Operation ROCHESTER.

Key Points.

Arthur CUNNINGHAM. Code A

Mr CUNNINGHAM was a frail 79 year old man who had suffered Parkinson's disease for many years. In addition he suffered long standing back pain due to an old war injury that required maximum doses of weak opioids.

His behaviour could be difficult and was the reason for an admission under the care of Dr BANKS consultant in old age psychiatry, during this admission his abnormal behaviour and disturbed nights were considered to be a combination of depression and dementia for which he was prescribed and antidepressant a mood stabilizer an antipsychotic and a sedative.

Mr CUNNINGHAM's health improved and he was readmitted to his nursing home.

Between 14th and 21st September 1998, Mr CUNNINGHAMS condition worsened he suffered severe pressure sores despite provision of antibiotics, and his general condition deteriorated, he was difficult to wake, refusing to talk, drink or swallow medication and was expressing a wish to die.

On the 21st September 1998 Mr CUNNINGHAM was admitted to Dryad ward Gosport War Memorial Hospital for treatment of the sore, a high protein diet, and Oramorph as required if in pain.

The consultant Dr Althea LORD noted that the patient's prognosis was poor, but asked his nursing home to keep his bed available for at least 3 weeks.

Dr JANE BARTON was responsible for the care administered to Mr CUNNINGHAM examining him upon admission.

Dr BARTON noted that the pressure sore was very extensive, his condition was frail and given Dr Lord's assessment of the prognosis Dr BARTON included in her entry on the medical notes that she was happy for the nursing staff to confirm death.

Dr BARTON according wrote on Mr CUNNINGHAM's notes 21.9.98 'Transfer to Dryad Ward, Make comfortable give adequate analgesia, 'I am happy for nursing staff to confirm death'.

Dr BARTON concerned that the oramorph prescribed by Dr LORD may be insufficient in providing pain relief given his significant pain and distress decided to write up diamorphine on a proactive basis and a dose range of 20-200mgs.

In addition Dr BARTON prescribed 200-800mcgs of hyoscine, and midazolam 20-80mgs.

The drugs administered resulted in Mr CUNNINGHAM sleeping soundly.

Dr BARTON assessed Mr CUNNINGHAM the following morning and diamorphine and midazolam were administered in increasing doses via syringe driver between 22nd and 25th September.

The decision to administer opioids via syringe driver was challenged by Mr CUNNINGHAMS stepson on 23rd September, Nurse HAMBLIN informed him that it could not be removed without a doctor's authorisation.

Ultimately Mr CUNNINGHAM died during the evening of Saturday 26th September 1998 without ever regaining consciousness; he had been reported as being in pain and 'chesty'

This patients cause of death was registered as 1. bronchopneumonia the cause being upheld by a post mortem.

Case assessed by multidisciplinary medical team during 2004.

Arthur CUNNINGHAM. 79. 21st September 1998 – 26th September 1998. Gosport War Memorial Hospital. Parkinson's disease, dementia, myelodysplasia, admitted from a nursing home with difficult behaviour. In June 1998 he was using a mobile telephone, and taking a taxi journey. Admitted from day hospital with a large necrotic sacral sore. The sore would have been painful but the reasons quoted for starting the diamorphine/midazolam infusion were related to behaviour. No mention of pain on the 25th and 26th September but the dose of diamorphine was increased on both days. Cause of death was bronchopneumonia although the medication might have contributed to it. Several Doctors involved in care. Rapid escalation of Diamorphine and high doses of Midazolam.

Dr Jane BARTON from a caution interview with police on 21st April 2005.

In summary:- Through provision of a prepared statement Dr BARTON commented that when she first took up the post at Gosport War memorial hospital, the level of dependency of patients was relatively low and that in general patients did not have major medical needs. Over time the position changed to one of patients becoming increasingly dependent, and by 1998 profoundly dependent.

The demands upon Dr BARTON's time were considerable with increasing bed occupancy; Dr BARTON faced the position of if making detailed notes to do so at the cost of patient care.

