually use that

in, it's the Haloperidol is the one that we don't usually use but we usually use Midazolam because the relaxes, quite a lot of patients if they're in a lot of pain, they're also, and very well, there's a lot of fear and anxiety going on as well, so it just relaxes them and calms them down, takes away some of the, some of the fear that's associated with their condition.

40.27 Code A Right, that's not a product that's licensed for subcutaneous use. Were you aware of that.

BEED Um, I'm, um, the information we work on is produced by um the local hospice and they do say in that, that the doses that are used and the medication that are used are sometimes being used outside of their er normal dosage range and where they'd be used but it's established, well established practices in Palliative care.

Code A It's common practice.....

BEED So yeah. Yeah.

Code A .....so the although the fact that it isn't licensed.....

BEED That's it.

Code A .....for the use is not a bar to using it.

BEED No, no.

Code A Because experience tells you.

BEED Because it's being, it is being used in a lot of cancers in that way.

Code A Right, so you're, we've reached that point where we're on the syringe driver with the, the

combination of drugs, how long does that continue.

41.29 BEED Given that we're recognising that Mrs RICHARDS is in Palliative care we would expect that to continue up until the time she passes away um because if anything sensitivity to the pain killers is going to (inaudible) or, or the pain, level of pain may increase, so you may need to increase the pain killers. If you withdrew um the analgesia then the patient would again be in the level of pain they were before you started it um, so it's expected to continue but it's constantly under review to check the level that you're giving is appropriate to the patient's needs, so really every time you go into the patient and every time you go to change the driver, every 24 hours, um you'll be monitoring how the patient is whether they're comfortable or uncomfortable and how they are over all.

Code A What, what steps are taken to insure that she remains hydrated.

BEED Our, our practice um with hydration is, is the patients are conscious and able to take food and fluids then we encourage them and help them, make sure they're not thirsty, um if patients become unconscious and we're delivering Palliative care um we base our work on studies that show that giving patients by alternative means actually doesn't do anything to effect the outcome,

um the fluids aren't likely to absorbed and they become uncomfortable so we don't usually hydrate patients when we're delivering Palliative care, um, unless there was a partic, a specific indication that it was the appropriate thing to do.

Code A — Right. When did we stop actively treating Gladys and move on to Palliative care.

BEED — Um, that was on the morning of the 17th.

Code A — Right, then on the morning of the 17th .....

BEED — Sorry, that was on the morning of the 18th. Tuesday the 18th.

Code A — And at that point, did her death become a matter of time.

BEED — Yes.

Code A — Right were any steps taken in the ensuing 3 days by yourself, Doctor BARTON or any of the nursing staff to ensure her level of pain hadn't decreased to enable her to come off of that drug regime.

BEED — We would have monitored that when we, every time we looked after her so when you, when you go to wash someone, check there clean and so on that's when you start getting pain if you're going to get any so you could see that if you were, um, cos you have to roll and turn people to get them clean and to change their bedclothes and their night clothes and so on, so if she was showing, showing no signs of pain whatsoever then that would say right you might need slightly less, far

more normal that someone shows some indication of being in pain when you start to move them and you have to judge is that a lot of pain that we're, you know we're, we're putting them through agony and we need to increase things or is it just the normal amount that you would associate with moving someone in which case level of pain killers you're giving is about right.

44.36 Code A Right, is it recorded anywhere in the notes that those checks were undertaken on Gladys.

BEED It's, it's not specific but it's integral with um the nursing care plan so um on the 18th um for her night care but she's comfortable and the daughter stayed. Um on the, on the hygiene that she's had, she's had bed bathes and she's had oral care. Um, on the 19th she's had a night change and wash, repositioned, apparently pain free during care.

Code A So if she's pain free during that period, is it not then a proper consideration to reduce.....

(the tape buzzer rings)

Code A I think we've got two minutes left, but don't, don't rush your answer because of that.

