LANGDALE (closing remarks)

DAY 39

THE CHAIRMAN: Good morning, everybody. Mr Langdale, you look fresh and ready to go, or perhaps not!

MR LANGDALE: No comment is the appropriate response! Turning to this last group of patients, if I may, I am starting with Mr Cunningham, Patient G. Again, I am going to follow the same method, if I may, of basing what I seek to say to the Panel on the patient history, so using the patient history for Mr Cunningham. I am going to begin by going, as it were, straightaway to page 8 of the patient history where one can see the situation with this gentleman as of the latter part of September 1998. On page 8, Monday 21 September, there is the review by Dr Lord and, over the page on to page 9, one can see the clinical notes of Dr Lord with regard to this patient, "Very frail. Tablets found in mouth ..." and so on. You will remember the "offensive large necrotic sacral ulcer with thick black scar" and so on. She set out a plan for him. It is not his only problem; he has the old back injury, depression and an element of dementia, diabetes mellitus and a catheter for retention. She sets out the plan and prescribes in the sense of prn Oramorph. It is important to bear in mind, since this is a man who has not been on opiates in general terms before this, that Professor Ford does not criticise the prescription for Oramorph. I suppose, following his own arguments, one would try to say that it should have been a step two analgesic of some kind but, no, he says this was perfectly reasonable to do so. If that is right in this, by way of illustration, why is Dr Barton criticised in other cases in relation to prescriptions of Oramorph in similar kinds of situations? Dr Lord indicated that so far as this patient was concerned, really what were the options? It was not sensible to return him to the nursing home and ask them to deal with the problem because it had developed there. The alternative was to send him to an emergency department at Queen Alexandra. That simply was not on. The appropriate course was to see whether this nursing care that could be provided at Gosport would succeed.

In terms of her evidence because Dr Lord's clinical notes end by saying "prognosis poor", she said that the outlook was not good for the various reasons that are set out there. In her view, the ulcer would take several months to heal. He was really quite distressed and that is the reason why she gave him Oramorph. She was asked about palliative care and she indicated that the treatment was to palliate his symptoms, in particular the ulcer. The quality of life, even with the ulcer treated in terms of his prospects, he might possibly be able to go to a nursing home. This was of course a worst grade pressure sore and, as Dr Lord made it clear, with someone as frail as this and with a sore like this, the chances of healing were remote. She illustrated the fact that he was unable for example to lie on his side. Bearing in mind that situation, it is perhaps not surprising that Professor Ford indicated that obviously this patient had a lot of problems.

I move over the page to page 10 where one sees Dr Barton's review of him and it says "on Mulberry Ward" but in fact it was Dolphin Day Hospital and this is the patient whom she actually accompanied from Dolphin Day Hospital on to Dryad Ward. So far as Dr Barton is concerned in her evidence, when she saw him, her view was that there was a remote possibility that they would successful treat the sacral ulcer. She was really thinking in terms of palliative care just as indeed Dr Lord had indicated was the appropriate situation. She was happy to follow the plan with regard to the sacral wound and tried to improve his nutrition. As she described it, "It was the second worst sacral sore I had seen. I was not so concerned about his nutrition as with making him comfortable".

The matter is then set out in the significant events documents and the nursing care plan. Dr Barton's evidence in terms of a syringe driver in relation to this general issue that was

raised with her is that it would not be unjustified to set up the syringe driver if he was not in pain. Agitation, distress, fright – if it was appropriate, one could start the syringe driver. She said that she was being realistic about his prospects, that he was likely to be toxic, that is the toxins in the blood as a result of a necrotic sacral sore. It is clear when one looks at page 10, bearing in mind that there is a history which follows, that it is worth bearing in mind that certainly in the evening on which he was commenced on the syringe driver, he was not so sedated that he could not drink. It is clear that he was able to take glasses of milk when awake. One perhaps moves on to page 12 to see what was prescribed by Dr Barton on the day of admission. Oramorph – there is no complaint about that I do not think; in the circumstances, it is difficult to see how there could possibly be – the anticipatory prescription is written up by her and in fact, in this particular case, it was later administered on the same day that it was written up. It is very important, we suggest, to bear in mind that it is not right to describe the prescribing, the anticipatory prescription, as putting Mr Cunningham on a terminal care pathway. That was the suggestion made by Mr Kark in his concluding address to you and that just is not right. It is the administration later on in the day that signifies that the nursing staff were treating him as being on the terminal care pathway.

