General Medical Council

Dr. Jane Barton

Exhibit AEGL/2

This is the Exhibit marked "AEGL/2" referred to in the statement of Dr Althea Everesta Geradette Lord:-

- Interview under caution 27 December 2000 (tape 14:14-14:58 hours)

Hall, Tamsin

From: Code A
Sent: 18 March 2008 11:43
To: Hall, Tamsin
Subject: Dr Lord 2 of 2

RECORD OF INTERVIEW

Number: Y13A

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(SDN, ROTI, Contemporaneous Notes, Full Transcript)

Person interviewed: **LORD, ALTHEA EUERESTA GEREDITH**

Place of interview: Farcham Police Station

Date of interview: 27/09/2000

Time commenced: 1519 Time concluded: 1554

Duration of interview: 35 mins Tape reference nos. (♦)

Interviewing Officer(s): Code A

Other persons present: Richard PRIVETT - Solicitor

Police Exhibit No: Number of Pages:

Signature of interviewing officer producing exhibit

Tape counter times(◆) | Person speaking | Text

(Sound of buzzer to indicate the start of the tape).

Code A This interview is being tape recorded and is a continuation of an interview of Dr LORD. The time by my watch is fifteen nineteen. I will remind you that you are still under caution, okay, and I'll just read that out again. You do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in Court. Anything you do say may be given in evidence, okay? What we were discussing before we took that break was the, the treatment that was prescribed to Mrs RICHARDS and some of the issues surrounding palliative care and just before the break we asked you for a definition of what that means, which you've given us. Just a couple of other issues I want to cover on that, there was one point made which was related to the hydration of a patient? And when it would, would be appropriate to hydrate a patient and when it wouldn't. I wonder if you could give me some examples of those two, when it is appropriate and when it isn't?

LORD Probably everyone requires some degree of hydration, particularly if you're awake and if it, it's something difficult to assess, if someone's distressed purely because they've got a dry

mouth. Now, if people can swallow that's going to be best way to hydrate them. But either, because the swallow is uncoordinated, happens in a lot of people with dementia or people with strokes or because they are in bed and the positioning is not right or they've got neck problems and can't really straighten their neck to swallow, then swallowing something orally would be, would be difficult. So alternatives to that would be, the best form to hydrate and probably provide nutrition would be using a gastric tube which is a tube skipped in through the nose right down into the stomach and if you've got a tube down there, you might as well give feed as well, proteins as calories as well as liquids. In order that you can satisfactorily feed someone through a nasal gastric tube, you need to be able to sit up in a chair or at least be able to sit upright in bed, because if you're pour feed into someone who's flat in bed, they'll just aspirate or they get it into their lungs and get a chest infection anyway. And someone's who's confused and restless, there's also a risk that they tug at the tube, because even if you tape it to their nose and forehead, anything in front of your face you're aware of and a small tug and the tape can come out. So, that form of feeding and hydration we probably wouldn't embark on in someone like Mrs RICHARDS where there will be behavioural problems with dementia. The intravenous road we cannot carry out at Gosport, even at present, because the nursing staff do not have the training for it, that's something that'll happen in the next few months and certainly we wouldn't have had the medical staff during the day to set up intravenous...

Code A Mmmm.

LORD ... which is hydration directly into the veins. The other form that would be available is something that's called Supplitaneous Fluid whereby we choose a very fine needle just under the skin and you can give people sort of two litres of fluid a day. That'll provide just the water and you can add something like Potassium salts and a little bit of Dextrose. You can't give too much Dextrose because it causes irritation under the skin. And that's something that you could you in a palliative care setting, again it is usually used if people are awake and you feel that hydration is going to be of benefit to them. It's a clinical issue...

Code A Mmmm.

LORD ... yet again.

Code A Certainly.

LORD So, you wouldn't have a blanket, there is not blanket policy and no definite one, two, three, four, you will do or you won't do...

Code A Sure...

LORD ... (inaudible).

Code A ... I do appreciate there's no, you know...

LORD Yeah.

Code A .. set, it's, it's based on...

LORD Yeah.

Code A ... every patient.

LORD Yeah.

Code A But I wonder if you could describe some of the scenarios that would exist for not hydrating, just, you know, based on a decision ...

LORD One is...

Code A ... a doctor would take?