BEED Right, okay. Right, okay. The difficulty was if you start then reducing the pain, reducing the analgesia and the pain breaks through um you're then right back to square one where you've not got the pain controlled um and you're having to go in with high doses again, so if the patient is, recognising that the patient's condition is deteriorating and

dying anyway, if they're pain free then you continue at the dose you're at.

Code A — But that doesn't give them the opportunity to recover.

BEED — But we're all, we're recognising that this lady, we didn't feel this lady was likely to recover anyway at this point in time.

Code A — Right, but she was never given the opportunity to recover was she.

BEED — (inaudible).

46.36 Code A — Had, had someone said hold on she's not in pain let's.....

BEED — Yeah, right.

Code A — .....reduce this to half the dose.

BEED — Yeah.

Code A — And see what happens.

BEED — Yeah.

Code A — Because if she was in pain from a broken hip.....

BEED — Yeah.

Code A — .....that may have well subsided over the 2 or 3 days. Is there a straight forward answer.

BEED — We, well, we, we didn't' expect that the pain would have resided, we would have expected if we'd reduced, reduced the analgesia that the pain would have came back at the same level.

Code A — Right and that decision is based on experience.....

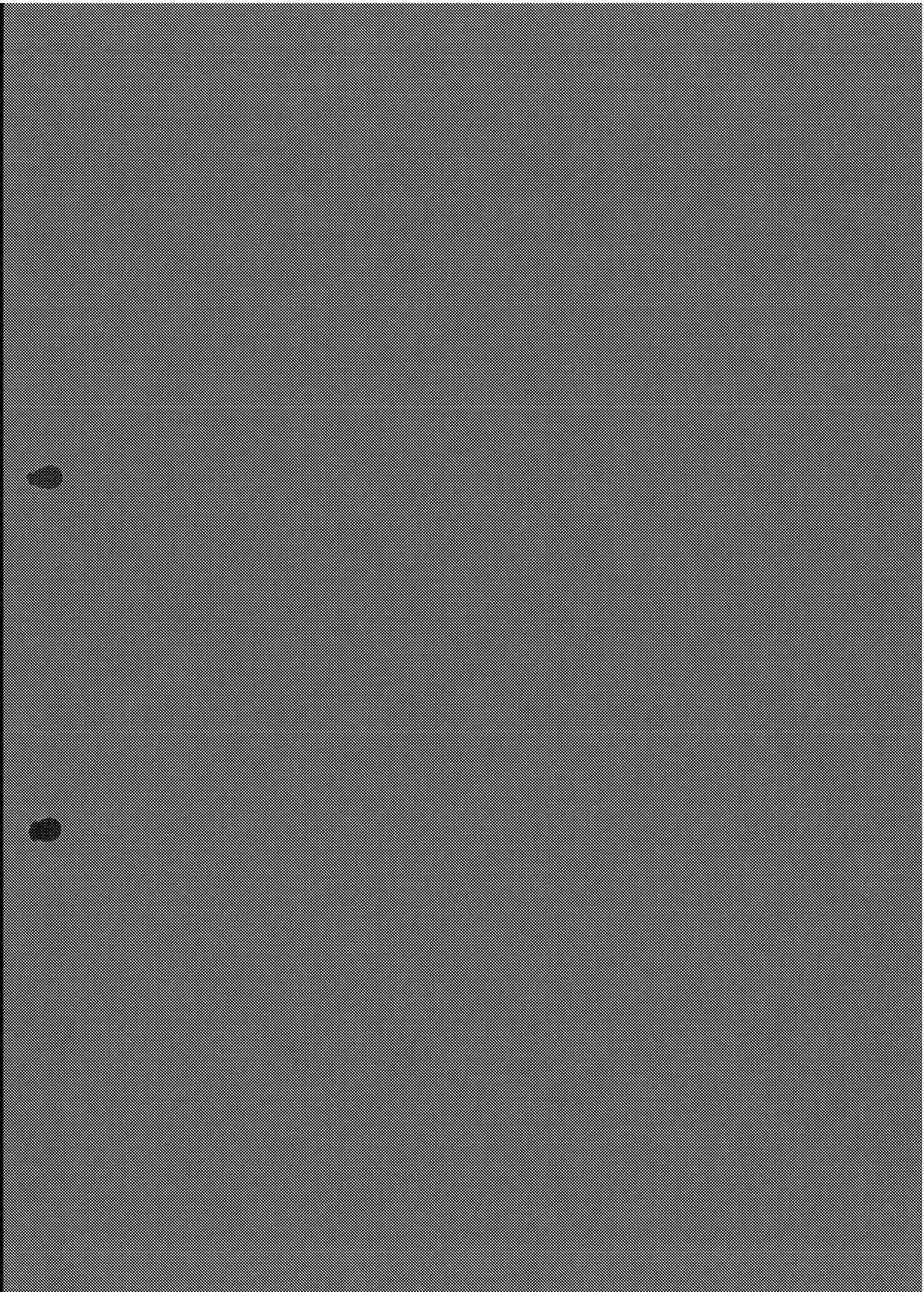
BEED — Yeah.

