Mr Kark (Closing Remarks) DAY 37

(Luncheon adjournment)

THE CHAIRMAN: Thank you, Mr Kark.

MR KARK: Sir, I was going to move on now to the case of Arthur Cunningham, Patient G. Again it is worth going back to the heads of charge, which once again are fairly limited. This patient was admitted for treatment to his very bad sacral ulcer. He was admitted from the Dolphin Day Hospital by Dr Lord, who well knew the abilities of GWMH and he had also, of course, been reviewed by Dr Barton herself. Dr Lord cannot surely be accused of an over-optimistic approach.

The heads of charge, so far as this patient is concerned, start at paragraph 8 and are specifically in relation again to the doses for diamorphine and midazolam on two occasions, 21 September and 25 September, and failing to obtain the advice of a colleague, or not obtaining the advice of a colleague when the patient's condition deteriorated.

As I say, the charges are very confined. There is also, of course, a lack of assessment before prescribing opiates and the additional charge that Dr Barton did not obtain the advice of a colleague is put simply in this respect. That is a fact which has been admitted and in due course you will have to decide whether that contributes in any way to an allegation of serious professional misconduct.

So far as the patient's progress is concerned, he was seen at the Dolphin Day Hospital on 21 September and reviewed by Dr Lord. He had a large necrotic sacral ulcer, which was described as "extremely offensive". He was being admitted with a view to more aggressive treatment of the sacral ulcer, and that was going to need this unpleasant chemical, apparently, called acerbine. But his social worker was to keep open his place at the Thalassa Nursing Home.

He was noted on 21st to have had tablets still in his mouth, although later on in fact we know he was able to drink some milk, so he was not unable to swallow anything. The plan from Dr Lord was that he should have acerbine for his sacral ulcer, he should be nursed on his side and he should have a high protein diet. Dr Barton saw him in the Dolphin Day Hospital and then he was literally wheeled, as we understand it, down the corridor to Dryad Ward.

The reality is that as soon as that patient was wheeled from one ward to another, he was almost literally on the terminal pathway because that is how we suggest this doctor approached his treatment. In her view it was not even practical to try to give him a high protein diet, as directed by Dr Lord - Dr Barton's evidence Day 29/62. Whatever the nurses were going to try to do for this patient, Dr Barton agreed with me that she would have spoken to the nurses and given her opinion that the best that could be done for this patient was to make him comfortable (Day 29/64).

That is quite important. The approach is governed from the top and in this case, on this ward, Dr Barton was the top. You will all recall that on the night of 21 September, on the day in fact of his admission, he has a period of agitation and frankly of behaving badly. Oramorph is given to him at 8.20. Ten minutes later he is described as no longer being agitated. Two and a half hours later the night staff appear to have thought it right to put this man on a syringe driver prescribed by Dr Barton. It is noted that that is "as requested" and nobody seems to know who made that request.

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Pausing for a moment, and going back and stepping away from this for a moment, we all know now because it has been agreed by a number of witnesses, that the starting of a syringe driver for any patient is the terminal pathway. So when this patient is wheeled from one ward to another and that same night he has got a syringe driver set up for him, that quite frankly was the end of any idea of treating his sacral sore, of rehabilitation or anything else.

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You heard from his stepson, Charles Stewart-Farthing, who described his step father as being, "Can be difficult. Had strong opinions". In summary he said, "When I first saw him on Dryad Ward he was perfectly normal. He said he had a sore butt. They said they decided to take him in for aggressive treatment so he knew what he was there for. He was quite frail and he had lost a fair bit of weight. He could not walk on his own but he could get in and out of a wheelchair himself. Nurse Hamblin said it was one of the worst sores she had ever seen".

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He said, "The following day I telephoned the ward and was told he had become aggressive to the staff. They had given him something to calm him down. I said I would be in the next day and would have strong words with him. On 23rd I went to the ward. He was unconscious, unrousable. He was totally different. He had gone from a normal person to someone who was totally comatosed. On 23rd I discovered the syringe driver and asked for it to be removed".

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This was first of all to Nurse Hamblin. "She said she couldn't. It was only the doctor who could authorise that. We came back the next day and Dr Barton did not come until the 24th at around 5 pm. He had not been conscious all day. Dr Barton told me bluntly that he was dying from the poisons emanating from his bed sores and she refused to remove the syringe driver due to the pain he would experience. I accused her or murdering him. The interview terminated rather quickly".

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That was Day 6, pages 2 to 23, where you will find his evidence. You will have to consider that. You have had a lot of evidence about the appropriateness or otherwise of reducing a dose so that a patient can at least speak. But let us go right back to the charges. What happens as this patient is wheeled from one ward to another? Dr Barton first of all prescribes him Oramorph. She then prescribes him diamorphine at the usual prescription and midazolam between 20 and 80 mg. We know that that night he had this episode of either acute bad behaviour on one view or acute distress on another. But the initiation of the

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syringe driver was some hours after that had happened and some hours after apparently this patient was no longer being agitated or aggressive.

Can I just remind you of the evidence of the nurses? Ingrid Lloyd told you at Day 15, page 84, that she had agreed that a syringe driver would commence in order that he remain in a pain-free and peaceful state. She said, summarising, "Although he was peaceful at 8.30 pm, it was not certain that he would remain so, and the syringe driver was commenced at 23.10.