Patient CUNNINGHAM suffered Parkinson's since the 1980's and in addition had an old spinal injury from a plane crash with associated chronic back pain.

In July 1998 the patient was admitted to Mulberry Ward Gosport War Memorial Hospital his problems including dementia, parkinsons disease, depression and being physically frail.

Mr CUNNINGHAM was seen by Consultant Dr LORD who felt that his Parkinson's had deteriorated.

Mr CUNNINGHAM's sacral sores were particularly evident by Mid September 1998.

He was admitted to Dryad Ward Gosport War memorial Hospital on 21st September 1998 suffering a combination of the afore-mentioned medical problems.

According to a sisters note Mr CUNNINGHAM was said to be terminally ill and not expected to survive beyond the weekend.

Dr BARTON examined Mr CUNNINGHAM just prior to admission, he was suffering an extensive pressure sore and a poor prognosis from Dr LORD, Dr BARTON was happy for the nursing staff to confirm death and accordingly noted this view on the transfer notes.

Dr LORD prescribed Oramorph for pain relief, Dr BARTON thought this may be inadequate due the size of the sacral sore and write a prescription for diamorphine on a proactive basis a dose range of 20-200mgs. Dr BARTON was conscious that it was a wide range that inevitably would be started at the bottom. In addition Dr BARTON prescribed a range of Midazolam and Hyoscine also for pain relief.

Nursing notes continue to record that Mr CUNNINGHAM was in pain and that a syringe driver was commenced at 11pm on 21st September 1998.

The following day Mr CUNNINGHAMS Bartel score was nil, ie he was totally dependent.

On 23rd September it was recorded that Mr CUNNINGHAM had become chesty overnight. Dr BARTON decided to add Hyoscine to the syringe driver.

It is recorded that family members Mr and Mrs FARTHING became angry at the decision to deploy a syringe driver, and that decision had been explained by Nurse HAMBLIN.

Levels of pain relief were increased as Mr CUNNINGHAM continued to suffer pain and discomfort.

On 24th September 1998 Dr BARTON wrote 'remains unwell, son has visited again today, is aware of how unwell he is SC analgesia is controlling the pain - just. I am happy for nursing staff to confirm death.

On 25th September Dr BARTON increased the dose range, her partner Dr Sarah BROOK was on duty from the evening of 25th September and commented that Mr CUNNINGHAM was for T.L.C.

Inevitably Mr CUNNINGHAM continued to deteriorate, the following morning the 26th September drug levels were further increased and he died at 1115pm that day.

Dr BARTON concluded that at all times the medication that she authorised was provided with the sole intention of relieving pain distress and anxiety in her accordance with her duty of care towards the patient.

Expert Witness Dr Andrew WILCOCK (Palliative medicine and medical oncology)

Comments:-

- Mr Cunningham was a frail 79 year old widower who lived in a nursing home. He had suffered from Parkinson's disease for many years and had an abnormal blood count possibly due to myelodysplastic syndrome. He had longstanding back pain due to an old war injury, that required maximal doses of weak (step 2) opioids.

- His behaviour could be difficult and this was the reason for a recent admission under the care of Dr Banks, consultant in old age psychiatry. During this admission, his abnormal behaviour and disturbed nights were considered to be due to a combination of depression and dementia. An antidepressant (mirtazapine), a mood stabiliser (carbamazepine), an antipsychotic (risperidone) and a sedative/hypnotic (triclofos) were commenced. These resulted in an improvement in Mr Cunningham's mood and sleep, which was maintained after his return to the nursing home.

- Mr Cunningham was followed up at Dolphin Day Hospital on the 14th, 17th and 21st September 1998. Over this time, his sacral pressure sore worsened despite antibiotics and his general condition appeared to deteriorate; he was difficult to wake and was refusing to talk, drink or swallow medication and expressing a wish to die. On the 21st September and was admitted direct to Dryad Ward for treatment of the sore, a high protein diet and for 'oramorph (morphine solution) p.r.n. 'as required' if pain'. Dr Lord noted that Mr Cunningham's prognosis was poor but asked that the nursing home keep the bed open for the next three weeks at least.