Code A — .....in.....

DOCUMENT RECORD PRINT

BEED	Yeah.
Code A	Between yourself and Doctor BARTON.
BEED	Yeah, yeah.
Code A	Right. With hindsight, was it not considered, was it not appropriate that.....
BEED	No wouldn't have.....

Tape ends as BEED is talking, at 1541 hours.



RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number:
Y21D

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

Person interviewed: BEED, PHILIP JAMES

Place of interview: Fareham Police Station

Date of interview: 24/07/2000

Time commenced: 1552 Time concluded: 1604

Duration of interview: 12 mins Tape reference nos. (◆)

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

Other persons present: Mr. GRAHAM (Solicitor)

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(◆)	Person speaking	Text
	Code A	This is a continuation of our interview with Philip BEED. The same people still present, Philip. The time by my watch is three fifty-two p.m. You can leave at any time if you want or speak to Mr. GRAHAM get your legal advice. We got to the point at the end of the last tape

where we were speaking about the drug regime over the last three/four days of Mrs RICHARDS's life and my question was that, having settled on a particular drug regime, why was no consideration given to, to reducing that dose, just to see?

BEED — At, I've just erm, come to, there's an entry in the contact record by Staff Nurse JOYCE at eight o'clock on the 18th, which was the, so that was 24, that's 36 hours after we had started that drug regime, er that she is sleeping in peace, that Mrs RICHARDS is peacefully sleeping but she reacted to pain when she was moved and that pain appeared to be in both the legs. So that's 36 hours in and we, we actually know that Mrs RICHARDS is in pain when we are moving her.

Code A — Is, is that right? If that was on the 18th, it only started..

BEED — That, we started at er eleven forty-five on the Monday so that was, and that was, this is eight o'clock on ..

Code A — No, on the Tuesday you started didn't you? She came to you on the 17th.

BEED — Sorry, started on a Tuesday, yeah, er sorry eight o'clock on the Tuesday night, yeah, that's right. So that, that's been assessed em..

Code A — So twelve hours into ..

BEED — Twelve, twelve hours in, yeah, yeah.

Code A — Are you aware at that time how that pain

manifested itself, how..

BEED — As Staff Nurse JOYCE has said its er, it appears to be in both legs when Mrs RICHARDS was moved, but she's, she's obviously comfortable when she is not being moved.

Code A — Right. She is not given any other hydration?

BEED — No.

Code A — So, is it safe to assume that is an inevitability?

BEED — Yeah.

Code A — At one point she's going to die?

BEED — Yeah, yeah.

Code A — On the drug doses, right, is that a particularly high....

BEED — No, that, that's er the bottom end of the scale really, erm, we, we sometimes up patient, patients on lower doses but we, we could, on the prescription here we could have gone up to two hundred milligrammes of diamorphine and eight hun...and eighty milligrammes of er midazalam. I've known patients go up to even higher doses than that, so five hundred milligrammes of diamorphine would not be er, an uncommon dose to give to someone who was in that much pain.

