SUMMARY OF EVIDENCE

CASE OF ARTHUR CUNNINGHAM

Background/Family Observations

Arthur CUNNINGHAM was born on Code A He was disabled during the war suffering a spinal injury hence he used a stick or a crutch. He married in the early 1980's although his wife died in 1989 leaving him with a stepson.

After his wife died he lived alone, though he was diagnosed with Parkinson's Syndrome and had a Home Help.

During the later years of his life he stayed in various rest homes, the last one being Thalasa Nursing Home. Mr CUNNINGHAM could be blunt and difficult and held a firm master/worker belief.

Mr CUNNINGHAM was suddenly admitted to the Gosport War Memorial Hospital without the knowledge of his stepson in September 1998 due to a bed sore. When visited on 21st September 1998 he was perfectly normal and cheerful. On speaking to Gill HAMBLIN the Ward Sister Mr CUNNINGHAM's stepson was informed that he had the worst bed sores she could remember seeing and that they were so serious that he could not survive them. The following day Mr CUNNINGHAM's stepson was told on the phone by Gill HAMBLIN that Mr CUNNINGHAM had become "difficult" and was rude to staff, so he had been given something "to quieten him down".

On Wednesday 23rd September 1998 Mr CUNNINGHAM when visited was found to be unconscious and on a syringe driver. His stepson demanded that the driver be removed. Gill HAMBLIN refused this saying that only a doctor could authorize it.

At 5pm that day Dr BARTON was spoken to and the stepson was told that Mr CUNNINGHAM was dying due to poisons emanating from his bed sores and it was too late to interrupt the administration of drugs which were needed to ensure he was not in any discomfort.

He died during the evening of Saturday 26th September 1998 without ever gaining consciousness.

On registering the death on the 28th September Mr CUNNINGHAM's stepson found that the cause of death had been given as bronchopneumonia, to which he objected to as Mr CUNNINGHAM had suffered no more than Parkinson's disease and bed sores, and insisted upon a post mortem, which was duly carried out but upheld the cause given by the doctor.

Mr CUNNINGHAM's stepson subsequently complained to the Inspector of Nursing Homes and Portsmouth Health Care Trust but considers the replies were a purely administrative exercise. He has no doubt that Mr CUNNINGHAM was 'the subject of a well-oiled disposal machine being administered by a culture of able individuals'.

Medical history of Arthur CUNNINGHAM.

Events at Mulberry Ward, 21st July 1998 until the 28th August 1998

Mr Cunningham, a 79 year old widower who lived in Thalassa Nursing Home was admitted to Mulberry Ward, Gosport War Memorial Hospital (GWMH) under the care of Dr Banks, consultant in old age psychiatry, for assessment of his physical and mental well being (page 241). This was precipitated by the staff at the nursing home finding Mr Cunningham's behaviour difficult. It was considered that these behavioural problems related to the combination of depression and dementia (pages 67, 453). Mr Cunningham also had long-term problems relating to Parkinson's disease, constipation and was known to have an abnormal full blood count (low white cells and platelets; cells that help fight infection and the blood to clot respectively) pages 67 and 68). The latter was discussed with Dr Cranfield, consultant haematologist, who considered it probably due to myelodysplastic syndrome (disorder of stem cells in the bone marrow that in 20-40% of patients it transforms into leukaemia) or possibly drug-related and it was noted that 'He [Mr Cunningham] is more susceptible to infection. Medical help should be sought early rather than later' (page 68). Repeated blood counts however, were stable and satisfactory, e.g. white cells 4.0 (neutrophils 2.8) x 10^9/L and platelets 113 x 10^9/L on the 26th August 1998 (page 191).