LORD .... one is if the person is really very poorly and not, not expected to survive very long, because the hydration probably just gives them a degree of comfort, we think. We think if your mouth is dry...

Code A Mmmm.

LORD ... it is uncomfortable, there's no way of checking that out and we think if you're hydrated, your, your skin's just a bit better. Your pressure areas don't, don't break down, so if someone was really awake and distressed, it might be one of the issues...

Code A ... to consider.

LORD Probably the person being away would be the most significant that would sort of say, 'Let's put some fluids up and keep them hydrated.'

Code A Okay. And for not doing that, what's the...

LORD Again, someone who's, who's very poorly, if they can take small amounts orally sometimes, just to keep themselves, keep them going and the other would be if they said they did not

wish to have it.

Code A Mmmm.

LORD You know, some people are quite clear as to what they will have and won't have.

Code A Okay. It's been explained by some members of staff that their understanding of, of reasons why they wouldn't, and I want to ask you if you would agree with this or not, is that it can on occasions be cruel or considered cruel to actually hydrate if it's considered the patient is, is dying. Is that something that you would subscribe to?

LORD It would depend on the behavourial problems the person is experiencing. If someone's very confused and agitated and it is possible to slip, to slip the needle, say between the shoulders or or the thighs where they can't actually see the needle rather than on an arm.

Code A Mmmm.

LORD ... but if, if people who are restless tend to pull at things, then it must restraining them to keep fluids going and I think in that situation that wouldn't be very kind to someone. If someone's pulling the lines out to persevere, try to give fluids in any form...

Code A Yeah.

LORD ... but it's six of one and half a dozen of the other, how do you know that they're not pulling the tube out because they're distressed because they're thirsty.

PRIVETT Can I just ask, Doctor, did you contribute to the guidance of fluid replacement?

LORD Yeah, I've drafted that in oh, about eighty five or thereabouts.

PRIVETT Oh, right, can you just, I'll hand you a copy of this, can you just take us through what that document deals with?

LORD Right, this is, this has now been employed by both Portsmouth Hospitals and Portsmouth Healthcare Trust but certainly back, since about the nine, mid nineteen eighties, late nineteen eighties would have been effective in our, in our department. Because we found that a lot of people say like the strokes, who needed therapy during the day to put drips up, you can't actually get them walking there with the drips down, the therapists can't actually get to them.

PRIVETT Mmmm.

LORD So, we use subcutaneous fluids in palliative care and if people after strokes and because you can give, probably, about two litres very easily certainly not more than three litres, it's to correct mild dehydration or maintain dehydration. If someone is severely dehydrated you need to, you need to use an intravenous line and the advantage is either you don't need to get into a vein so the nurses can administer that. It's not uncomfortable 'cause it doesn't involve a limb. You can put it in a restless patient but it's amazing how good people with stiff arthritis can get taking things out, either back or wriggling against the cot side or...

PRIVETT Mmmm.

LORD ... something like that. And you can use it just for one litre overnight, so for argument's sake, if someone's able to take about eight hundred, nine hundred during the day, and particularly people with the strokes, that's something good to encourage, so that they're swallowing is maintained, then you can just top them up overnight, take it off in the morning so they can have their therapy again. So, the nurses can decide, they don't need to call a doctor out to change. And the contra indications would be the tendency to bleed. If they're swollen, if the skin's infected and again, there's a, the dehydration is quite severe, the method of administration really that's a guideline for the nurses, the size of needle you use and that the needle needs to be changed every forty eight hours, that's a guideline of what fluids can be used and you can give Potassium as well, so if someone's, needs a little bit of Potassium and sometimes, most of the elderly people who don't have their bananas and orange juice do get short of Potassium, you can add a small amount into the bags. It's, sometimes you find, particularly in older people, where the skin's sort of very, and the elastic has stretched, that what, the principle is that to give this fluid under the skin and eventually gets absorbed into the veins, into the system, the circulation and then excreted as urine, is that that whole process gets very delayed and instead of this getting absorbed it just ends up in sort of lumps...

PRIVETT Mmmm.

LORD ... all over and after a couple of days you sometimes have just got to stop if they're not absorbing it.

PRIVETT Mmmm.