- During this admission, the medical care provided by Dr Barton fell short of a good standard of clinical care as defined by the General Medical Council that included the lack of clear note keeping, adequate assessment of the patient and the prescription of a large dose range of diamorphine (up to 200mg) that was likely to be excessive to Mr Cunningham's needs. The lack of access to stat SC doses of diamorphine and midazolam, made some of the increases in the doses of diamorphine and midazolam he received in the syringe driver difficult to justify, especially when the increment was larger than generally seen.

- Further, other strategies of managing Mr Cunningham's pain on turning that may have been more successful were not pursued.

- In this regard, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mr Cunningham by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Cunningham by unnecessarily exposing him to the risk of receiving excessive doses of diamorphine. In the event, however, Mr Cunningham did not receive such high doses.

- Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mr Cunningham a peaceful death, albeit with what appears to be a lack of sufficient knowledge regarding the use of diamorphine as detailed above. In my view, Mr Cunningham was dying in an expected way, the use of diamorphine, midazolam and hyoscine were justified given that both his chronic pain and behavioural disturbances required medication, and subsequently for retained secretions in his terminal phase.

- The starting doses used and the doses he subsequently received of diamorphine, midazolam and hyoscine were not unusual and had been arrived at in a step wise fashion. Although in my view, alternatives existed that would have better managed his pain on turning, other practitioners may well have followed a similar course to Dr Barton.

- There should have been clear documentation in the medical notes as to why a syringe driver containing possibly diamorphine, midazolam and hyoscine was prescribed 'as required'. It is unusual to prescribe a syringe driver 'as required' especially containing drugs with a range of possible doses. This is because of the inherent risks that would arise from a lack of clear prescribing instructions on why, when and by how much the dose can be altered within this range and by whom. For these reasons, prescribing a drug as a range, particularly a wide range, is generally discouraged. Doctors, based upon an assessment of the clinical condition and needs of the patient usually decide on and prescribe any

change in medication. It is not usual in my experience for such decisions to be left for nurses to make alone.

- If there were concerns that a patient may experience, for example, episodes of pain, anxiety or agitation, it would be much more usual, and indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine, diazepam/midazolam and levomepromazine respectively that could be given intermittently 'as required' orally or SC. This allows a patient to receive what they need, when they need it, and guides the doctor in deciding if a regular dose is required, the appropriate starting dose and subsequent dose titration.

- The wide dose range of diamorphine 20mg–200mg, is not justified at all in the notes. Doses at the upper of this range are likely to be excessive for Mr Cunningham's needs. Doses of opioids excessive to a patient's needs are associated with an increased risk of drowsiness, delirium, nausea and vomiting and respiratory depression. The reasons for the inclusion of midazolam and hyoscine hydrobromide in the syringe driver should also have been documented.

- It is unclear why Mr Cunningham was given the 10mg dose of Oramorph. He had only received 5mg of Oramorph previously and this was to cover a dressing change. It would be usual to repeat the same dose of opioid (i.e. 5mg), unless it was ineffective in providing analgesia. Opioids are not indicated for the relief of anxiety and agitation per se. In a confused, elderly patient, opioids may worsen the confusion, particularly at doses associated with sedation. It is possible that the 10mg dose may have contributed to Mr Cunningham being too 'sedated' to take his 22.00h medication.

- It is not clear who decided to start the syringe driver on the 21st September 1998, the drugs it contained and the doses to use. It should be clarified why, if Mr Cunningham was able to take oral medication, his usual medication had not been given, or, if unable to take oral medication, why stat SC doses of a sedative or analgesic were not considered appropriate. Doctors, based upon an assessment of the clinical condition and needs of the patient usually decide on and prescribe any change in medication. It is not usual in my experience for such decisions to be left for nurses to make alone.

- Morphine is used in palliative care for generalised pain related to muscle or joint stiffness due to immobility or painful pressure sores and the starting dose of diamorphine used were within the starting dose range considered reasonable given Mr Cunningham's prior analgesic use and age.

