Code A

Code A

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Operation ROCHESTER.

Key Points.

Arthur CUNNINGHAM. Born 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.

<u>Expert Witness Dr David BLACK (Geriatrics) comments:-</u>

- 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.

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

OPERATION ROCHESTER

Investigation Overview 1998-2006.

Background.

Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed during much of the period under investigation by the Fareham and Gosport Primary Care Trust. The hospital fell under the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002 when services were transferred to the local Primary Care Trust.

The hospital operates on a day-to-day basis by nursing and support staff employed by the PCT. Clinical expertise was provided by way of visiting general practitioners and clinical assistants, consultant cover being provided in the same way.

Elderly patients were generally admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who in 1988 took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

Police Investigations.

Operation ROCHESTER was an investigation by Hampshire Police into the deaths of elderly patients at GWMH following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at levels or under circumstances that hastened or caused death. There were

further concerns raised by families of the deceased that the general standard of care afforded to patients was often sub-optimal and potentially negligent.

Most of the allegations involved a particular General Practitioner directly responsible for patient care Doctor Jane BARTON.

Two allegations (SPURGIN and PACKMAN) were pursued in respect of a consultant Dr Richard REID.

Of 945 death certificates issued in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Doctor BARTON.

The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr BARTON.

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Dr BARTON to continue to practice should be withdrawn. On each of the three occasions that the matter was heard the GMC was satisfied that there was no requirement for such an order and Dr BARTON continued to practice under voluntary restrictions in respect of the administration of Opiate drugs.

<u>The First Police investigation.</u>

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS aged 91 years.

Mrs. Richards died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. Richards two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

The Reviewing CPS Lawyer determined that on the evidence available he did not consider a criminal prosecution to be justified.

Mrs. MACKENZIE then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

Hampshire Police commenced a re-investigation into the death of Gladys RICHARDS on Monday 17th April 2000.

Professor Brian LIVESLEY an elected member of the academy of experts provided medical opinion through a report dated 9th November 2000 making the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."

- "Mr. Philip James BEED, Ms. Margaret COUCHMAN and Ms. Christine JOICE were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs. RICHARDS was unlawfully killed."

A meeting took place on 19th June 2001 between senior police officers, the CPS caseworker Paul CLOSE, Treasury Counsel and Professor LIVESLEY.

Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

Professor LIVESLEY provided a second report dated 10th July, 2001 where he essentially underpinned his earlier findings commenting:-

- "It is my opinion that as a result of being given these drugs Mrs RICHARDS death occurred earlier than it would have done from natural causes."

In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH as a result four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY were reviewed by the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to

the RICHARDS case and would therefore attract a similar response as the earlier advice from counsel. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October 2001 the Commission for Health Improvement (CHI) launched an investigation into the management provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible at GWMH interviewing 59 staff in the process.

A report of the CHI investigation findings was published in May 2002 concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality patient care.

The CHI further reported that the Trust post investigation had adequate policies and guidelines in place that were being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer Sir Liam DONALDSON commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor BAKER. Immediately following the meeting nurse Anita TUBBRITT (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

The documents were copies of memos letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including :-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol).
- Particular concerns regarding the conduct of Dr BARTON in respect of prescription and administration of Diamorphine.

Nurse TUBRITT'S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19th September 2002 the following decisions being made:-

- Examine the new documentation and investigate the events of 1991.
- Review existing evidence and new material in order to identify any additional viable lines of enquiry.
- Submit the new material to experts and subsequently to CPS.
- Examine individual and corporate liability.

A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

On 23rd September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients that had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns (including the five original cases)

In addition Professor Richard BAKER during his statistical review of mortality rates at GWMH identified 16 cases which were of concern to him in respect of pain management.

14 further cases were raised for investigation through ongoing complaints by family members between 2002 and 2006.

A total of 92 cases were investigated by police during the third phase of the investigation.

A team of medical experts (key clinical team) were appointed to review the 92 cases completing this work between September 2003 and August 2006.

The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

The terms of reference for the team were to examine patient notes initially independently and to assess the quality of care provided to each patient according to the expert's professional discipline.

The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1- Optimal care.
Category 2- Sub optimal care.
Category 3- Negligent care.

The cases were screened in batches of twenty then following this process the experts met to discuss findings and reach a consensus score.

Each expert was briefed regarding the requirement to retain and preserve their notations and findings for possible disclosure to interested parties.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN to further confirm the decision that there was no basis for further criminal investigation.

Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly were referred to the General Medical Council and Nursing and Midwifery Council for their information and attention.

Fourteen Category 3 cases were therefore referred for further investigation by police. Of the fourteen cases, four presented as matters that although potentially negligent in terms of standard of care were cases where the cause of death was assessed as entirely natural. Under these circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.

Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant Geriatrician Dr David BLACK who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.

Accordingly the four cases ...Were released from police investigation in June 2006:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR

The final ten cases were subjected to full criminal investigation upon the basis that they had been assessed by the key clinical team as cases of 'negligent care that is to day outside the bounds of acceptable clinical practice, and cause of death unclear.'

The investigation parameters included taking statements from all relevant healthcare staff involved in care of the patient, of family members and the commissioning of medical experts to provide opinion in terms of causation and standard of care.

The expert witnesses, principally Dr Andrew WILCOCK (Palliative care) and Dr David BLACK (Geriatrics) were provided guidance from the Crown Prosecution Service to ensure that their statements addressed the relevant legal issues in terms of potential homicide.

The experts completed their statements following review of medical records, all witness statements and transcripts of interviews of Dr Reid and Dr Barton the

healthcare professionals in jeopardy. They were also provided with the relevant documents required to put the circumstances of care into 'time context' The reviews were conducted by the experts independently.