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The drugs were prescribed to be given at our discretion".

That is a worrying circumstance, you may think, in which this gentleman who had been admitted to that ward on the same day for treatment of the sacral sore, is put by nurses on to the terminal pathway.

Professor Ford gave evidence about this patient on Day 21/50. He said in terms of the

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assessment and plan,

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"I think it has to be looked in the context that he has already had a detailed assessment by Dr Lord, so one would not expect that to be repeated",

So far as his plan is concerned. Then he was asked about the diamorphine and midazolam, and he said this:

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"It appears in my initial report to Hampshire Police; I indicated it might raise concerns that the midazolam and diamorphine infusions were commenced to control his behaviour and sedate him.

Q And how appropriate or inappropriate would that be?

A He is taking Oramorph, so he is getting morphine to control the pain, so there is no need to change that unless he is refusing to take medication, which this note does not say. Midazolam is not a treatment for behavioural difficulties and agitation in older people. It is, to remind ourselves of the Wessex protocols, a treatment for terminal restlessness".

Code A

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He was asked,

"First, if the nurses had started diamorphine and midazolam inappropriately and the doctor treating this patient comes across that, what in your view could or should the doctor have done?

A At this point, the first thing is there was a recognition that the patient should have pain treated, so the first thing to assess is are they in pain, and do they have any adverse effects from the diamorphine that they are now receiving".

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He said,

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"That might likely require adjustment or conversion back to oral morphine, in the sense he is able to swallow. I really would be very critical about the continuation of midazolam because this is highly likely at this dose, if one continues it, to produce marked sedation, particularly in the context of giving a large dose, starting dose, of the 20mg or 60 mg of oral morphine equivalent".

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A ... You would always review drug management for agitation and behavioural problems unless, obviously, we are now in a position where it has been decided he is dying and for terminal care."

Code A

Just pausing for a moment, if the nurses had that night inappropriately put this patient on a syringe driver, the doctor needs to review that – needs to review the reason for that – the next day. In this case, the doctor had every reason for reviewing it because Mr Stewart-Farthing was asking her to do so. Dr Barton agreed when she gave evidence. We will go back to what happened with the doses of midazolam which in fact were tripled. Dr Barton agreed that Charles Stewart-Farthing was clearly a caring and loving relative, but she described as inhumane and abhorrent the suggestion that the patient's infusion should be stopped or reduced – Day 26/69 and Day 31/11.

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This patient, two days earlier, when Charles Stewart-Farthing had seen him, had been sitting up in bed asking for chocolate. You may think it would have done little harm to reduce the dose sufficiently to be able to speak to the patient, even if it was for the final time. You will recall – and I am sorry I do not have the reference for this – that Dr Barton eventually agreed that if the patient says to her, "Please, take that thing out. I am not consenting to have a syringe driver," she would have to follow that instruction. One wonders what would have happened in this case if that conversation had taken place. Dr Barton's comment to me, Day 29/72: "...your idea of withholding analgesia from somebody who was dying was just abhorrent to me."

As you know, he was started on the syringe driver that night, and it continued. It continued throughout the next day and then, on 23 September, there is a comment that he became a little agitated again at night, and the following day the diamorphine continues, but the midazolam is tripled up to 60 mg.

Professor Ford said this, Day 21/53:

> "A ... One of the problems of using sedation therapy is exactly this. It sedates people and they are unable to communicate at the end of life, and that is why, irrespective of any effects it may have on shortening life, it has to be weighed up very carefully if you introduce sedation therapy because it means you have somebody dying who is no longer alert who might otherwise be."

This was a very large dose. This is page 53 again – "this was a very large dose, a very large increase" in relation to the midazolam. There was no attempt to titrate or adjust it. What could have been done was to reduce the midazolam at this point and see what happened. He was variable in his agitation. We had the problem that it was possible that it was the diamorphine and its metabolites that might be worsening his agitation. If you have somebody who is over-sedated, it is best to stop for a few hours and then see what happens to the patient, and re-start the infusion at a lower rate. He said:

> "A ... I think the fact that he became unconscious, it is very likely that drugs contributed to respiratory depression and him getting bronchial pneumonia. But he was at high risk of getting bronchial pneumonia and dying anyway, so again you cannot conclude that the drugs definitely caused his death."

Finally this, in relation to 24 September, which was the day when the diamorphine was first of all doubled to 40 mg, and then the same day increased again to 60 mg, the midazolam then went up to 80 mg, there was this CPN note: "Physical decline. Pressures sores development. Admitted to Dryad Ward, terminally ill. Not expected to live past the week-end." That is referring to a staff report on 24 and 25 September, the 24th being the day when these drugs were increased, as I have just indicated. Professor Ford said, "It is unclear what they are observing in their response to pain. This is a man who was, as far as we can see, not complaining of major pain. He was obviously thought to have some discomfort when he was seen at the Dolphin Day Hospital. Then he has escalated within a very short period to a very high dose of diamorphine. It is a very dramatic change. At the same time, he has also been escalated to a very high dose of midazolam. I find it very difficult to know what signs the nurses were interpreting, as to whether this man was in pain or not." That is Day 23/25.