DAY 2

A THE CHAIRMAN: Good morning everybody. Mr Kark?

MR KARK: I was about to move on to deal with Patient G, who is Arthur Cunningham. Arthur Cunningham was 79 years old when he was admitted to the hospital, to Dryad Ward, on Monday 21st September 1998 under the care of Dr Lord, the consultant to whom he was known. He had been admitted to the psychiatric ward, Mulberry Ward, some months earlier, on 21st July 1998, when he was depressed and tearful, and since 27th August that year he had

B been living in a local nursing home known as 'The Thalassa'.

He had been seen at the Dolphin Day Care Hospital by Nurse Pamela Gell, where he was found to be very frail, with a large necrotic sacral sore. He was depressed, he suffered from dementia and he was diabetic. Dr Lord decided that he should be admitted to Dryad Ward for treatment of his sacral ulcer, and she wrote on the day before his admission – and in due course when you have these notes you will find it at page 644 – she wrote that he was to be

C admitted to Dryad Ward for treatment of his sacral ulcer; he was to be given a high protein diet, and Oramorph if he was in pain. Dr Lord notes that the nursing home was to keep his bed available for him to return for at least three weeks, but his prognosis was described as being 'poor'.

GELL

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The day after that note, Dr Barton saw him on the day of his admission, on 21 September, and she made the following note:

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"Transfer to Dryad Ward. Make comfortable, give adequate analgesia. I am happy for nursing staff to confirm death."

It appears that she prescribed Oramorph 2.5 to 10 mg as required, and diamorphine at a variable dose of between 20 mg and 200 mg, and midazolam between 20mg to 200 mg, and she wrote out that prescription, it would appear, on that very day, even though in fact the

E prescription was undated. Really, it seems, as soon as he arrived at Dryad Ward, or soon thereafter, he was given Oramorph 5 mg at 2.15 in the afternoon, and then 10 mg at 8.15 in the evening.

I say that the prescription was undated, but it has to be presumed to be the 21st because he was in fact also put onto a syringe driver on that same day, at ten minutes past eleven that night, to deliver opiates to him automatically.

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Dr Barton's explanation for her prescription, to the police, was that she was concerned that the Oramorph might become inadequate in terms of pain relief.

The patient's stepson Charles Stewart-Farthing went to see him on the Monday of his admission, so before the syringe driver had started, and he found him to be cheerful but complaining that "his behind was a bit sore". The patient was started on a syringe driver that

G night at a rate of 20 mg diamorphine and 20 mg midazolam; and according to Nurse Lloyd's notes the other drugs he had been on, co-proxamol and senna, were not given because the patient was being or about to be sedated. The notes reveal that the patient remained agitated until approximately 8.30 in the evening, and they also reveal, frankly, that the patient had been behaving pretty offensively. However, the driver was not commenced, as I say, until ten past eleven that night, and by that time, before the driver was commenced, the patient was described as 'peaceful'. That may well have been as a result of the Oramorph kicking in, as it

H were. So it is hard to glean, at least from the notes what caused the commencement of the

LLOYD

A syringe driver. Nurse Lloyd states that although the patient was peaceful, it was not certain that he would remain that way.

LLOYD

Two days later, on Wednesday 23rd , the medication was increased to 20 mg diamorphine but 60 mg midazolam. A note made by Nurse Hallman records that he was seen by Dr Barton on the 23rd, he had been chesty overnight, and so hyoscine was added to the driver. That note is at page 868 of the records.

HALLMAN

B

His stepson, Charles Stewart-Farthing, was informed of a deterioration and he asked if it was due to the commencement of the driver. He was informed that the patient was on a small dosage, which he needed. Charles Stewart Farthing saw his step-father again that day, two days after he had last seen him, when he described him as being cheerful but complaining that his behind was a bit sore, and when he saw him, now on the Wednesday, he found his step-father to be unconscious, and he was shocked by the difference in his condition. He was so concerned that he asked for the syringe driver to be stopped so that at least he could have a conversation with his stepfather, but this was denied.

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He insisted, apparently, on a meeting with Dr Barton, who informed him that the patient was dying due to his bedsores and that it was too late to interrupt the administration of the drugs. Dr Barton says that she reassessed the patient on a daily basis; but if she did, she failed to make any notes about it, and she refers in her police statement to the doses the patient received as "small and necessary".