Supplementary expert medical evidence was obtained to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's BLACK and WILCOCK.

A common denominator in respect of the ten cases was that the attending clinical assistant was Dr Jane BARTON who was responsible for the initial and continuing care of the patients including the prescription and administration of opiate and other drugs via syringe driver.

Dr BARTON was interviewed under caution in respect of the allegations.

The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr BARTON in respect of care delivered to individual patients. Dr BARTON responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.

During the second interview challenge phase (following provision of expert witness reports to the investigation team) Dr BARTON exercised her right of silence refusing to answer any questions.

Consultant Dr Richard REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by expert witnesses. Dr REID answered all questions put.

Full files of evidence were incrementally submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.

- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

Additional evidence was forwarded to the CPS through the compilation of generic healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

The ten category three cases were:-

1. Elsie DEVINE 88yrs. Admitted to GWMH 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21st November 1999, 32 days after admission cause of death recorded as Bronchopnuemonia and Glomerulonephritis.

2. Elsie LAVENDER 83yrs. Admitted to GWMH 22nd February 1996 with head injury /brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died 6th March 1996, 14 days after admission cause of death recorded as Cerebrovascular accident.

3. Sheila GREGORY 91yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22nd November 1999, 81 days after admission cause of death Bronchopnuemonia.

4. Robert WILSON. 74 yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and alcoholic hepatitis. Died 18th October 1998 4 days after admission cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died 13th April 1999 18 days after admission cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 yrs. Admitted to GWMH 18th August 1998 with a fractured neck of the femur, diarrhea atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died 21st August 1998 3 days after admission cause of death recorded as bronchopneumonia.

7. Leslie PITTOCK 82 yrs. Admitted to GWMH 5th January 1996 with Parkinsons disease he was physically and mentally frail immobile suffering depression. Died 24th January 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Helena SERVICE 99 yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5th June 1997 2 days after admission cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66yrs. Admitted to GWMH 23rd August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3rd September 1999 13 days after admission cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died 26th September 1998 5 days after admission cause of death recorded as bronchopneumonia.

Dr David WILCOCK provided extensive evidence in respect of patient care concluding with particular themes 'of concern' in respect of the final 10 category ten cases including:-

- *'Failure to 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'*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues Including:-*

  Enid Spurgin – orthopaedic surgeon, microbiologist
  Geoffrey Packman – general physician, gastroenterologist
  Helena Service – general physician, cardiologist
  Elsie Lavender – haematologist
  Sheila Gregory – psychogeriatrician
  Leslie Pittock – general physician/palliative care physician
  Arthur Cunningham – palliative care physician.

Many of the concerns raised by Dr WILCOCK were reflected by expert Geriatrician Dr David BLACK and other experts commissioned, the full details being contained within their reports.

There was however little consensus between the two principal experts Drs BLACK and WILCOCK as to whether the category 3 patients were in irreversible end stage terminal decline, and little consensus as to whether negligence more than minimally contributed towards the patient death.

As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that Doctors were negligent to criminal standard.

Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.

Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction.

Family group members of the deceased and stakeholders were informed of the decision in December 2006 and the police investigation other than referral of case papers to interested parties and general administration was closed.

David WILLIAMS.
Detective Superintendent 7227
Senior Investigating Officer.
16th January 2007.

SUMMARY OF EVIDENCE

CASE OF ARTHUR CUNNINGHAM

Background/Family Observations

Arthur CUNNINGHAM was born on 19th March 1919. 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 Code A 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.

DRAFT REPORT

regarding

ARTHUR DENNIS BRIAN CUNNINGHAM (BJC/15)

PREPARED BY: Dr Andrew Wilcock MB ChB FRCP DM
Reader in Palliative Medicine and Medical Oncology

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

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.

2. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be suboptimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

3. ISSUES

3.1 Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day?

3.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

4. BRIEF CURRICULUM VITAE

Dr Andrew Wilcock MB ChB, FRCP, DM, Reader in Palliative Medicine and Medical Oncology, University of Nottingham and Honorary Consultant Physician, Nottingham City Hospital NHS Trust.

Trained in general medicine, including experience in health care of the elderly (acute medicine and rehabilitation) prior to specialising in Palliative Medicine, working in Specialist Palliative Care Units in Nottingham and Oxford. Appointed to present post as Senior Lecturer in 1995. Promoted to Reader in 2001. Carries out research in pain, breathlessness and exercise capacity. Regularly lectures on national and international courses. Palliative care

prescribing advisor to the British National Formulary (2002-). Expert reviewer for Prodigy national palliative care guidelines for general practitioners. Joint author of the Palliative Care Formulary that has sold over 30,000 copies, and the 3rd edition of Symptom Management in Advanced Cancer, with Dr Robert Twycross. Previously Chair of the Mid-Trent Cancer Services Network Palliative Care Group, Nottingham Cancer Centre Palliative Care Group, inaugural Secretary for the Science Committee of the Association for Palliative Medicine of Great Britain and Ireland and member of the National Institute for Clinical Excellence Lung Cancer Guidelines Development Group.

Operates the international Palliative Medicine mailbase mailing list and co-owns and edits www.palliativedrugs.com that publishes the Palliative Care Formulary on the internet. With over 17,000 members it is the largest Palliative Care resource of its kind. Provisional Member of the Expert Witness Institute.

5. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Arthur Dennis Brian Cunningham, including the entry in the Death Register.

[2] Full set of medical records of Arthur Dennis Brian Cunningham on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

[4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[5] Hampshire Constabulary Summary of Care of Arthur Cunningham.