Mr Cunningham was also known to the geriatric services and Dr Lord, who had seen him several times over previous years. This mainly related to his Parkinson's disease (initially diagnosed in 1988) impairing his mobility, and the difficulties encountered with undesirable effects as the dose of his antiparkinsonian medication was increased; these included abnormal involuntary movements (dyskinesia), confusion (with hallucinations) and postural hypotension (low blood pressure on standing)(pages 345, 349, 351, 375, 377). Mr Cunningham had also injured his lumbar spine and both ankles in an aeroplane crash in 1945, requiring lumbar spine fusion and bone grafts. This led to numbness and weakness in the left leg and he was invalided out of the RAF. Backache, thought related to this injury, had been reported as a considerable problem but that Solpadol (codeine 30mg and paracetamol 500mg), five to eight a day (i.e. 150–240mg codeine/day) was effective (pages 139 and 375). Other previous problems included a kidney stone (1992), a transurethral resection for an enlarged prostate (1992), diabetes mellitus (1994), initially tablet and subsequently diet controlled and high blood pressure (pages 7, 50, 65, 375, 445, 305, 379).

During his stay on Mulberry Ward, Mr Cunningham was commenced on an antidepressant, mirtazapine (page 71). It was noted that he would often call out for the first couple of hours in bed (page 72). The nurses commented that it took a long time to get him comfy at night having to make adjustments to his back rest and pillows etc. (page 72, 73 and 80) and he did complain of pain in the base of

his spine (page 73). On the 4th August 1998, this led to his paracetamol being switched for co-proxamol 2 tablets four times a day, a similar strength analgesic to the Solpadol he had required before (page 80).

On the 17th August 1998 he had a very disturbed night with shouting and was subsequently commenced on an anti-epileptic drug carbamazepine 100mg at night (page 87 and 161), presumably as a mood stabiliser. The following night he was described as confused with paranoid and delusional ideas (page 87) and a sedative, triclofos 20ml (2g) at night was added. It was commented that this would be for a few nights, although this was continued long-term (page 88 and 161). Due to ongoing problems, on the 19th August 1998, an 'atypical' antipsychotic risperidone 0.5mg was added at 6pm (page 88). An antipsychotic is usually indicated in confused patients with paranoid and delusional ideas. However, they risk worsening Parkinson's disease and this may be why other approaches were tried first. An 'atypical' antipsychotic like risperidone would be less likely to worsen Mr Cunningham's Parkinson's disease compared to a 'typical' antipsychotic such as haloperidol. Mr Cunningham's mood and nights subsequently improved.

On admission to Mulberry ward, the skin over Mr Cunningham's pressure areas was intact (page 248). He was, however, at high risk of pressure sore development, scoring 19–20 on a Waterlow Score (>15 indicates high risk; >20 a very high risk of pressure sore development) (page 309). On or around the 23rd August 1998, a nursing care plan was started for a broken area on his sacrum that was treated with a thin DuoDERM dressing (page 293).

Mr Cunningham also had two urinary tract infections requiring antibiotics (pages 205 and 207) and developed renal impairment due to urinary retention, necessitating urinary catheterisation, following which his kidney function improved (urea 15.6mmol/L, creatinine 144micromol/L)(pages 173 and 175 of 928).

Mr Cunningham was reviewed by Dr Lord whilst on Mulberry Ward. Initially Dr Lord considered that his Parkinson's disease was stable and that his deteriorating mobility was more likely related to a weak pelvic girdle due to his old spinal injury (pages 74 and 105). Dr Lord suggested continuing the same dose of his antiparkinsonian medication (l-dopa) and to only add an extra controlled release formulation (Sinemet CR) at night if thought necessary. This was subsequently added by Dr Bank's team the same day (page 75). On a subsequent review on the 27th August 1998, Dr Lord considered that Mr Cunningham's Parkinson's disease had indeed deteriorated (pages 91, 92, 97) and offered to follow him up at Dolphin Day Hospital. Dr Lord also noted that Mr Cunningham was eating better and had gained weight from 65.5 to 69.7kg during his admission (pages 325, 327 and 329).
Mr Cunningham was discharged from Mulberry Ward on the 28th August 1998 on the following medication: Careldopa as Sinemet-110 (carbidopa 10mg/levodopa 100mg) one tablet four times a day; careldopa as Sinemet CR (carbidopa 50mg/levodopa 200mg) one tablet at night (antiparkinsonian medication); co-proxamol two tablets four times a day (analgesic); mirtazapine 30mg at night (antidepressant); risperidone 0.5mg at 6pm ('atypical' antipsychotic); triclofos 20ml (2g) at night (hypnotic); carbamazepine 100mg at night (anti-epileptic; mood stabiliser); amlodipine 5mg once a day (for high blood pressure); co-danthramer two capsules at night; magnesium hydroxide 10mg twice a day; senna two tablets at night (laxatives) (pages 162, 453).