Dr Barton, in terms of that prescription, so far as her evidence is concerned, spoke about it on Day 28 and I am quoting passages from pages 5, 6 and 7. She said that she was aware when she saw him at the Day Hospital with Dr Lord that there had been problems with his tablets, that he had difficulty swallowing them,

> "... and that if we were going to give adequate analgesia we might well need to give this subcutaneously rather than as tablets or orally. I know he had taken milk overnight but his eating and drinking, and his taking of tablets, was possibly a bit suspect".

She was asked about what was her rationale in relation to starting the syringe driver and she is dealing of course with the question of the psychotic episode which occurred on the evening of his arrival,

> "A In my opinion there were two main reasons for starting the syringe driver. My advice to my day staff, when I saw Mr Cunningham that afternoon, would have been, 'Start with the Oramorph, but you do have a pro-active prescription for the syringe driver should his distress and pain deteriorate and you feel you are going to be able to manage it with oral medication'. Both the diamorphine and the midazolam would have been ideal medication to control his discomfort, distress, anxiety overnight, as well as the pain he was receiving. ... So that was what the pro-active prescription was for".

She did not have any recollection of being contacted about this and, when she was asked why she did not administer something for

> "his agitation, psychotic behaviour ... as opposed to administering subcutaneous analgesia?"

she said,

> "Because if you felt that the underlying cause for this behaviour, which was not typical of him, was the pain and the toxicity of the sacral sore, it would seem more

A humane to treat it using the subcutaneous analgesia and anxiolytic, rather than giving him a major tranquiliser".

Then,

> "Q There is no record of him actually being in pain. Obviously the sacral sore, the sacral ulcer, would have been very painful in any event".

B In terms of haloperidol, she said:

> A ... it was not just an acute episode that was not going to last. In my opinion it was all related to the toxic state and the anxious state he was in due to the sacral ulcer and the indignity of being brought into the ward and the dressings being done, it was a whole picture of that man in that bed, not the theoretical elderly medical problem of
> C somebody suddenly becoming anxious and behaving badly"

and she said that she would have seen him the following morning, the Tuesday, and would have been very content with the improvement in his state of comfort. Just bearing in mind the incident that occurred, it is not right to see it as one incident. There are plainly two on the day of his admission. If we go back to page 10, we can see the note made by Nurse Lloyd halfway down on the left-hand side that he remained agitated until approximately 8.30 in the
D evening. The syringe driver was not commenced until 11 o'clock and it is not because of the agitation at 8.30 that the syringe driver is commenced. If one looks over the page, one can see at page 11 the fact that he had been very agitated at 5.30 in the afternoon, had been given some Oramorph, that being at 20.20, and that he had pulled off the dressing to the sacrum. There is another instant – and this is the rather more dramatic incident – which is shown on page 13. This sets out why the syringe driver was commenced. If you look at the top on the left of page 13:

E

> "Mr Farthing has telephoned"

and it is worth noting that it is Nurse Hallman who made this note.

> "Explained that syringe driver commenced yesterday evening for pain relief and to allay his anxiety following an episode when Arthur tried to wipe sputum on a nurse ..."
> F

etc, etc. This is something rather different than there being a problem with him pulling off his sacral dressing.

> "Later syringe driver changed at 20.20. Contains diamorphine ..."

G and so on and that appears to be the following day.

Dr Lord, when asked about this, said, "He would not have known exactly how he was but it would be really unusual for us to stop a syringe driver" and this leads on to what Mr Farthing said about later requesting that the syringe driver be stopped. "It is always a balance. By and large, once you have decided, you stay with that option".