[6] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

[7] Portsmouth Health Care NHS Trust Policies:

i) Control of Administration of Medicines by Nursing Staff Policy (January 1997).

ii) Prescription Writing Policy (July 2000).

iii) Policy for Assessment and Management of Pain (May 2001).

iv) Compendium of Drug Therapy Guidelines, Adult Patients (1998).

v) Draft Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion, Medical Director (December 1999).

vi) Medicines Audit carried out by the Trust referred to as Document 54 on page 52 in the Chi Report (reference 6).

[8] General Medical Council, Good Medical Practice (July 1998).

[9] British National Formulary (BNF). Section on Prescribing in Terminal Care (March 1998).

[10] British National Formulary (BNF). Section on Prescribing in the Elderly (March 1998).

6. CHRONOLOGY/CASE ABSTRACT

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 wellbeing (page 241 of 928). 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 of 928). 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 of 928). The latter was discussed with Dr Cranfield, consultant haematologist, who considered it probably due to myelodysplastic syndrome (see technical issues) 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 of 928). 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 of 928).

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 of 928). 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 of 928). 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 of 928).

During his stay on Mulberry Ward, Mr Cunningham was commenced on an antidepressant, mirtazapine (page 71 of 928). It was noted that he would often call out for the first couple of hours in bed (page 72 of 928). 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 of 928) and he did complain of pain in the base of his spine (page 73 of 928). 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 of 928).

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 of 928), presumably as a mood stabiliser. The following night he was described as confused with paranoid and delusional ideas (page 87 of 928) 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 of 928). Due to ongoing problems, on the 19th August 1998, an 'atypical' antipsychotic risperidone 0.5mg was added at 6pm (page 88 of 928). An antipsychotic is usually indicated in confused patients with paranoid and delusional ideas.

However, they risk worsening Parkinson's disease (see technical issues) 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 of 928). 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 of 928). 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 of 928).

Mr Cunningham also had two urinary tract infections requiring antibiotics (pages 205 and 207 of 928) 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 of 928). 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 of 928). 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 of 928) 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 of 928).

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 of 928).

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 of 928).

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 of 928). 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 of 928); 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 of 928).

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 of 928). 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 of 928).

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 of 928). 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 of 928). 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 of 928). 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 of 928).

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 of 928). 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 of 928). 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 of 928). 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 of 928). Finally, he was prescribed metrotop, a topical antibiotic gel (page 756 of 928). 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 of 928). 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 of 928).

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 of 928).

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 of 928).

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 of 928).

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 of 928). 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 of 928).

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 of 928). Syringe driver changed to 20.20h contains diamorphine 20mg and midazolam 20mg, appears less agitated this evening (page 868 of 928).

Nursing care plan relating to the ulcer notes '23.00h. Dressing came off. Reapplied as above' (page 880 of 928). 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 of 928).

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 of 928).

23rd September 1998

The drug chart reveals that Mr Cunningham took Sinemet-110 at 06.00h (page 753 of 928). 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 of 928). 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 of 928).

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 of 928) An entry timed 13.00h reads 'Mr and Mrs Farthing seen by me - Sister Jean 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 made comfortable. Driver renewed at 20.20h with diamorphine 20mg, midazolam 60mg and hyoscine 400microgram. Family have visited. (page 868 of 928).

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 of 928).

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 of 928).

At 10.55h a syringe driver containing diamorphine 40mg, hyoscine 800microgram and midazolam 80mg was commenced (page 756 of 928).

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 of 928). 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 of 928).

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 of 928).

25th September 1998

An entry in the medical notes reads 'Remains very poorly. On syringe driver. For TLC (tender loving care)' (page 645 of 928).

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 of 928). Mr Cunningham received a syringe driver containing diamorphine 60mg, hyoscine 1200micrograms and midazolam 80mg (page 837 of 928).

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 of 928).

Nursing care plan entry relating to settling for the night notes 'peaceful night, position changed still does not like being moved' (page 876 of 928).

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 of 928).

A syringe driver containing diamorphine 80mg, hyoscine 1200microgram and midazolam 100mg was commenced at 11.50h (page 837 of 928).

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 of 928). A later entry timed

'night' reads 'Brian's condition continued to deteriorate' and noted that he died at 23.15h (page 869 and 872 of 928).

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). I note that the copy of the entry in what I have assumed to be the death register, records cause of death as Ia. Bronchopneumonia only (supplied by Hampshire Constabulary).

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Myelodysplastic syndrome

This is a disorder of the stem cells in the bone marrow that reduces the effective production of various types of blood cells. It is characterised by a progressive fall in one or more of the red, white or platelet cell counts causing, for example, anaemia, reduced immunity to infections or an increased risk of bleeding; 30–40% of patients die of infection ± bleeding. In 20–40% of patients it transforms into a leukaemia.

ii) Syringe drivers, diamorphine, midazolam, haloperidol, levomepromazine (nozinan) and hyoscine hydrobromide

A syringe driver is a small portable battery-driven pump used to deliver medication subcutaneously (SC) via a syringe, over 24h. Indications for its

use include swallowing difficulties or a comatose patient. In the United Kingdom, it is commonly used in patients with cancer in their terminal phase in order to continue to deliver analgesic medication. Other medication required for the control other symptoms, e.g. delirium, nausea and vomiting can also be added to the pump.