- If symptoms are 'difficult to control', this should prompt an adequate (re)assessment to carefully (re)consider the possible contributing factors to ensure that all reasonable steps had been taken. If symptoms were not improving despite several increases in analgesic and sedative medication it

would be seen as good practice for a doctor to seek additional information or advice from one of the consultants, another colleague or a member of the palliative care team. There is no documentation in the notes that suggests that Dr Barton did this.

- Dr Barton had a duty to provide good palliative and terminal care and an integral part of this is the relief of pain and other symptoms to ensure the comfort of the patient. In doing so, as in every form of medical care provision, she would be expected to demonstrate a good standard of practice and care. In this regard, Dr Barton fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, October 1995 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient, providing treatment that could be excessive to the patients' needs and willingness to consult colleagues.

- In my view, given Mr Cunningham's circumstances, the use of diamorphine, midazolam and hyoscine was reasonable. The main issues of contention are firstly, the large dose range of diamorphine prescribed for the 'as required' syringe driver (200mg), as this was likely to exceed the dose likely to be appropriate for Mr Cunningham. It is unclear how Dr Barton determined or justified this dose. A dose of diamorphine excessive to Mr Cunningham's needs would be associated with an increased risk of drowsiness, confusion, agitation, nausea and vomiting and respiratory depression. Mr Cunningham's administered dose of diamorphine did not however, reach these high levels.

- Secondly, the lack of p.r.n. stat SC doses of diamorphine and midazolam meant that the there was a lack of guidance to aid appropriate dose titration or justification for the continued increases in the doses of diamorphine and midazolam. Mostly these were increases within the 33–50% range that would be considered typical. Sometimes increases were greater than this (i.e. diamorphine 20mg to 40mg, 100%) or without documented reason/justification, e.g. the diamorphine 60mg to 80mg and the midazolam 20mg to 60mg and subsequently 80 to 100mg. It was not clear who determined these increases, Dr Barton or one of the nursing staff, and this should be clarified. However, my understanding is that Dr Barton, as the prescriber, retains overall responsibility for the administration of these drugs.

- Finally, other strategies exist that could have been employed to manage Mr Cunningham's pain on turning, that in my view could have been more successful than continuing to increase the regular doses, and in this regard it is possible that the doses of diamorphine and midazolam Mr Cunningham received risked being excessive for the majority of the time he was still and comfortable. Even so, at the doses Mr Cunningham did receive, they were not excessive to the point of leaving him unresponsive, as he reacted to being moved.

- In patients with cancer, the use of diamorphine and other sedative medications (e.g.midazolam, haloperidol, levomepromazine) when appropriate for the patients needs, do not appear to hasten the dying process. This has not been examined in patients dying from other illnesses to my knowledge, but one would have no reason to suppose it would be any different. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients needs. Although the principle of double effect could be invoked here, it remains that a doctor has a duty to apply effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose of strong opioid that was *appropriate* and not excessive for a patient's needs.

- There appears little doubt that Mr Cunningham was 'naturally' coming to the end of his life. His death was in keeping with a progressive irreversible physical decline, documented over at least 10 days by different clinical teams, accompanied in his terminal phase by a bronchopneumonia. Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mr Cunningham a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on large dose range of diamorphine by syringe driver rather than a fixed dose along with the provision of smaller 'as required' doses that would allow Mr Cunningham's needs to guide the dose titration.

- Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mr Cunningham by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Cunningham by unnecessarily exposing him to potentially receiving excessive doses of diamorphine. In the event, however, such large doses were not administered, and in my opinion, the use of diamorphine, midazolam and hyoscine in these doses could be seen as appropriate given Mr Cunningham's circumstances.

Expert Witness Dr David BLACK (Geriatrics) comments:-

- Mr Arthur Cunningham a 79 year-old gentleman, suffers from long-standing Parkinson's disease with multiple complications followed by a fairly rapid decline in health leading to his first admission to the Gosport War Memorial Hospital on 21st July, 1998 and a final admission 21st September, 1998.

- Mr Cunningham receives terminal care including subcutaneous Diamorphine and Midazolam through a syringe driver and dies on 26th September 1998.