Mr Cunningham's improved mood and nights appear to have been maintained on his return to Thalassa Nursing home; on the 11th September 1998, a community psychiatric nurse noted 'settled well back at the Nursing Home....no management or behavioural problems... Compliant, mood seems good' (pages 93 and 99).

Events at Dolphin Day Hospital, 14th September 1998 until 21st September 1998.

Mr Cunningham was reviewed by a doctor at Dolphin Day Hospital on the 14th September 1998. Due to increasing stiffness from his Parkinson's disease, the careldopa (Sinemet-110) was increased to five times a day. Other plans were to liaise with the nursing home about his bowel habit, with a view to rationalising his laxative therapy, and his behaviour/sleep with a view to stopping his benzodiazepine p.r.n. ('as required'). It is unclear if Mr Cunningham was still taking a benzodiazepine p.r.n. He was not given a supply of diazepam on discharge from Mulberry Ward (pages 162, 163). The Dolphin Day Hospital nursing records note that Mr Cunningham reported that he was happy at Thalassa, that the nursing home staff said his bowels were satisfactory and that he slept well. The nursing staff at Dolphin Day Hospital were aware of his sacral sore and took a photograph (page 639); they clarified that he had a pressure relieving Spenco mattress and wheelchair cushion at the nursing home. The nursing home staff were asked to redress the sore later that week and it would be checked again at Mr Cunningham's next day hospital attendance (page 907 and 908).

Mr Cunningham next attended Dolphin Day Hospital on the 17th September 1998. It was noted that his sacral pressure sore appeared infected and he was commenced on an antibiotic, metronidazole 200mg three times a day (page 317, 459). The nursing notes entry for this visit report that the occupational therapist (OT) was to order a wheelchair and a Roho cushion. They noted that the pressure sore was exuding++ but not redressed due to reduced compliance from Mr Cunningham, although no specific details are given. It was noted that he would not wake after a rest on bed and was refusing to talk, drink or swallow medication but expressed a wish to die. It was noted he was seen by Dr Lord, and that the plan was to possibly admit him when next reviewed (pages 908, 909).

On the 21st September 1998, Mr Cunningham was reviewed at Dolphin Day Hospital by Dr Lord who noted that he was very frail. Tablets were found in his mouth some hours after they had been given. There was an offensive smelling large necrotic sacral ulcer with a thick black scar and grazes over his buttocks (photographed, page 64). In addition there was a small black scar and redness over the left lateral malleolus (ankle). Dr Lord listed Mr Cunningham's problems as 'sacral sore (she specified 'in nursing home' possibly meaning that this is where it developed. My understanding is that it started during his admission to Mulberry ward, but considerably worsened at the nursing home), Parkinson's disease (she considered this no worse), old back injury, depression and element of dementia, diabetes mellitus – diet (controlled) and catheter for urinary retention' (page 642). Dr Lord admitted Mr Cunningham direct to Dryad Ward that day, stopped the amlodipine (his blood pressure was normal/low for someone his age), the co-danthramer laxative (this can irritate the skin around the perineum/sacrum), the metronidazole and asked for Mr Cunningham be nursed on his side and to apply Aserbine to the sacral ulcer; this is a desloughing agent, that helps to ablate local infection. She also noted that Mr Cunningham should receive a high protein diet and 'oramorph (morphine solution) p.r.n. 'as required' if pain' (page 643).

Dr Lord asked that the nursing home keep the bed open for the next three weeks at least and noted that Mr Cunningham was agreeable with the admission. Dr Lord also noted that Mr Cunningham's prognosis was poor (page 457, 642, 643, 909).

Events at Dryad Ward, Gosport War Memorial Hospital, 21st September 1998 until 26th September 1998.