Diamorphine is a strong opioid that is ultimately converted to morphine in the body. In the United Kingdom, it is used in preference to morphine in syringe drivers as it is more soluble, allowing large doses to be given in very small volumes. It is indicated for the relief of pain, breathlessness and cough. The initial daily dose of diamorphine is usually determined by dividing the daily dose of oral morphine by 3 (BNF number 29 (March 1995)). Others sometimes suggested dividing by 2 or 3 depending on circumstance (Wessex protocol). Hence, 60mg of morphine taken orally a day could equate to a daily dose of 20 or 30mg of diamorphine SC. It is usual to prescribe additional doses for use 'as required' in case symptoms such as pain breakthrough. The dose is usually 1/6th of the 24h dose. Hence for someone receiving 30mg of diamorphine in a syringe driver over 24h, a breakthrough dose would be 5mg. One would expect it to have a 2–4h duration of effect, but the dose is often prescribed to be given hourly if required. As the active metabolites of morphine are excreted by the kidneys, caution is required in patients with impaired kidney function.

Midazolam is a benzodiazepine, a diazepam like drug. It is commonly used in syringe drivers as a sedative in patients with terminal agitation. Sedation can be defined as the production of a restful state of mind. Drugs that sedate will have a calming effect, relieving anxiety and tension. Although drowsiness is a common effect of sedative drugs, a patient can be sedated

without being drowsy. Most practitioners caring for patients with cancer in their terminal phase would generally aim to find a dose that improves the patients' symptoms rather than to render them unresponsive. In some patients however, symptoms will only be relieved with doses that make the patient unresponsive. A typical starting dose for an adult is 30mg a day. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The BNF (March 1995) recommends 20–100mg SC over 24h. The Wessex protocol suggests a range with the lowest dose of 5mg a day. The regular dose would then be titrated every 24h if the sedative effect is inadequate. This is generally in the region of a 33–50% increase in total dose, but would be guided by the severity of the patients symptoms and the need for additional 'as required' doses. These are generally equivalent to 1/6th of the regular dose, e.g. for midazolam 30mg in a syringe driver over 24h, the 'as required' dose would be 5mg given as a stat SC injection. The duration of effect is generally no more than 4h, and it may need to be given more frequently. As an active metabolite of midazolam is excreted by the kidneys, caution is required in patients with impaired kidney function.

Haloperidol is an antipsychotic. It is frequently used in syringe drivers for its antipsychotic and anxiolytic effects in patients with terminal delirium/agitation or as an anti-emetic. Compared to other antipsychotics, like levomepromazine, it is less sedative but can cause more problems with extrapyramidal effects and should be used with caution in patients with parkinsonism or Parkinson's disease. Extrapyramidal effects include parkinsonism, acute dystonia, acute akathesia and tardive dyskinesia. Parkinsonism consists of tremor, rigidity and slowing of movements; acute dystonia is spasm of muscles including those involving the eyes, head,

neck, trunk and limbs. They are usually abrupt in onset and associated with anxiety; acute akathesia is a form of restlessness of the muscles in which the person is compelled to move or change position and is associated with variable degrees of patient distress; tardive dyskinesia typically presents as involuntary chewing movements of the face and orofacial muscles.

Levomepromazine is an antipsychotic. It is frequently used in syringe drivers for its antipsychotic and anxiolytic effects in patients with terminal delirium/agitation or as an anti-emetic. It is more sedative than haloperidol but less likely to cause extrapyramidal effects.

Hyoscine hydrobromide is an antimuscarinic drug most commonly given to reduce excessive saliva or retained secretions ('death rattle'). It also has anti-emetic, antispasmodic (smooth muscle colic) and sedative properties. Repeated administration can lead to cummulation and this can occasionally result paradoxically in an agitated delirium, highlighted in both in the BNF and the Wessex protocol (page 41). It is usually given in a dose of 600–2400microgram SC over 24h (BNF (March 1995)) or 400–600microgram as a stat SC dose. The Wessex protocol gives a dose range of 400–1200microgram over 24h.

The titration of the dose of analgesic, antipsychotic or sedative medication is guided by the patients symptom control needs. The number and total dose of 'as required' doses needed over a 24h period are calculated and this guides the increase necessary in the regular dose of the drugs in the syringe driver in a way that is proportional to the patients needs. The ideal outcome is the relief of the symptoms all of the time with no need for additional 'as required' doses. In practice, this can be difficult to achieve and the relief of the symptoms for the majority of the time along with the

use of 1–2 'as required' doses over a 24h period is generally seen as acceptable.

iii) Boosting syringe drivers

Given that it was in widespread use, I am assuming that Dryad Ward had access to the Graseby MS26 syringe driver that has a boost button, but this should be clarified. The use of the boost button is generally not recommended as, for example:

1) The dose delivered by the boost is generally insufficient

Generally, the contents of a syringe being delivered by a Graseby MS26 syringe driver would be made up to a certain length, e.g. 50mm to be infused over 24h, i.e. just over 2mm/h. One actuation of the boost button moves the plunger on the syringe driver 0.23mm. In relation to the recommended rescue dose for breakthrough pain, this is likely to be inadequate. For example, a reasonable breakthrough dose is generally 1/6th of the 24h dose and this would equate to about 8mm. Nevertheless, boosting also presents a problem on how the amount and frequency of the boosting is prescribed and how it is recorded by the nursing staff.

2) There is no lockout period

Although each booster dose is small, there is nothing to stop the boost button being repeatedly depressed and released. Hence, the potential exists for the contents of the syringe driver to be administered much more quickly than the intended 24h.

3) The overall duration of the infusion is reduced

This may cause problems in some settings, e.g. the community.

4) There are usually several drugs in the syringe driver

It may only be indicated to boost the dose of one of the drugs in the syringe driver, but all of the contents are unavoidably boosted.