Code A — Right. Was there any other evidence of, of other illness?

BEED — Er, it was, it was more a general overview of the patient's condition, a combination of er, the severe pain, the, the er reluctance to eat and

drink, the appearing frail, er and difficulty moving, so it wasn't one specific thing but (inaudible) the overall picture that she presented of being a very poorly lady.

Code A — Right. What did she die of?

BEED — Er, Doctor BARTON had er, er, stated she died of Bronchopneumonia and certainly on the, on the 19th she was getting a very rattley chest er, which is caused when you have got actual secretions in your chest and we had started er Hyocine at that point.

Code A — Right, Did, did the sisters agree with that?

BEED — Er, in the statements that I have seen then they haven't but of course if Mrs RICHARDS had developed a chest infection then the, the drugs which we are using to control her pain, keep her comfortable, would have masked a lot of the symptoms of a chest infection. So...

Code A — Can I just ask a question? So, I mean the decision is made on the 18th, bearing in mind her condition and that pain, that, that she is dying?

BEED — Yeah.

Code A — So, the decision to go down the road of palliative care is taken then?

BEED — Yeah, yeah.

Code A — So, but she is dying then

BEED — Yeah.

Code A — But she is not dying of..

BEED — A chest infection at that point.

Code A at that stage?

BEED At that point, no.

Code A But later on, which is, I mean is that caused by the drugs she's on? The, the chest infection?

BEED No, but, but when the, its er really to do with being, being very frail and very susceptible and her respiration not being so good and of course the, the drugs she's on do have an effect on respiration, depressed respiration but her overall condition would have affected the respiration as well.

Code A Right. In terms of the 18th at the time, the, the consultation occurs and a decision is taken, what was she dying of then? Or what was you impression of what she was dying of then?

BEED Just a combination of factors. There wasn't one specific factor.

Code A Yeah.

BEED Er that she was dying of.

Code A Can you, can you just go over those?

BEED Just that she was very frail, that she wasn't eating, she had been very reluctant to eat and drink, she was in pain which wasn't controllable er and that she wasn't able to mobilize or, or doing anything to meet her own needs.

Code A Okay.

If I went into hospital, as fit and healthy as I hope to be, and were put immediately on a syringe-driver, with that combination of drugs,

would I die?

BEED — No. I don't think so. Er but you wouldn't, you wouldn't go on that if you were fit and healthy.

Code A — (Laughter) I know. But, if I were to put another ninety-one year old woman without any, I mean would that kill her?

BEED — No. Patients have been on this, these levels of sort of pain control and sedation er we've upped conditions and have gone on to recover so, no, not necessarily.

Code A — In your experience, that's, that's happened.

BEED — Yeah, yeah.

Code A — In terms of ..

In terms of recovery process for other patients, and this may be a hypothetical question, how do they come out of that? How was that accessed that they could, they can come out of that situation? If in particular they are sedated as a result of what they are on?

BEED — Um. You probably wouldn't be (inaudible). If someone was going to er recover you wouldn't see, er and given that levels of sedation um, so its a bit difficult to answer really.

Code A — Right. So really those four...

BEED — Are.....

Code A — .....taken together....

BEED — ... are appropriate to palliative care, they wouldn't, I don't know that, that those, that combination would be appropriate to anyone in

anything other than a palliative situation.

Code A — So someone who there, there's a consideration that they may well recover that would not be a combination?

BEED — No, you, you would, may use one or more of those drugs but probably not the entire combination.

Code A — But all taken together. So if you were to look at some notes, you've never seen the patient but you've seen they're on a driver and on those sort...

BEED — Yeah.

Code A — .....of drugs, would your impression be well this is someone who, who may well be, be dying..

BEED — Yeah.

Code A — ..and try and assist in giving her a comfortable, painfree death?

BEED — Yeah, yeah.

Code A — Okay.

I was just going through Mrs LACK's statement at the end of the day. She, she mentions a conversation about euthanasia - do you recall that?

BEED — Does...does she say what day that was on? Was that on the, Monday the 17th?