H

Professor Ford criticised this administration in terms of the subcutaneous analgesia and indicated that the real problem for him was the midazolam. It is worth bearing in mind Nurse Collins's evidence about this. She said how bad the sacral sore was in terms of the dressing at 18.30 and she said that was not the incident being described, the incident that she had witnessed herself. It is not the same as the one Nurse Hallman had noted. She said,

> "I imagine he had quite a severe pain from his sacral sore".

Over the page, looking at what happened on Wednesday 23 – this is the day when Mr Farthing says he was unconscious when she saw him – you can see from the note that he was contacted, that is Mr Farthing was contacted, and he asked if it was due to the commencement of the syringe driver and he was informed that Mr Cunningham was on a small dosage which he needed, and again that is Nurse Hallman. It cannot be claimed that that did not happen.

Dr Barton's evidence was that she did not feel he was over-sedated and there was no problem for her in reducing the dose if, in her view, he was. As Dr Lord said, "Whether it was appropriate in terms of reducing the dose in this case, I cannot say" and the reason she cannot say why is because she had not seen the patient. It is worth bearing in mind too when suggestions are made that this subcutaneous analgesia was not in the patient's best interests or was inappropriate that in fact the pain clearly continued. If you look on page 14 at the last paragraph on the left, "Seems in some discomfort when moved ..." and so on.

It is perhaps worth bearing this in mind in terms of the evidence of Mr Farthing who says that, on this day, Wednesday 23rd, Mr Cunningham was unconscious when she saw him. A statement was read, the statement of Shirley Sellwood, Day 6/26, a lady who was Mr Cunningham's domestic helper, recorded in fact as next of kin. She visited Mr Cunningham twice in Gosport War Memorial Hospital. She said in her statement that, a few days later, she got a call from the hospital saying that he was close to dying. Mr Cunningham died on Saturday 26 September. So, the day before she got a call from the hospital saying that he was dying, she visited him. She said that it was not his normal self.

> "... this time he asked me to leave as he was very drowsy and was being given Diamorphine".

That plainly means that she saw him when he was on the syringe driver, plainly not unconscious when she saw him. A small bit of evidence but pretty important, we suggest.

Dr Barton has explained, if one moves on to page 15, why the midazolam was increased. Professor Ford's view is that this was a very high dose and a very large increase and would definitely produce a very marked sedation. It is worth looking then at what the picture was the next day, Thursday 24 September, when Professor Ford says that is what would have happened,

> "Remains unwell. Son has visited again today and is aware of how unwell he is. [Subcutaneous] analgesia is controlling pain just".

Those are Dr Barton's notes. Dr Barton is not an unreliable person in recording what she observed. That does not indicate somebody who is over-sedated or having their conscious levels so lowered that it is a problem. The plain fact of the matter is that, on her evidence as

she gave it to the Panel, he was not exhibiting the signs of over-sedation and it is worth looking at the position generally with regard to what is recorded in terms of pain. Both day and night staff report pain on the 24th and indeed the following day, 25 September. Professor Ford indicated that he found it difficult to understand how the nursing staff could know this patient was deeply unconscious and unrousable. He seems perhaps unprepared to accept that he might not have been unconscious at least at times. If you look over the page you can see the remark, the Panel may remember it, on page 16, the day staff are recording the fact that he was in pain when being attended to:

> "...also in pain with day staff, especially his knees."

That does not appear to indicate somebody who is unconscious or unrousable. The diamorphine is increased at page 16 at the bottom, Dr Barton's evidence. This was an increase on her authorisation and one can fairly ask this question, or make this statement about it – it is simply not credible that Dr Barton would have increased the dosage if this man was unconscious, over sedated or was respiratorily depressed. There was no reason to do that. The only sensible conclusion, we suggest to the Panel, that should be drawn is that the increase was justified because his pain, distress and agitation was not controlled.

That is not simply an extraordinary view of Dr Barton's, because if one goes over the page to page 17, another doctor came on the scene on Friday 25 September, Dr Brooke. Obviously he did not consider that this patient was over sedated in an improper sense. What did he do? He recorded the fact in his clinical notes:

> "Remains very poorly. On syringe driver. For TLC."