Hence, rather than boosting a syringe driver, usual practice is to ensure that patients have access to stat p.r.n. medication, that they may require to control their symptoms, in appropriate doses to be given subcutaneously, e.g. an analgesic, sedative and antipsychotic.

iv) The principle of double effect

The principle of double effect states that:

'If measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable provided the doctor's intention is to relieve the distress and not kill the patient.'

This is a universal principle without which the practice of medicine would be impossible, given that every kind of treatment has an inherent risk. Many discussions on the principle of double effect have however, involved the use of morphine in the terminally ill. This gives a false impression that the use of morphine in this circumstance is a high risk strategy. When correctly used (i.e. in a dose *appropriate* to a patient's need) morphine does not appear to shorten life or hasten the dying process in patients with cancer. Although a greater risk is acceptable in more extreme circumstances, it is obvious that effective measures which carry less risk to life will normally be used. Thus, in an extreme situation, although it may occasionally be necessary (and acceptable) to render a patient unconscious, it remains unacceptable (and unnecessary) to cause death deliberately. As a universal principle, it is also obvious that 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.

8. OPINION

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

Mr Cunningham was a 79 year old man who suffered from depression and dementia. He also had Parkinson's disease and probable myelodysplasia, which left him more susceptible to infection. He had chronic back pain caused by an injury to his lumbar spine. This meant that it could take a long time to get him comfortable at night, requiring several adjustments to his backrest and pillows. The pain was helped by regular co-proxamol and previously codeine, about 240mg/day, but not by paracetamol alone.

Mr Cunningham was considered to be depressed and was commenced on an antidepressant. His behaviour was erratic and he had a number of disturbed nights. He was subsequently commenced on carbamazepine and triclofos without apparent success. Carbamazepine is an anti-epileptic drug. I am not familiar with its use for a disturbed night per se in the depressed and demented elderly, but I am aware that it can be given as a mood stabilising drug, usually in the setting of a manic-depressive disorder. Triclofos is a chloral hydrate derivative. I am not familiar with the use of triclofos as a hypnotic in the confused, depressed and demented elderly. The addition of the atypical antipsychotic risperidone did however, appear to coincide with an improvement with Mr Cunningham's nights and subsequently during the admission his mood improved. He was at high risk of developing a pressure sore and the skin over his sacrum broke

down during the admission. He developed two urinary tract infections and required catheterisation for urinary retention. By the time of his discharge he was eating better and had gained weight. His mood, behaviour and nights had improved and this was maintained on his return to Thalassa Nursing Home. There are no issues relating to the standard of care or treatment proferred to Mr Cunningham during his admission to Mulberry Ward.

Events at Dolphin Day Hospital, Gosport War Memorial Hospital, 14th September 1998 until 21st September 1998

Mr Cunningham appeared happy at Thalassa and the staff reported that his behaviour was manageable and he slept well. The sacral pressure sore had progressed despite pressure relieving aids at the nursing home. The day hospital staff appropriately examined, photographed, swabbed and redressed the sacral area and arranged follow up. Over the subsequent two visits the sacral pressure sore worsened despite an antibiotic. On the 17th September 1998, Mr Cunningham's physical and mental state appeared to be deteriorating; he was difficult to wake after resting on a bed, refused to talk, drink or swallow medication and expressed a wish to die. When Dr Lord saw Mr Cunningham on the 21st September 1998, tablets were found in his mouth some hours after they had been given. Dr Lord noted that Mr Cunningham was very frail and that his prognosis was poor. Prognostication can be difficult, but increasing immobility and difficulty with swallowing/taking oral medication are recognised poor prognostic factors. However, it does not appear as though Dr Lord necessarily anticipated that Mr Cunningham was imminently dying

as she admitted him for more intensive therapy to his ulcer, as opposed to terminal care; she recommended a high protein diet, indicating that he might live long enough to benefit from this, and asked the nursing home to keep his bed open for the next three weeks at least. Dr Lord also asked that Mr Cunningham receive Oramorph p.r.n. for pain, underlining p.r.n. It should be clarified if this represents an intentional emphasis, and if so, the significance of this. There are no issues relating to the standard of care or treatment proferred to Mr Cunningham during his attendance at Dolphin Day Hospital.

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

Compared to the notes during Mr Cunningham's stay on Mulberry Ward and attendance at the Dolphin Day Hospital, infrequent entries in the medical notes during his stay on Dryad Ward make it difficult to closely follow Mr Cunningham's progress over the last six days of his life. There are three short entries prior to the confirmation of death, taking up half a page in length. In summary and in approximate chronological order, there is no formal clerking on Mr Cunningham's admission to Dryad ward. Instead, there is a short entry that gives the impression that Mr Cunningham was for terminal care which is at some variance to Dr Lord's assessment. The Oramorph was prescribed p.r.n. as requested by Dr Lord. In addition, diamorphine 20–200mg, hysocine (hydrobromide) 200–800microgram and midazolam 20–80mg subcutaneously (SC) over 24h were prescribed p.r.n. On the 21st September, Mr Cunningham received Oramorph 5mg at 14.50h prior to a wound dressing, which is a reasonable

approach to try and minimise discomfort and an appropriate dose given his existing analgesic use. He was then reported to be very agitated at 17.30h. Nevertheless, he took his regular co-proxamol at 18.00h and a wound dressing applied at 18.30h. At 20.20h he was given Oramorph 10mg. The reason for this is unclear and it should be clarified if the Oramorph was given for pain or anxiety. Oramorph is not indicated for anxiety per se, particularly in the confused elderly, and risks aggravating the confusion. It should be clarified why a 10mg dose was considered necessary rather than repeating the 5mg dose. Given that he was 'sedated' at 22.00h, it is possible that the 10mg dose was excessive for Mr Cunningham.