LORD You can add something that's called Hyuronedes (?) which helps it to spread a bit, but

if they're not absorbing it often adding hyorenedes doesn't really add a lot more to it. This doesn't, this really tells you, once you've made the decision to give it, how to set about it. The decision to use it, again, needs to remain a clinical one and one that you need to see, does this person...

PRIVETT Mmmm.

LORD ... would there be an alternative that would be more acceptable.

PRIVETT So, with the exception of those, or that guidance there, in your view, the rest of the decision would be a clinical one for the...

LORD Yeah.

??? ... doctor with care.

LORD Yeah.

PRIVETT Can I hand that in to you?

Code A Certainly, okay. That's the drug therapy, that's just the cover sheet.

LORD (inaudible)

Code A Subcutaneous fluid replacement.

LORD Mmm.

Code A If someone in the palliative care course of treatment, if I take it, they're not usually considered for hydration and nourishment in they're in that phase that is accepted that they are dying?

LORD I think only if you feel that they're far advanced down the line.

Code A Yeah.

LORD Some people take three weeks to die.

Code A Yeah.

LORD You can't predict with people.

Code A Right, so if, if that, hypothetically that person who took three weeks to die, I take it that they're deprived of hydration and nourishment?

LORD Not always.

Code A No?

LORD It depends on how awake they are. If someone's awake but still very poorly...

Code A Right.

LORD ... you'd probably set up subcutaneous fluid.

Code A Right.

LORD That would be my criteria for giving someone fluids or not.

Code A Mmmm.

PRIVETT Equally, I presume someone could be on a palliative care regime and still able to...

LORD To swallow.

PRIVETT ... to swallow?

Code A Yeah.

LORD Yeah.

PRIVETT Mmmm.

LORD That would always be the preferred way of...

Code A So, in a case where someone is unconscious...

LORD Yeah.

Code A ... and therefore unable to swallow because of the fact they're not conscious, would there still be a case for not hydrating?

LORD Yes, if I felt that someone was unlikely to survive more than a few days, then I wouldn't necessarily put fluids up.

Code A Mmmm.

Code A Right, okay.

Code A And what would you reasons be for that?

LORD That the person wasn't distressed by being dehydrated...

Code A Mmmm.

LORD And that there, there was so many other things that were going wrong and if the body was failing any way, that given them this bit of fluid wasn't going to put that right. A lot of relatives seem distressed when they don't have fluids up and strangely although subcutaneous fluids does give them a bit of fluid, seem much happier...

Code A Mmmm.

LORD ... because they personally see fluids going through.

Code A Mmmm.

LORD But it doesn't really provide much calories at all because you can't keep the 5 percent and Dextrose which is the strongest we can, we can give, we can only use four percent Dextrose which is (inaudible) Dextro saline...

Code A Right.

LORD ... so you can't give a lot of calories that way.

Code A So, there's nothing to say really that somebody who is unconscious and in a palliative care situation, that, if they were hydrated and nourished, would make them live longer?

LORD I don't think there's, any, any evidence to prove that either way.

Code A Either way, right.

LORD And often I think if people are dying it is, particularly the very elderly and the people with the dementia, the other organs are failing as well.

Code A Yeah.

LORD And it is a sort of, it's probably cruel to say, just like an old car.

Code A Mmmm.

LORD When does an old car give up?

Code A Mmmm.

LORD It's probably that all the little bits are, are beginning to break down and then one event and the whole thing just goes.

Code A So, by asking the body, I take it, to process nourishment and water is giving it extra work to do and it could be, have an adverse affect on somebody's health?

LORD I wouldn't go as far as...

Code A No?

LORD ... to say that.

Code A I'll never become a doctor.

LORD I think the evidence is not there.

Code A No?

LORD I think our bodies do like food and water and I don't think it protests too much if it's given it, if I think that the situation and the circumstances are right.

Code A Yeah.

LORD I mean, a lot of the feeds produce gastrics, you can, again you can get diarrhoea, that's pure carbohydrate and some people can't tolerate the feeds because of that.

Code A Yeah.

LORD So, yes, sometimes the body can't take it.

PRIVETT Would it be right that, at consultant level there hasn't been any directive given as to when and when not...

LORD No.

PRIVETT ... to introduce hydration therapy?

LORD You couldn't really, there's no, you couldn't give or have a written policy or written guidelines.