Code A — Yeah.

BEED — Yeah, yeah she, I, I remember. Was that Mrs LACK or Mrs MacKENZIE?

Code A — My sister, so, Mrs MacKENZIE.

BEED — Yeah, I remember Mrs MacKENZIE um, asking about euthanasia um and of course I advised her that that's not something what we would ever contemplate or consider. Its, its not er something we can do and not something we would do.

Code A — What's the difference between euthanasia and palliative care?

BEED — Palliative care is when we recognize that someone's dying um and the care we are providing is to make that death um a comfortable and dignified experience and meet someone's nursing needs. Um, euthanasia is, euthanasia as I understand it is actually actively um assisting someone in dying.

Code A — Yeah. One thing we haven't covered. I am drawing to a close now, is a suggestion of a massive haematoma. Do you recall this or..

BEED — Dr. PETERS, who was the G.P. who looked at the xray um said that he felt the cause of the pain was a massive haematoma. Um, as I understand it that's um, bruising as a result of the dislocation and the manipulation to put it back in. Um and, and that could be quite painful. I think Mrs RICHARDS' level of pain, to me seemed to be much more than just a haematoma, she, she was in a awful lot of uncontrollable pain, and distressed from the pain as well, but, but cos I expect anyone, and we have seen

patients have dislocations put back it and they do have bruising and some discomfort but not on the level that Mrs RICHARDS was experiencing yeah.

Code A

Okay. Just somebody has written down a question here which I am not quite sure is appropriate is why was Mrs RICHARDS not given fluids subcutaneously during the period 18th, 19th and 20th?

Well then.. it wasn't...

BEED

That's, that's because we, we don't feel that's an appropriate course of action with palliative care and that it doesn't make anyone any, it doesn't change the outcome. Um, it makes them uncomfortable cos the fluids don't get absorbed properly, they, they collect under the skin and don't get absorbed and um, you're just, just adding another intervention which is making a patient uncomfortable um and isn't changing what's actually happening.

Code A

Am I right in saying that, at that time, the hospital wasn't licensed to, or authorize to, provide fluids through a subcutaneous route?

BEED

We, we, no we could give fluids subcutaneously. What we couldn't do is give fluids intravenously and um that's cos we haven't got a doctor on site who could re..re-establish an intravenous line.

Code A

Right.

BEED Subcutaneously is, is an alternative route at giving fluids and that's, that's what we can ...

Code A And you always been, as far as you are aware..

BEED Always been able to give subcutaneous fluids and that doesn't need a doctor to set it up, the nursing staff can actually establish subcutaneous fluids, so we could have, if, if, if it had been appropriate to Mrs RICHARDS care we could have established subcutaneous fluids er and run them.

Code A Phil, what I intend to do in a second is, is to, to kill the tape, run upstairs just to see if there is any other points that I may have missed that they feel need covering, but I am getting to the point now where I think we've had a fairly thorough going over of, of your actions throughout that period, is there anything that, that you wanna, we want to add to your account so far? Is there anything that you feel that either myself or Lee have missed or misunderstood. Just so you can leave here saying well I, I've told them everything that they wanted to know.

BEED Yeah. The only thing really is, is that some of, is that I spent an awful lot of time with, with er Mrs LACK and Mrs MacKENZIE talking to them and answering all sorts of questions and I, I just find it strange that they're now asking questions which they had lots of opportunity to ask at the time and didn't, and I, I find that, that

puzzling.

Code A

I think, I think that's explained if, if explanation is the right word, with the fact that they perhaps found it difficult to deal with what they termed as the early stages of the loss, dealing with the loss of their mother, and perhaps with the benefit of hindsight, that they felt that some things weren't addressed properly and perhaps there was a case. With hindsight, would Philip BEED have done anything differently at all?