21st September 1998

An entry in the medical notes reads 'Transfer to Dryad Ward. Make comfortable. Give adequate analgesia. I am happy for nursing staff to confirm death' (page 645). The drug chart used in the day hospital was continued as an inpatient. This revealed that Mr Cunningham had prescriptions for regular co-proxamol, mirtazapine, risperidone, Sinemet-110, Sinemet CR, senna, carbamazepine, magnesium hydroxide and triclofos. Prescriptions for his amlodipine, co-danthramer and metronidazole had been crossed out (pages 753, 755). On the p.r.n. 'as required' section Oramorph 2.5–10mg up to every four hours and Actrapid insulin 5–10 units according to a sliding scale were prescribed (page 752). On another section, the where the word 'regular' prescription has been crossed out and replaced with p.r.n. and circled, Mr Cunningham was also prescribed diamorphine 20–200mg, hysocine (hydrobromide) 200–800microgram and midazolam 20–80mg all subcutaneously (SC) over 24h (page 756). Finally, he was prescribed metrotop, a topical antibiotic gel (page 756). Mr Cunningham received 5mg oramorph at 14.50pm and 10mg at 20.15pm (page 753 of 928). A syringe driver containing diamorphine 20mg and midazolam 20mg was commenced at 23.10pm (page 756 of 928).

At 18.00h Mr Cunningham took co-proxamol (but none thereafter), Sinemet-110 and magnesium hydroxide. Following his admission, it does not appear as though Mr Cunningham received any mirtazapine, risperidone, Sinemet CR, carbamazepine or triclofos (753 and 755). The 'Exception to prescribed orders' section of the drug chart gives 'sedated' as the reason that Mr Cunningham did not receive his co-proxamol, Sinemet CR and senna at 22.00h (page 754).

The nursing summary notes read 'Admitted from DDH with history of Parkinson's, dementia and diabetes diet controlled diabetic. Catheterised on previous admission for retention of urine. Large necrotic sore on sacrum. Seen by Dr Barton. Dropped left foot. Back pain from old spinal injury. 14.50h Oramorph 5mg given prior to wound dressing. A later entry notes 'Remained agitated until approximately 20.30h. Syringe driver commenced as requested. Diamorphine 20mg, midazolam 20mg at 23.00h. Peaceful following (page 867).

The nursing care plan entry relating to the ulcers notes 'Dressing applied to buttock at 18.30h. Aserbine cream to black necrotic area and zinc and caster oil to surrounding skin: very agitated at 17.30pm, Oramorph 10mg/5ml at 20.20pm. Pulled off dressing to sacrum (page 880).

Nursing care plan entry relating to settling for the night notes 'Driver commenced at 23.10pm containing diamorphine 20mg and midazolam 20mg. Slept soundly following. BS (blood sugar) at 23.20pm 3.4mmol/L. 2 glasses of milk taken when

awake. Much calmer this am. Sacral sore oozing but left exposed as requested' (page 876).

22nd September 1998

The drug chart reveals that Mr Cunningham took doses of Sinemet-110 at 06.00, 09.00, 12.00 and 18.00h, magnesium hydroxide at 09.00h and senna at 22.00h (page 753 and 755). The 'Exception to prescribed orders' section of the drug chart gives 'not in stock' as the reason that Mr Cunningham did not receive his Sinemet CR and carbamazepine and 'on syringe driver' as the reason he did not receive the triclofos at 22.00h (page 754).

The nursing summary notes read 'Mr Farthing has telephoned. Explained that a syringe driver containing diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode when Arthur tried to wipe sputum on a nurse saying he had HIV and was going to give to her. He also tried to remove his catheter and emptied the bag and removed his sacral dressing throwing it across the room. Finally, took off his covers and exposed himself (page 867). Syringe driver changed to 20.20h contains diamorphine 20mg and midazolam 20mg, appears less agitated this evening (page 868).

Nursing care plan relating to the ulcer notes '23.00h. Dressing came off. Reapplied as above' (page 880). Further entries on the 24th, 25th and 26th of September all report renewal of the dressing with no comments that it was of any discomfort or distress to Mr Cunningham (page 880).

Nursing care plan entry relating to settling for the night notes 'Driver running as per chart. Very settled night. Blood sugar 5mmol/L at 06.00h (page 876).