- Arthur Cunningham is an example of a complex and challenging problems in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point at which to stop trying to deal with each individual problem or crisis, to an acceptance the patient is dying and that symptom control is appropriate.

- In my view, Mr Cunningham was managed appropriately, including an appropriate decision to start a syringe driver for managing his symptoms and agitation as part of his terminal illness in September 1998.

- My one concern is the increased dose of Diamorphine in the syringe driver on 25th and 26th September 1998, as I was unable to find any justification for this increase in dosage in either the nursing or the medical notes. In my view this increase in medication may have slightly shortened life for at most no more than a few hours to days, however, I am not able to find evidence to satisfy myself that this is to the standard of "beyond reasonable doubt".

Evidence of other key witnesses.

Charles Rodney STEWART- FARTHING stepson of Arthur CUNNINGHAM, describes him as a blunt and difficult man who had alienated most of his family. Describes him as cheerful on admission to Dryad Ward Gosport War memorial hospital and suffering a bedsore on his behind. Mr STEWART –FARTHING was surprised to be told by Sister HAMBLIN that he suffered the worst bedsores she could remember seeing and that he could not survive them.

Was informed by sister HAMBLIN that Mr CUNNINGHAM had become rude and difficult on 22nd September and that he had been given something to calm him down. By Lunchtime on Wednesday 23rd September he was shocked to find Mr CUNNINGHAM totally unconscious and being administered drugs via syringe driver.

He was appalled and demanded removal or interruption of the syringe driver, Sister HAMBLIN refused saying that this could only be authorised by a doctor.

Later informed by Dr BARTON that Mr CUNNINGHAM was dying due to poison emanating from his bedsores, the drugs were required to ensure that he was not discomforted.

Was shocked to note that the cause of death had been registered as Bronchopnuemonia, and demanded a post mortem. Cause of death was confirmed by post mortem, and the pathologist with whom Mr FARTHING spoke.

Mr FARTHING felt that there was a conspiracy afoot extending to the coroners office.

Mr FARTHING was left with no doubt that his step father was the subject of a well oiled disposal machine being administered by a culture of able individuals.

Doctor John GROCOCK GP. Mr CUUNINGHAMS GP at the Brune medical centre GOSPORT of many years. Referred the patient to Dr LORD on 11th June 1998. Discussed within the letter how Mr CUNNINGHAM was suffering Parkinsons and poor mobility had moved to the Merlin Rest Home and had antagonised the staff. Details Mr CUNNINGHAMS medical history from 1989 -1998.

Victoria BANKS Consultant in Old Age Psychiatry. A consultant at the Mulberry 'A' ward Gosport War Memorial Hospital, a short term functional assessment ward for the elderly. July 1998 admitted Mr CUNNINGHAM, suffering from depression, poor mobility, Parkinsons, demanding behaviour and falls. Prescribed a range of drugs including anti-depressants, patient made reasonable progress and was discharged to a nursing home.

Rachael ROSS GP 1993-2003 employed as a clinical assistant in elderly medicine at Dolphin Day Hospital, GOSPORT and 2 half days a week at Gosport War memorial hospitals a clinical assistant to DR LORD. Reviewed Mr CUNNINGHAM July 1998 at DOLPHIN, significant weight reduction 84-68 kilos since 1977, Parkinson's and low blood pressure. Describes drug regime at that time.

Details further examination of Mr CUNNINGHAM 14th September 1998 at Dolphin day hospital, blood pressure and pulse low, poor urinary drainage, suffering a bone marrow condition and receiving anti-psychotic drugs. Parkinson's worsening.

Wendy CHILDS GP in July 1998 whilst a senior house officer at Gosport War Memorial Hospital, queried low platelet and white cell levels in terms of whether could have been caused by drug regime. Detailed comment re patient's condition July/August 1998.

Mary Muriel SCOTT-BROWN, staff grade doctor Gosport War memorial Hospital. Discusses patient condition June /July 1998. Particularly detailed interview with Mr CUNNINGHAM 7th July 1998, diagnosed as depressed. No further involvement with patient after 8th July 1998.