An entry in the nursing notes on the 22nd September, in response to enquiry by the family, retrospectively reports that the syringe driver was commenced on the 21st September for pain relief and anxiety following an episode the evening before (time not specified) when Mr Cunningham exhibited abnormal and possibly delusional behaviour. Given that Mr Cunningham was prone to such behaviour, it would have been particularly appropriate in my view to ensure that he continued to receive his usual carbamazepine, risperidone, mirtazapine and triclofos as recommended by the old age psychiatry team. It should be clarified why this was not done on the day of his admission. He may have been having difficulty with taking/co-operating with taking oral medication, although he managed some of his medication that day. It should also be clarified who decided to commence the syringe driver containing diamorphine 20mg and midazolam 20mg at 23.10h. Diamorphine is not indicated for anxiety per se, particularly in the confused elderly, and risks aggravating the

confusion. If it was for pain, 20mg is in keeping with the starting dose range (10–20mg/24h) that many would use for a patient with inadequately relieved pain despite the maximal use of co-proxamol/codeine. A number of practitioners probably would use midazolam in this setting, although as it impairs memory, it can sometimes aggravate rather than improve confusion and the use of an antipsychotic is preferable in my view. His Parkinson's would limit the use of the most commonly used antipsychotic, haloperidol, although a small dose of levomepromazine could have been a reasonable alternative in my view (see technical issues). A midazolam dose of 20mg is in keeping with the usual starting dose range (5–30mg/24h).

Nevertheless, most practitioners in my experience, would initially prescribe small stat PO/SC doses of an analgesic, sedative anxiolytic and antipsychotic to be used p.r.n. (e.g. diamorphine 2.5mg, midazolam 2.5mg, levomepromazine 6.25mg respectively would be reasonable given Mr Cunningham's age and frailty). Firstly, this is because the needs of patients vary greatly and makes judging their requirements difficult; sometimes multiple increasing doses are needed; sometimes, a small one-off dose is adequate as the 'crisis' is temporary. For example, whilst there are a number of possible causes for Mr Cunningham's agitation, one may have been that he was a patient with dementia reacting to the initial move to unfamiliar surroundings and unfamiliar staff. In these circumstances, non-drug approaches, maintaining his usual medication and, if necessary, intermittent sedation could be seen as more appropriate initial responses rather than commencing a syringe driver straight away. Hence, the patients' p.r.n. requirements guide the need for regular analgesia/sedation

and the appropriate dose. Secondly, the continuing use of additional p.r.n. doses informs the need to increase the regular analgesia/sedation and guides an appropriate dose increment. It should be clarified why this approach was not considered appropriate for Mr Cunningham.

Mr Cunningham's behaviour did appear to settle on the syringe driver and on the 22nd September there were no reports of pain during the night or when his dressing was reapplied to the sacral ulcer. It is unclear how sedated he was, but he was able to take his Sinemet-110 orally regularly on the 22nd September, but again, no carbamazepine, risperidone, mirtazapine or triclofos were given.

From the 23rd September Mr Cunningham's condition deteriorated; he was unable to take his oral medication and had become chesty. This was most likely the start of a bronchopneumonia. Given his overall condition, biological prospects and his expression of the wish to die, it was reasonable in my view not to pursue aggressive therapy. Hyoscine hydrobromide 400microgram was added to the syringe driver to try and reduce secretions. This was appropriate and the dose within the usual starting dose range (400–600microgram/24h). However, it should be borne in mind that hyoscine can worsen an agitated delirium (see technical issues). Mr Cunningham's son appeared angry that the syringe driver had been commenced and the reasons for this should be further explored. It was explained to him that the consultant would need to give her permission to discontinue the driver. He saw the pastor and subsequently appeared accepting of the situation. It should be clarified if Dr Barton or Dr Lord were made aware of this consultation and Dr Lord specifically asked to comment. As Mr Cunningham was no longer able to take his usual

analgesic and sedative medication, a syringe driver would be clearly indicated at this point. The syringe driver was renewed at 20.00h with an increased dose of midazolam (increased from 20mg to 60mg). It should be clarified who decided to increase the dose and why. There were no comments relating to agitation in the notes prior to its renewal and it is unclear why 60mg was chosen as opposed to an increase to 30mg or 40mg for example. Later, at 23.00h the nursing notes document that the syringe driver was boosted when Mr Cunningham became agitated and also prior to changing his position. It should be clarified what usual practice, guidelines or policy existed on Dryad Ward with regard to boosting syringe drivers. This practice is not generally recommended (see technical issues).

The medical notes entry on the 24th September reports that the analgesia was 'just' controlling Mr Cunningham's pain. It is not clear from the medical notes exactly what pain this relates to, although the night staff had reported he appeared to be in some discomfort on turning and the day staff reported that he was in pain when attended to, especially his knees. No additional details are given that would help in considering appropriate management, e.g. was it short-lived or prolonged etc. Mr Cunningham had Parkinson's disease and was immobile and highly likely to experience muscle and joint stiffness that could lead to pain on turning/moving his knees. Pain on turning, often settles quickly once in the new position. If not, it is usually managed by keeping the number of turns to a minimum, and by giving supplementary stat SC doses of diamorphine ± midazolam prior to turning. Increasing the regular opioid is not always satisfactory, as the dose of opioid required to eliminate all pain on movement can be excessive for the

patient whom for the majority of the time is resting and pain free. A dose of opioid that is excessive to a patients' need is associated with undesirable effects such as nausea, vomiting, sedation, confusion and respiratory depression. Mr Cunningham's diamorphine was increased from 20mg to 40mg. At 100%, this is a greater increment than usual (33-50% of the preceding dose) and it should be clarified why this was felt necessary. Increments of this magnitude may be appropriate, but are usually indicated/justified by the amount of additional p.r.n. doses of diamorphine a patient may be requiring. Mr Cunningham's midazolam was increased from 60mg to 80mg and the hyoscine from 400microgram to 800microgram. Similar to the reasons stated above, providing supplementary stat doses of midazolam prior to turning is often more effective than increasing the regular sedative.