PRIVETT No.

LORD Because I think, anything to that effect, no two people with the same condition will be the same.

PRIVETT Mmmm.

LORD And you really couldn't have guidelines that were acceptable by the medical bodies, people relevant.

PRIVETT Sure.

LORD So, you've got to take each person as you find them.

Code A Certainly.

Code A (inaudible)

Code A Yeah.

Code A Okay, just a few more points. We've obviously taken receipt of this report...

LORD Mmmm, yeah.

Code A ... which I'm showing you now, which was compiled by yourself?

LORD Yeah.

Code A Back in December ninety eight. Can you tell me the reasons for this report being drawn up? What...

LORD Well, basically, I was vaguely aware that the nurses had been questioned about various nursing issues about Mrs RICHARDS dying but again I, no one contacted me and the nurses even, after she'd died didn't mention that there could be a medical come-back.

Code A Mmmm.

LORD And I was unaware that one of the daughters, I can't remember which, had made a complaint to the trust and that complaint had been investigated by a senior nurse who had formulated a report and submitted it at (inaudible) with various medical, with various comments in it. I wasn't contacted by her for the interview at all and I also wasn't aware that the family had been offered an interview to be seen and presumably I would have needed to have been at that. The first contact I had was from Lesley HUMPHREY, who is the...

Code A Quality controller.

LORD (Laughs) Yeah, for Portsmouth Health Care Trust, to say that, and I think she, this was certainly over a weekend, just before Christmas, she contacted me on the Thursday or Friday and said, can I prepare a statement on this, because I was the consultant in charge on Gladys RICHARDS, so it meant getting the notes and asking people a few questions very quickly and I, this was compiled in (inaudible) certainly over a couple of days.

Code A Mmmm. On that point, were you asked, were you asked specifically, because you were the consultant for the ward?

LORD Yeah.

Code A So, you weren't approached as a, like an independent...

LORD No, well, not that I'm aware of.

Code A No.

LORD The request came through Lesley HUMPHREY, I might have a copy of her letter here... I can't remember, it might have been I suppose.

Code A So, I take it you weren't asked as an independent body to have a look at this patient and ....

LORD No, no, no, no.

Code A ... the matters that had been, or the issues that had been raised to form your opinions or anything. This was a case that....

LORD No.

Code A ... it's your ward.

PRIVETT Yeah. The letter from Mrs HUMPHREYS to Dr LORD says, 'On reflection I think the best way forward would be for you, as consultant in charge, to prepare a statement explaining the decision with regards to Mrs RICHARDS' care etceteras.

Code A Have you the...

LORD We've got the letter, yeah.

Code A Mmmm, I wonder if we could have copy of that.

PRIVETT I've only got one. Can we take a copy here?

Code A We can get a copy made from it, yeah.

PRIVETT Have you got the original one?

LORD It must have been, to have given it to you, haven't I? Here's mine...

PRIVETT Carry on and I'll...

LORD Yeah, yeah.

PRIVETT That's it.

LORD And that's probably the background...

Code A So, this report would have been based on, summarising what you said, based on looking at the notes and talking to the ...

LORD Yeah.

Code A ... various members of staff?

LORD Yeah.

Code A Who would that have included?

LORD Dr BARTON and Philip BEAD mostly, I can't remember speaking to any of the more junior nurses.

Code A Mmmm.

LORD I might have done, but I can't remember that.

Code A Okay. Was there ever, were you ever made aware, you know, was there any, why you weren't contacted? Was that ever brought up, why you weren't aware of it?

LORD I complained about it. Because one of the conclusions was that the medical consultant team had said that there was a policy not to move people out of hours and that was never so. And I wrote to about three people about it, I, one manager acknowledged that that wasn't correct, but no one, no one's mentioned why they didn't contact me.

Code A Right, okay. So where does the, where does the fault lie there then, that you weren't notified?

LORD I think both with the Trust and with the person who was investigating it, the senior nurse, who was investigating it.

Code A Right. Okay.

LORD Because the Trust was going to set up a meeting with the family. As it happened they didn't make, they didn't take up any of the appointments that were offered, but I'd have been horrified if they'd actually have met without me being present.

Code A Mmmm.