That does not appear to be a contention that can be supported to suggest that there was something inappropriate about what he was receiving when Dr Brooke himself had seen the patient and certainly did not disagree with what was being done.

On page 18, Saturday 26th, it is worth bearing in mind, Dr Lord, who said that:

> "The death of this patient did not cause her any concern. I heard that he had passed away. I did not look at the notes."

This was a patient she could remember with whom she had had quite a history on certain occasions. I think it starts on the date I mentioned in terms of critical matters, but it goes back to early 1998, so somebody who would have, no doubt, registered with her if there had been anything surprising about his having passed away at Gosport in this way.

Professor Ford found it difficult to conclude that the drugs did not play a part in causing death. He was at high risk of getting bronchopneumonia anyway.

Therefore one is left again with the situation as applied to a number of other patients, the administration of subcutaneous analgesia may have played a part in causing death, but if it was administered to prevent pain and distress, that is not something that can be held against Dr Barton.

In relation to the charge, as far as Mr Cunningham is concerned, if I can draw the attention of the Panel to that, it is allegation 8 on page 8 of the document. I think in all the matters I have

submitted to the Panel so far, it is clear what the defence answer is to those aspects of charge. Just looking at 8(d) there is an allegation that she did not obtain the advice of a colleague when Mr Cunningham's condition deteriorated; no she did not. It is difficult to see from any source as to why she should have consulted any colleague in relation to the deterioration of his condition. I do not think there has been any specific evidence adduced to say that she should have done.

I turn to the next patient, Patient H, Mr Wilson. Mr Wilson is the person who had problems with alcoholic liver disease and so on and who sustained, following a fall, a fractured left humerus, which is notorious – we have heard in the evidence, as being a very painful fracture indeed. He was in Queen Alexandra Hospital for a number of days, somebody who was not ready to have any surgical intervention in relation to the fracture and somebody who was plainly given, although at times he also appears to have not wanted enough, analgesia at such a level that his pain was not controlled.

It is worth bearing in mind, we suggest, when considering Professor Ford's criticisms of the administration of morphine to this patient on the basis that he was somebody with the liver problem, that he was prescribed intravenous morphine analgesia when he was at QAH, page 3. They did not feel his liver disease prevented that being a proper administration. Over the page, page 4, on the 23 September, morphine by means of subcutaneous injection. They did not feel it was inappropriate that that further administration should be given. We can see the references to morphine which continue as we move through the pages – page 5, 24 September, "Diamorphine given with little effect", and then given again, it seems; a total of 5 mgs that is injected directly. Hardly a sign of the hospital feeling they could not administer morphine with this man's background.

There are times when he is drowsy in hospital. One of the relatives who gave evidence, Gillian Kimbley, said at the time she saw him in hospital, on page 7, 27 September, "He was in a terrible state, he did not even know who I was". Therefore, one can see the situation that pertained at times with regard to this particular patient. Drowsiness continues to be mentioned on page 9. The statement of the hospital was, page 9, On the left-hand side halfway down:

> "Not for resuscitation in view of poor quality of life and poor prognosis."

As well as the occasions when he received morphine, he received co-dydramol and so on.

Over the page, on page 10, on 30 September when he is reviewed by Dr Ravindrane, he remains drowsy. It is not being suggested that that was the effect of drugs. He was complaining of pain in his left arm and saying that the tablets were inadequate. Again, these references to drowsiness are perhaps important. It shows how patients whose condition is going downhill can be drowsy without being administered any opiates at all.

Further difficulties with regards to his nursing continue, as does his pain and discomfort. We can pick up on page 13, 4 October, when his arm is still remaining extremely painful. He is still refusing paracetamol, morphine is given as he was unsettled and uncomfortable. No problem for the hospital using that method of analgesia, yet Dr Barton is criticised for prescribing Oramorph, which we will come on to later on. The pain remains uncontrolled, the situation continues to deteriorate. On page 16, on 8 October Dr Lusznat reviews him.