On the 25th September 1998 the dose of the diamorphine in the syringe driver was increased to from 40mg to 60mg (i.e. a 50% increase) and the hyoscine from 800microgram to 1200microgram. There is no entry in the medical notes explaining this but the nursing notes suggest it was for pain on turning. Again, in my experience, when a patient is in pain on turning but at all other times pain free, settled and relaxed, it is more effective and more appropriate to provide additional analgesia and/or sedative prior to turning rather than increase the overall dose.

On the 25th the diamorphine was further increased from 60mg to 80mg (a 25% increment) and the midazolam from 80mg to 100mg. There is no reason documented for this increase and this should be clarified. Mr Cunningham died at 23.15h. Mr Cunningham's death was not unexpected, he was frail, immobile and susceptible to infection. Bronchopneumonia is

the most likely cause of death. I am uncertain why Parkinson's disease and sacral ulcer that appear to have been put on the death certificate were not on the copy of the entry of what I assume to be the death register and this should be clarified.

Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day?

The overall care given to Mr Cunningham whilst on Mulberry Ward or attending Dolphin Day Hospital, Gosport War Memorial Hospital was not substandard.

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.

Specifically:

i) 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.

ii) 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.

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

iv) 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.

v) 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.

If the care is found to be suboptimal what treatment should normally have been preferred in this case?

In relation to the above:

Issue i (lack of clear documentation that an adequate assessment has taken place)

A medical assessment usually consists of information obtained from the patient or others and existing medical records (the history), and the findings of a physical examination that is documented in a structured fashion. Although the history can be restricted to the most salient points, it is unusual to omit relevant sections, e.g. past medical history, drug history,

etc. For example, a read through Mr Cunningham's notes from his time on Mulberry ward, would help a doctor to appreciate the importance of ensuring the continuation of his mirtazapine, carbamazepine, triclofos and risperidone medication. Or, in circumstances where this may not be possible, providing the use of oral or, if unable to use the oral route, subcutaneous stat doses of a sedative and/or antipsychotic to be used as required.

Clerking of a patient also provides a baseline for future comparison. If new problems subsequently develop, and abnormal physical findings are found on examination, it can be helpful for the doctor when considering the differential diagnosis and management to know if the findings are really new or old. A clear assessment and documentation of subsequent medical care are particularly useful for on-call doctors who may have to see a patient, whom they have never met, for a problem serious enough to require immediate attention.

Issue ii (lack of clear, accurate, and contemporaneous patients records which report drugs prescribed; prescribing only the treatment, drugs, or appliances that serve patients' needs)

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.

Issue iii (prescribing only the treatment, drugs, or appliances that serve patients' needs)

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.

Issue vi (lack of clear, accurate, and contemporaneous patients records which report drugs prescribed; prescribing only the treatment, drugs, or appliances that serve patients' needs)

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.

Issue v (lack of clear, accurate, and contemporaneous patients records which report drugs prescribed; prescribing only the treatment, drugs, or appliances that serve patients' needs; willing to consult colleagues)

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.

If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

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 (see technical issues), 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.

9. LITERATURE/REFERENCES

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10. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

SUMMARY OF CONCLUSIONS:

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.

The expert opinion is:

> 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".

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

2.3. If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

3. CURRICULUM VITAE

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DOB	23rd March 1956
Place	Windsor, England.
Marital status	Married with 2 children.
GMC	Full registration. No: 2632917
Defence Union	Medical Defence Union. No: 152170C

EDUCATION	Leighton Park School, Reading, Berks.	1969-1973
	St John's College, Cambridge University.	1974-1977
	St Thomas' Hospital, London SE1	1977-1980

DEGREES AND QUALIFICATIONS

BA, Cambridge University	1977
(Upper Second in Medical Sciences)	
MB BChir, Cambridge University	1980
MA, Cambridge University	1981
MRCP (UK)	1983
Accreditation in General (internal) Medicine and Geriatric Medicine	1989
FRCP	1994
MBA (Distinction) University of Hull.	1997
Certificate in Teaching	2001
NHS/INSEAD Clinical strategists program	2003

SPECIALIST SOCIETIES

British Geriatrics Society

British Society of Gastroenterology

British Association of Medical Managers

PRESENT POST

Dean Director of Postgraduate Medical and Dental Education	
Kent, Surrey and Sussex Deanery.	2004-present
Consultant Physician (Geriatric Medicine)	1987-present
Queen Mary's Hospital, Sidcup, Kent.	
Associate member General Medical Council	2002-present

PREVIOUS POSTS

Associate Dean.	
London Deanery.	2004
Medical Director (part time)	1997-2003
Queen Mary's Hospital	
Operations Manager (part time)	1996-1997
Queen Mary's Hospital, Sidcup, Kent	
Senior Registrar in General and Geriatric Medicine	
Guy's Hospital London and St Helen's Hospital	
Hastings.	1985-1987
Registrar in General Medicine and Gastroenterology	
St Thomas' Hospital, London.	1984-1985
Registrar in General Medicine	
Medway Hospital, Gillingham, Kent	1983-1984
SHO rotation in General Medicine	
Kent & Canterbury Hospital, Canterbury	1982-1983
SHO in General Medicine	
Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Arthur Cunningham

[2] Full set of medical records of Arthur Cunningham on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

[4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[5] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[7] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

5. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

5.1. During the 1980's Mr Cunningham noted a tremor in his left hand and by 1987 a clinical diagnosis of Parkinson's disease had been made and he had been started on Sinemet a drug specifically for the treatment of Parkinson's disease (445). He then remains on Sinemet in one form or another for the rest of his life. In 1992 another drug called Selegiline is added to his Sinemet (445). His only previous problem had been a lumbar spinal fusion following a war accident (375) that left him with chronic back pain and foot drop.