LORD Neither would I have wanted to go to a meeting where there is two days' notice with the family so, I, to be honest, I wouldn't have had the notes and it's only because I picked the notes up to do the report that I realised there'd been another complaint.

Code A Mmmm.

LORD To the Trust, through the normal complaint system.

Code A At the time, in ninety eight, would you, I mean, bearing in mind what you know now about this thing and what, what your knowledge is of what happened at the time in relation to the family concerns, are you concerned that you weren't aware of, of what was happening at that time, in August ninety eight, with Mrs RICHARDS?

LORD While she was alive?

Code A Yeah, while she was alive.

LORD I think with hindsight I would have, I think I'd have preferred the nurses to have contacted me or contacted someone else because, or Dr BARTON to have contacted me at any stage and say there were, there were concerns.

Code A Are there many families that raise issues with other members of family that are in hospital about the treatment they're getting, do you get many complaints at all?

LORD People get anxious at different stages.

Code A Right.

LORD Some people get anxious just by view of the fact that they're in Gosport War Memorial Hospital particularly if they're not Gosport residents.

Code A Mmmm.

LORD 'Cause sometimes the only beds available are in Gosport and they could be from Hayling Island.

Code A Mmmm.

LORD So sometimes people sort of come down, think, Oh, gosh, what's going to happen to Mother now? If the communication hasn't been good before.

Code A Yeah.

LORD Sometimes you find families that haven't really got on, you find a member of the family sometimes appearing when someone's poorly and people get very distressed. You haven't seen a parent say for a couple of years, you get a phone call and then you come down and they're, and they're dying. It's distress, it's distressing.

Code A Mmmm.

LORD And I think in general, a lot of sudden deaths, people find very difficult to handle and take a lot of time. A lot of people on transfer don't take the journey well even from Haslar to the War Memorial.

Code A Mmmm.

LORD And they might have been stable when they left but sometimes they come in and they're very poorly.

Code A Mmmm.

LORD They're gasping and they pass away, so you get people at all stages.

Code A Yeah.

LORD Reacting to people who are dying.

Code A That was going to be a question, later on I'll ask you about the transfer, where, if they leave Position A, does it sometimes cause them, when they arrive at Position B, that they are a different patient that left the...

LORD Could well be.

Code A Yeah.

LORD Could well be. We've seen people that we transferred say from QA where I've seen them that morning and they've been stable...

Code A Mmmm.

LORD ... and they've been really poorly in the ambulance going down, just down to Gosport. For some reason people don't take the move very well, which is why we have probably been over protective about moving people unnecessarily.

Code A Mmmm.

LORD It's again something that's very difficult to predict. Some people are just sort of sick en route and that's all that's happened but you can't tell when you see them. And if the people sort of sending them, weren't, didn't give them sort of something for travel sickness....

Code A Mmmm.

LORD ... they could be quite poorly when they, when they get there.

Code A Mmmm.

Code A Okay. Just a couple of things, I didn't ask about the drugs. And those four drugs, which is the Hyoscine, Midazalam, the Diamorphine and ...

LORD Helaperidol.

Code A ... the Helaperidol, that's it. Are you aware of any side effects with those, anything that would...

LORD Well, they would, apart from the Hyoscine can cause some amount of agitation but not in the small doses that we used.

Code A Mmmm.

LORD The Helo..., all the others could be sedating, if you was moving for any length of time you always get problems with constipation and dry mouth and things like that.

Code A Mmmm. And what about combinations of those four, is there anything...?

LORD I, as far as I know, they don't particularly interact. Except they could all be sedating in their, in their own right and certainly there, you can use all three of them in a syringe driver. Though sometimes we add in something else for sickness but if you've Helaperidol also acts as an anti (inaudible) for sickness as well...

Code A Right.

LORD ... because Morphine can cause a lot of sickness. Usually with the first few doses rather than when you're giving for a little, for a little while and there's something called Cyclozine that we can use over twenty four hours which we didn't use in her, that causes things to precipitate and often we would use a second battery operated syringe rather than mix it in with the others, but I think as far as administration goes, you can use all three in the same syringe.

Code A Okay.

Code A Are you aware of any guidelines from the, the manufacturing company, especially in relation to Med...

LORD Midazalam?

Code A Midazalam and Hyoscine?

LORD Yeah.

Code A Regarding possible respiratory affect?