Lesley CROFT-BAKER, senior house officer elderly mental health Gosport War Memorial Hospital 1998/1999 to consultants Dr BANKS and Dr MEARS. On 28th August 1998 diagnosed Mr CUNNINGHAM as suffering dementia, parkinsons, depressive episode and Mylodsplasia. Describes significant drug regime applied, and Dr LORD recommending for discharge on 28.8.1998.

Pamela GELL Nursing director to Thalassa Nursing home 1998. Admitted Mr CUNNINGHAM to nursing home 28th August 1998. Describes concerns over the

patients sacral sore resulting in his admission to Gosport War Memorial Hospital on 21st September 1998.

Shaun GOLDING Mental health social worker general pre August 1998, power of attorney issues, home visits etc.

John Leslie ALLEN Nurse 1998 grade G working on Pheonix Ward Gosport War Memorial Hospital. Made two entries on nursing notes, 11th Sept 1998, described as settling well into Thalassa Nursing Home, no real management or behavioural problems, can be awkward at times but mostly pleasant and compliant, mood seems good. On 24th September wrote 'Physical decline, pressure sores developed, admitted to dryad ward, he is terminally ill and not expected to live past the weekend according to sister on ward.

Althea LORD Consultant Geriatrician assessed Mr CUNNINGHAM September 1997, March 1998, June 1998, July 1998, August 1998, and 23rd September 1998 when Dr LORD wrote that Mr CUNNINGHAM had a large necrotic sacral ulcer, Parkinson's and continued to be very frail. Admitted to Gosport War memorial Hospital with a view to more aggressive treatment of the ulcer. She felt that he was unlikely to recover. A 26 page statement with a detailed analysis of Mr CUNNINGHAM's condition and treatment during his last 12 months of life.

William PITT Clinical assistant in Old age psychiatry Gosport War memorial Hospital 22hrs a week between 1993 and October 2004. Examined Mr CUNNINGHAM on Mulberry Ward, 17th August 1998 following him suffering a noisy and disturbed night. Diagnosed the patient as suffering severe dementia.

Sarah BROOK Gosport GP during 1998 and a practice partner of Dr BARTON would cover for her at Gosport War Memorial Hospital when she was away. Made entry on medical notes 25th September 1998, 'remains poorly, on syringe driver for TLC' she felt that the patient was dying. She discussed the death certificate with Dr LORD before writing it up as 1/ Bronchopneumonia 2 /Parkinson's disease and Sacral Ulcer'.

Ruth DEVERELL Speech Therapist examined Mr CUNNINGHAM July 1998 reports swallowing problems and general speech issues.

Gillian HAMBLIN Clinical Manager Dryad Ward describes ward rounds, syringe driver issues, remembers Mr CUNNINGHAM as an extremely uncooperative patient with a deep sacral sore caused by non-compliance with regard to sitting and laying, pulling off his dressings and throwing them across the floor.

Describes regime of administration of variable doses of diamorphine, hyoscine and midazolam drugs written up by Dr BARTON in consultation with Dr LORD.

Describes concerns raised by Mr FARTHING re syringe driver and informing him that contents were to control pain and consultant would need to give permission to discontinue.

Sister HAMBLIN administered doses of Diamorphine with Nurse Shirley HALLMANN on 21st September.

Comments that Diamorphine administered by Nurses, WALKER, LLOYD, SHAW, BARKER, HALLMAN, RING.

Nurses SHAW, DOLAN, BARKER, RING,TAYLOR, COATES, CAPES, TURNBULL, NELSON ,CAWTE and YOUNG statements attached, general nursing issues, explanation of nursing notes, and diamorphine and general drug administration.

Dr Yasir HAMID. Conducted Post Mortem upon Mr CUNNINGHAM deceased on 2nd October 1998. Determined cause of death as bilateral bronchopneumonia, death due to natural causes.

DC YATES Detective Constable Conducted voluntary attendance caution interview with Dr BARTON on 21st April 2005.

Code A

D.M.WILLIAMS.
Det Supt 7227.
15th November 2005.