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On the following day, Thursday 24th, the midazolam was increased to 80 mg, and on the following day after that, the 25th, the diamorphine was increased to 60 mg. That followed a further prescription from Dr Barton dated Friday 25th now for a variable dose between 40 mg to 200 mg diamorphine and 20 mg to 200 mg of midazolam, so the lowest dose of the diamorphine had gone up.

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On each occasion that the dose was increased, Dr Barton claims in her police statement that she "anticipates that the patient's agitation might have been increasing".

The following day, Saturday 26th, the diamorphine was delivered to the patient's body at a rate of 80 mg, and the midazolam at a rate of 100 mg. That of course was well within the variable dose that Dr Barton had prescribed. The patient died at 11.15 that night apparently, according to the death certificate, of bronchopneumoniA

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The first prescriptions on the day of his admission written out by Dr Barton are described by Professor Ford as "highly inappropriate" and "reckless", particularly in light of Dr Lord's assessment, as you will recall, from Haslar, that he should be prescribed intermittent Oramorph if in pain. There is no doubt that the patient would have been in pain from his sacral sore, but there was no indication prior to him getting to the GWMH that the patient have been unable to take any medication. The prescription written by Dr Barton which allowed the nurses to administer the diamorphine and midazolam was undated but, as I say, it must have been written on the day of admission because it was administered that night, and was for a dose range of between 20 mg to 200 mg diamorphine, and 20mg to 80 mg midazolam. It was, according to Professor Ford, poor management to prescribe those drugs to an elderly frail underweight patient – I think the patient at this time weighed about 68 kg – and it created the hazard that the combination of drugs could result in profound respiratory

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A depression. You will recall the guidance, or course, in the *BNF* about reducing the dosage for elderly patients.

The increases on the 23rd and thereafter are described as inappropriate and dangerous by Professor Ford. He also expresses the concern as to whether the nursing staff would have understood how long it takes for the opiates delivered through a syringe driver to take full effect, which in this case would have been between 15 and 25 hours. So it appears, in fact, in

B the records that they were being increased before they would have the full effect in the original dose.

As his condition worsened, in all likelihood, we submit, as a result of the drugs which were being administered to him, there was apparently no assessment to discover the cause – or at least none that was recorded. Dr Barton admits that she did not seek advice from a consultant, as she could, and we say should, have done.

C

The various dose increases without explanation is described as very poor practice. Even if that was being done independently by the nurses, Dr Barton, we say, had created the situation where that had become a possibility.

The administration of 100 mg midazolam and 80 mg diamorphine would produce respiratory depression and severe depression of the consciousness level.

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In addition to all of this there is no note that the patient was provided with food or fluid during the period following his admission until his death five days later, and that is despite the note from Dr Lord that the patient was to be provided with a high protein diet. The very opposite seems to have occurred.

The cause of death, given as bronchopneumonia, can occur as a secondary complication to

E opiate-induced respiratory depression.

Let me turn to Patient H, better known as Robert Wilson.

Robert Wilson was 75 years old when he was admitted to Queen Alexandra Hospital on 21 September 1998. He had sustained a fracture of his humerus bone following a fall. Whilst at the Queen Alexandra Hospital he was given relatively small doses of morphine for pain.

F On assessment his Barthel score was 5.

On 7 October it was noted that he did not want to go into care but wanted to return home. He was seen by a Dr Luznat, who was a consultant in old age psychiatry. She noted that he had been a heavy drinker during the previous five years, and she thought he may have developed early dementia.

G The following week, on 13th October, which was a Tuesday, he was assessed by his consultant physician at the Queen Alexandra Hospital, Dr Ravindrane, who found that he needed both nursing and medical care, and that a short spell in a long-term NHS hospital would be appropriate. Dr Ravindrane felt that he would remain at risk of falling until fully mobilised and he thought that the patient's kidney function should be reviewed. He prescribed his patient frusemide, which is a diuretic, and for pain relief he prescribed paracetamol. The patient could, according to the doctor, have stabilised or alternatively he

H could have died quite quickly.