LORD With all of them probably in syrine drivers could cause respiratory problems.

Code A Right.

LORD Particularly Midazalam given intravenously. Strictly speaking Midazalam is not

licensed for palliative care use and subcutaneous, but it's again good practice.

Code A Mmmm.

LORD And all the palliative care teams and physicians use it and they have certainly been using it for a long time. It's a drug that's mostly used for anaesthesia, intravenously and that's where the main problem with respiratory depression and things, been of concern.

PRIVETT It's used as a heavy sedation?

LORD Yeah.

Code A On, on that vein, so to speak, are there any items of equipment available on the ward or at the hospital for resuscitation or...?

LORD They're is a resuscitate, it's basic resuscitation that's available at Gosport and we've got all the resuscitation and emergency trolley and resuscitation equipment. They are looking at getting in automated defibrillators...

Code A Right.

LORD ... to treat at the hospital fairly quickly.

Code A Right.

LORD So, if someone, it's basic, you do basic CPR...

Code A Mmmm.

LORD ... which is the same as you would probably do in Fareham Down Centre...

Code A Yeah.

LORD ... and ring 999.

Code A Yeah, 'cause I mean, I think what we've understood talking to some of the nursing staff, that if there is an emergency, the basic policy is immediate first aid...

LORD Yeah.

Code A ... and a 999 call to get an ambulance?

LORD Yeah.

Code A Yeah.

LORD Because I mean, I need to have doctors inside. I need some good people who can (inaudible) and ventilate. The basis for the defibrillators now is that it's the same as would apply to any place that has them, is that you would have is what's called as VF arrest, the changes of getting someone out of it is quite good and it doesn't do any harm if it wasn't. The problem with it all is that you've got to spot the sudden cardiac arrest.

Code A Mmmm.

LORD Not everyone that dies has a cardiac arrest. Some people fade away.

Code A Mmmm.

LORD And that's something that the public now are finding difficult to handle. 'Mum died, why wasn't she resuscitated?'

Code A Yeah.

LORD It never came to that. Because she faded away. You've got to be quick to pick up the arrest and you've got to be quick to get all the equipment in...

Code A Mmmm.

LORD Get things going.

Code A And you obviously need the equipment to identify the arrest in the first case...

LORD Mmmm.

Code A ... unless you've got twenty four hour monitoring?

LORD Mmmm.

Code A Okay, so, just one final question. It's a hypothetical one. You got a ninety one year old, who's frail, demented, has had effectively two operations and has been moved from pillar to post, basically, from Haslar back to Gosport and then back again. In relation to the treatment she was on in her final days, is that someone who's dying at that time.

LORD My prediction from the notes of what I've discussed with people is that the impression, clinical impression was that this was a lady who was, who was dying.

Code A Okay. And is that through the treatment given or is that through the condition, whatever she had, at that time? I haven't worded that very well really. Let me rephrase that. I mean, it's difficult...

LORD Yeah.

Code A Because I appreciate you weren't there at the time. So, that level of drugs, that level of, of treatment for that particular type of individual, would be indicative of someone who is dying with the palliative care situation?

LORD It would be unusual to have, extremely unusual to have someone who was say, up and walking, like very agitated on that combination of drugs, well, the drugs wouldn't have helped, but the impression I got is that people were trying to give her as peaceful as they could...

Code A Mmmm.

LORD ... and inevitably with any form of sedation, as the whole body gets quieter, everything else gets affected as well. All the other systems are beginning to melt down if you like.

Code A Mmmm.

LORD So, they certainly wouldn't have helped but I certainly wouldn't have thought that they were the cause of her death.

Code A Okay, okay. Anything else you want to...

Code A It's a similar sort of question. Hypothetically, we have a lady who is ninety one, she's fit and healthy, she lives at home, she goes, she does her own shopping, does her own cooking and she can look after herself. If that lady was taken to a hospital and put on a bed and a syringe driver with those same drugs with the same quantities was administered to her, what would happen to that lady, who, for all intents and purpose is fit and healthy?

LORD The argument would be that if she is someone who hasn't had what we call psychotropics, the Heloperidor....

Code A Mmmm.

LORD ... which in fact Mrs RICHARDS has already had before, it's again impossible to predict.

Code A Mmmm.