BEED

There, there were things that happened with Mrs RICHARDS when I wasn't on the ward, um, when she fell, which um it would have been better if Mrs RICHARDS had been transferred earlier than she was for the dislocation to look at - I don't know whether that would have changed, I don't believe that would have actually changed anything but it would have um answered one of the big questions that the family had, er more than anything. In terms of Mrs RICHARDS' care when she returned to us, then no, we, we, we looked at Mrs RICHARDS um and examined her thoroughly and made decisions appropriate to her and we discussed things with the, the family and tried to get, keep them involved um in what was happening and make sure that, that they were understanding the care we were giving and in agreement. So um I can't see that um, in terms of the overall care of Mrs RICHARDS, er

there was anything er that we'd have done differently now if we were in the same situation again.

Code A

One last thing for me, is, is a point that is raised by Mrs LACK in her statement where, and if I read the paragraph out it is on Page 13, she says I told Dr. BARTON and the Ward Manager that I'd been to Haslar that morning and explained what happened and told them that Haslar would be prepared to re-admit my mother. I considered that this was essential so that the cause of my mother's pain could be treated and sim..not simply the pain itself. Dr. BARTON said that it was inappropriate for a ninety-one year old who had been through two operations to go back to Haslar where she would not survive further surgery.

(inaudible) ... contact this has been at some point on the 17th..

Was it ever a consideration to return?

BEED

Yeah, that was after Mrs RICHARDS been x-rayed and Dr. BARTON had come back in, um Dr. PETERS had looked at the xray and Dr. BARTON had then come back in so DR. BARTON looked at results of the xray on Mrs RICHARDS, um and discussed it with Mrs LACK, the daughter, um. I, I can't remember Mrs LACK um saying those particular words to Dr. BARTON but know, I know it was, that was

in looking at Mrs RICHARDS' care we consider the options what do we, what do we do here um and Dr. BARTON's view was the...there was nothing specifically wrong that Haslar would be able to treat um and heal and thought that transfer would be more traumatic. That, that Mrs RICHARDS might not even survive the transfer er, cos we know the transfer itself is quite traumatic, and that they wouldn't be able to do anything when she arrived there so the most appropriate thing to do was to keep Mrs RICHARDS in our care er and she discussed that with the daughter at that time.

Code A — So it would have been to the detriment of her health had she been transferred....

BEED — If we had transferred her back.

Code A — ..cos, and there was nothing wrong with her to look at

BEED — (inaudible) cos, when she got there, if there was an obvious, if the hip dislocated again then yeah that would have been an obvious indication or if there was something else that, that Haslar could have er done that we couldn't have done, then it would have been appropriate to transfer.

Code A — Great. I am ever so grateful you are taking (inaudible)...no, there's someone with a finger up in the corner (laughter)

Just one .there is more. Just a, just to go over,

back to the 11th and a very quick question on the care plans and the letter in relation to consideration being given to the immobilization. Now it's not docu...there is no care plan for the mobilization. Is there any particular reason for that?

BEED — Um, what we, we were working on mobilize...we didn't have a care plan but we were trans ..trying to transfer Mrs RICHARDS where we could and, had things not gone in the direction they'd gone in, we would have got a physiotherapist involved in looking at transfers over the, the next few days, er but the fact that she fell and dislocated really overtook the plan to mobilize because obviously once she had re-dislocated we couldn't do anything but we would, at that point in time we were assessing well what sort of level of mobilization er was Mrs RICHARDS actually capable of.

Code A — In terms of instructing the physio, who, who does that fall down to on the ward to, to do that.

BEED — Er, nurse in charge of any particular shift, cos the physiotherapist comes on ev...we've got our own physiotherapist and we're saying we've got a patient here that we want you to, to look at please and, and see how they are

Code A — Great. Anything else that you would like to say at this point? Right, I will run upstairs to make sure there isn't any points but I am sure if we

have missed anything we'd better resolve those quickly, but thanks for taking the time and trouble to answer the questions so fully. All things being equal, the time is eight minutes past four.....

Mr. GRAHAM?? I am quite happy for you to leave those tapes in there while you run upstairs (inaudible)

Code A That' very kind of you, you are all heart. (inaudible) etc.....