23rd September 1998

The drug chart reveals that Mr Cunningham took Sinemet-110 at 06.00h (page 753). The 'Exception to prescribed orders' section of the drug chart gives 'unable to take' as the reason that Mr Cunningham did not subsequently receive his co-proxamol, risperidone, Sinemet-110, carbamazepine and triclofos (page 754). A syringe driver containing diamorphine 20mg, hyoscine 400micrograms and midazolam 20mg SC over 24h was commenced at 09.25h. This was discarded at 20.00h to be replaced by one containing diamorphine 20mg, hyoscine 400microgram and midazolam 60mg (page 756).

The nursing summary notes read 'Seen by Dr Barton. Has become chesty overnight to have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to the commencement of syringe driver and informed that Mr Cunningham was on a small dosage which he needed. To phone him if any further deterioration' (page 868) An entry timed 13.00h reads 'Mr and Mrs Farthing seen by me - Sister Hamblin and Staff Nurse Freda Shaw. Very angry that driver had been commenced. It was explained yet again that the contents of his syringe driver were to control his pain. It was also explained that the consultant would need to give her permission to discontinue the driver and we would need an alternative method of giving pain relief. Has also been seen by Pastor Mary for 1½h

this afternoon. He is now fully aware that Brian is dying and needs to be made comfortable. Driver renewed at 20.20h with diamorphine 20mg, midazolam 60mg and hyoscine 400microgram. Family have visited. (page 868).
Nursing care plan entry relating to settling for the night notes 'Became a little agitated at 23.00h, syringe driver boosted with effect. Seems in some discomfort when moved, driver boosted prior to position change. On back at time of report. Sounds chesty this morning. Catheter draining urine very concentrated (page 876).

24th September 1998

Entry in the medical notes reads 'Remains unwell. Son has visited again today and is aware of how unwell he is. SC analgesia is controlling pain just. I am happy for nursing staff to confirm death.' This note is written out of sync, most likely in error, on the page preceding the first inpatient entry (pages 643, 645).

At 10.55h a syringe driver containing diamorphine 40mg, hyoscine 800microgram and midazolam 80mg was commenced (page 756).

The nursing summary notes read 'Report from night staff that Brian was in pain when being attended to. Also in pain with day staff especially his knees. Syringe driver renewed at 10.55 with diamorphine 40mg, midazolam 80mg and hyoscine 800micrograms. Dressing renewed this afternoon – see care plan. Son – Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition. In the event of death, Brian is for cremation' (page 869). A later entry timed 21.00h notes 'Mr Cunningham's grandson telephoned, informed of grandfathers condition. Nursed on alternate sides during night, is aware of being moved. Sounds "chesty" this morning. Catheter draining (page 869).

Nursing care plan entry relating to settling for the night notes 'All care given, nursed from side to side. Peaceful nights sleep. Syringe driver running as prescribed. On back at time of report. Starting to sound chesty this morning (page 876).

25th September 1998

An entry in the medical notes reads 'Remains very poorly. On syringe driver. For TLC (tender loving care)' (page 645).

A new drug chart was written with prescriptions for diamorphine 40–200mg, hyoscine 800microgram–2g and midazolam 20–200mg all SC over 24h (page 837). Mr Cunningham received a syringe driver containing diamorphine 60mg, hyoscine 1200micrograms and midazolam 80mg (page 837).

The nursing summary notes read 'All care given this a.m. Driver recharged at 10.15h, diamorphine 60mg, midazolam 80mg and hyoscine 1200microgram.....Son present at time of report, carer also visited' (page 869).

Nursing care plan entry relating to settling for the night notes 'peaceful night, position changed still does not like being moved' (page 876).

26th September 1998

An entry was made in the medical notes by nurses Turnbull and Tubbritt to confirm Mr Cunningham's death at 23.15h (page page 645).

A syringe driver containing diamorphine 80mg, hyoscine 1200microgram and midazolam 100mg was commenced at 11.50h (page 837).

The nursing summary notes read 'Condition appears to be deteriorating slowly. All care given. Sacral sore redressed, mouth care given. Driver recharged and 11.50h, diamorphine 80mg, hyoscine 1200micrograms, midazolam 100mg. No phone calls from family this a.m. Mrs Sellwood phoned to enquire on condition (page 869). A later entry timed 'night' reads 'Brian's condition continued to deteriorate' and noted that he died at 23.15h (page 869 and 872).