LORD People who haven't had any medication before are often very susceptible. On the other hand they could be someone who tolerated it so you, you don't know.

Code A Right.

LORD But probably they'd have got quite drowsy anyway. Probably.

Code A Mmmm.

Code A Okay.

MCNALLY All right?

Code A Okay. Is there anything you'd like to add?

LORD No.

Code A Is there anything you wish to clarify, anything you said that...

PRIVETT Sorry, there's just that one point in relation to the validity or otherwise of the locum consultant having done a ward round at Gosport. Can you just pick up from that?

LORD Yeah. When I'm away, there was a duty rota that there would be Dr BRANSTEIN who would be covering in case of emergencies.

Code A Mmmm.

LORD He was a regular full time consultant as well. And he wouldn't have been able to do the ward round for me, because his time table would have already been, is already booked.

Code A Yeah.

LORD So, he was there for nominal cover and basically (inaudible) in the community hospitals. If the consultant is not there, on our own time tables it is impossible to make the time up later in the week and it is impossible for a covering consultant....

Code A Yeah.

LORD ... to actually go and do the round for you, for me. In addition, he wouldn't have known the patients from before at all, so he would have ended up seeing sixteen patients from new with problems he didn't know. Just for that one day.

Code A Yeah.

LORD So, though there was cover, it wasn't sort of, it is difficult within our department ...

Code A Mmmm.

LORD .. even with, though we have seven consultants, to actually cover each others' duties because we're so busy.

Code A I think, I think we all appreciate the difficulties and the pressure that everybody in the National Health Service is under...

LORD Mmmm.

Code A ... and I appreciate what you're saying. On, I don't know the question, I've forgotten it. Never mind, it couldn't have been that important. It's gone.

PRIVETT I think, I think the point we were making was that it wouldn't be practical for a consultant to pick up the ward round, fill in...

Code A Yeah.

PRIVETT ... is the (inaudible)

Code A Yeah, physically...

PRIVETT Yeah.

Code A ... because of the amount of work he's got on his plate on his own....

PRIVETT He wouldn't know any of the patients.

LORD (inaudible)

Code A ... but he would have been available...

LORD ... (inaudible)

Code A .. on a phone call for advice...

LORD ... for advice.

Code A ... or even go to the ward if he was needed.

LORD Yeah.

Code A Yeah. And I think it's fair to say that, I've one more point, you probably don't get to see every patient that goes through the Gosport War Memorial because they may be only there for two or three days before they're sent on to somewhere else?

LORD Yeah, I mean, people who come in and die the same day they arrive so we wouldn't seen them.

Code A So that you may never see them any how, yeah.

LORD Or it may be that they come in and something happens and they, they go back or if they need surgery within two days of coming down.

Code A Mmmm.

LORD So, we're trying to have a daily consultant present in Gosport, but that's a long way away.

Code A And obviously we're all governed by money.

LORD Aren't we?

PRIVETT Did you want to pick up on anything about the transfer aspect. I know you mentioned it earlier on, are you happy we've dealt with that?

Code A It's just that, I don't know whether you are aware, we interviewed the ambulance crew...

LORD Mmmm.

Code A ... and they're...

PRIVETT Mmmm.

Code A We've spoken to them and I think it was an issue at the hospital on the second occasion, the seventeenth, when she arrived and obviously that all going to be encompassed in the package that's sent off to the guy in London who's gonna look at it all.

PRIVETT Mmmm.

Code A And I think, having been investigating this for the last three months I think we're all happy that travelling from A to B can cause major upsets in patients.

PRIVETT But there wasn't, I think you confirmed, officer, that there wasn't any set policy in relation to when to transfer, when not to transfer so again, it was a question of clinical judgement and the individual patient.

LORD Yeah.

Code A Mmmm. So, in terms of a judge it would be based obviously on the patient's well-being....

LORD Yeah.

Code A ... as opposed to a guideline saying you can't do it at this time or that time or...

LORD You couldn't have guidelines, can you?

Code A Okay. Allright...
LORD Did you want...
Code A ... anything else? Anything else you want to say?
LORD No.
PRIVETT No, thanks.
Code A Okay. I'll hand you a notice explaining the tape recording procedure which is there. The time by my watch is fifteen fifty four and I'm turning the recorder off.