Nursing care plan entry relating to settling for the night notes 'Condition continued to deteriorate. Relatives informed. Arthur died peacefully at 23.15h' (page 876 of 928).

28th September 1998

An entry in the medical notes by Dr. Brook reads "Death Certificate D/W (discussed with) Dr Lord". I. Bronchopneumonia, II. Parkinson's disease, sacral ulcer (page 645 of 928). The copy of the entry in the death register, records cause of death as Ia. Bronchopneumonia only.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Arthur CUNNINGHAM was a Clinical Assistant Dr Jane Barton. The medical care provided by Dr Barton to Mr Cunningham following his transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (Good Medical Practice, General Medical Council, October 1995, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination.
- in providing care you must keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

The medical records were examined by two independent experts. Dr David BLACK in his review of Dr Barton's care reported specifically:-

In my view the dose of Diamorphine and Midazolam was excessive on 25th and 26th and the medication may have slightly shortened life. This opinion does not meet the standard of proof of "beyond reasonable doubt". I would have expected a difference

of at most, no more than a few hours to days if a lower dose of either or both of the drugs had been used instead during the last few days.

Dr Andrew Wilcock reports,

1. The notes relating to Mr Cunningham's transfer to Dryad Ward are inadequate. On admission, even when a patient is already known to the service, they are usually clerked highlighting in particular the relevant history, examination findings, planned investigations and care plan.

2. It is unclear why the syringe driver was prescribed p.r.n. on the 21st September 1998. No instructions were given on the drug chart on when the syringe driver should be commenced, what drugs it should contain, in what dose, how this would be decided and by whom. The dose of diamorphine was initially written as a wide dose range of 20–200mg with no justification given for this in the medical notes. Based on Mr Cunningham's existing opioid dose, whilst a starting dose of 20mg was reasonable, the higher doses are likely to be excessive for his needs. In patients with cancer, it is unusual if opioid requirements have to be increased by more than 3-fold in the terminal phase (check Lancet paper – may need to adjust), i.e. in Mr Cunningham's case, an increase from 20mg to 60mg would not be that unexpected. The need for a 10-fold increase however, i.e. 20mg to 200mg, is rarely necessary and likely to be excessive for his needs. Similarly, the indications for the prescription of the hyoscine hydrobromide and midazolam should have been documented in the medical notes.

3. It is unclear why Mr Cunningham received the 10mg dose of morphine.

4. It is unclear why the syringe driver was commenced on the 21st September 1998. The nursing notes retrospectively suggest that the syringe driver was commenced to allay Mr Cunningham's anxiety and pain. It is not clear who decided to start it, the drugs and the doses to use. It should be clarified why, if he was able to take oral medication, his usual medication had not been offered to him, or if he was unable to take oral medication, why stat SC doses of a sedative or analgesic were not considered appropriate.

5. Justification for continued increase in diamorphine, midazolam and hyoscine. Mr Cunningham's diamorphine was increased four-fold and his midazolam five-fold over a six day period. This appeared from the nursing notes to be due to Mr Cunningham being 'aware of being moved/does not like being moved'. The reason for the final increase is not clear. Mr Cunningham appeared comfortable in between times 'peaceful nights sleep/'peaceful night'. In this setting increasing the regular analgesic/sedative is not always effective in my experience and other strategies could have been considered, e.g. minimising turning, stat SC doses of diamorphine and/or midazolam prior to turning. Dr Barton could have sought advice, particularly when several dose increments had not been effective in

preventing Mr Cunningham's apparent distress on turning. Other practitioners may well have followed a similar course of action however.

Interview of Dr Jane Barton.

Dr Jane Barton has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified as a registered medical practitioner in 1972. In addition to her GP duties she took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 21st April 2005 Dr Barton in company with her solicitor Mr Barker, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Arthur Cunningham at the Gosport War Memorial Hospital. The interviewing officers were DC Yates and DC Quade.

The interview commenced at 0902hrs and lasted for 30 minutes. During this interview Dr Barton read a prepared statement, later produced as JB/PS/5. This statement dealt with the specific issues surrounding the care and treatment of Arthur Cunningham.

The expert response to the statement of Dr Barton is awaited.