5.2. In 1992 he had a percutaneous nephrolithotomy for kidney stones. (9). During that admission he was written up for Omnopon 10 – 20 mgs and received a dose of 20 mgs (12). There were no ill effects.

5.3. He was assessed in December 1994 (439 and 441) for declining mobility. He was noted to have a weight of 102 kgs, a mental test score of 10 out of 10, and a Waterlow score of 13 (391) suggesting some dependency. His wife had died in 1989 (439). His Barthel was 17 (433) some help needed was with dressing. The problems were assessed to be due to be Parkinson's disease, a weak leg from his war injury and obesity.

5.4. He was followed up in 1995 with a diet and change to his Sinemet regime in the Day Hospital. He was also treated with Ranitidine and Gaviscon, presumably for acid reflux (425) and was on regular Co-proxamol for pain (425). Subsequently Enalapril was started for hypertension (399 and 417). In March 1995 his weight was 99.4 kgs (407) and he was discharged shortly after from the Day Hospital (400).

5.5. In September 1997 the GP requests a domiciliary visit (379). He notes that he has been diagnosed with diabetes and was now losing weight (379). The GP refers to diabetes being diagnosed in 1986 when this should have been 1995 (555). His Parkinson's disease has deteriorated and he is now getting dystonic movements. Dystonic movements are writhing and jumpy movement that occur as a side effect of drug therapy in people who have had Parkinson's disease for many years. These movements often occurs at times of peak drug levels and may alternate with periods of severe stiffness and immobility at times of low drug levels. It was also noted that he had lost some lower body strength (379). He was now spending most of his time in his chair (379). His drugs included the regular analgesia, Solpadol (381).

5.6. An assessment in September 1997 (375, 377) finds he has weak lower limbs and has difficulty in transfers. He can walk indoors slowly with sticks. He has a poor appetite and daily home care. He is documented to have very weak flexion and extension of the left hip, wasting of the left quadriceps and left foot drop (377). It is suggested that he comes to the Day Hospital for physiotherapy. His weight in October 1987 (629) is 84 kgs. However in November 1987 he cancels further appointments (355). In September 1997 his white cell count is 4.0 and his platelet count is 112. It is likely that his haematological abnormalities date from this time.

5.7. In March 1998 he is seen again in outpatients with new episodes of shortness of breath (139 – 141). The diagnosis is not clear but was thought possibly to be cardiac in nature. However a chest x-ray (519) was normal. There is no further investigation of this problem. One note suggests that he had just moved to a nursing home (141).

5.8. In June 1998 he is seen at the Merlin Park Residential Home by Dr Lord, following a GP request (345). He is noted to have significant weight loss, is transferring very unsteadily, is occasionally breathless and has had two falls in the home. He remains on a five times a day dose of his Sinemet and is

also on a hypertensive drug Amlodipine, Diazepam and drugs for constipation. Examination (349) finds that he has markedly dystonic movements and records that the home had noticed visual hallucinations after he moved in. Dr Lord feels that he is on too much Levodopa (the main drug in Sinemet). She feels the Sinemet is causing his dystonic movements, too low a blood pressure on standing leading to falls, and his hallucinations. The notes state that Mr Cunningham never agreed with this diagnosis. Dr Lord also feels that he is depressed (349).

5.9. On 22nd June 1998 he is brought to the Gosport War Memorial Hospital by Social Services as he was refusing to stay at Merlin Park (343). He is described as a difficult and unhappy man (59). No acute health problems are found (343). Social Services place him in the Alvestoke Nursing Home (341).

5.10. On 6th July 1998 he is seen again at the Gosport War Memorial Hospital (339) and is noted to have decreased mobility and his weight has now decreased to 68.7 kgs. He is not happy with his new nursing home placement. His functional status has declined and his Barthel is 9/20 (334). His blood count that day shows a normal haemoglobin but a white cell count of 2.7, platelets of 103 (650). The reduced white count particularly his neutrophil count and reduced platelets count is thought to be due to "likely myelodysplasia known since February 1997" (68). This was never confirmed with specialist haematologist investigation.

5.11. On 8th July he is seen by Dr Scott Brown a psychiatrist and is thought to be depressed (117). Other problems including his Parkinson's disease and his myeloproliferative disorder are noted (115).

5.12. On 20th July his care is discussed with Dr Lord in the Day Hospital (111 and 113). It is though his Parkinson's disease is stable but because of concern about his weight loss, he is referred for a speech and language assessment, which subsequently occurs on 27th July (101). This finds he has difficulty in initiating swallow but there is no aspiration. This likely to be a complication of his Parkinson's disease.

5.13. On 21st July he is admitted to Mulberry Ward with depression (323) his weight is 65.5 kgs (303) a bed sore is now noted (293) he is thought to have dementia (67) and there is a documented mental test score in June of 23 out of 29 on the Folstein Mini Mental State Examination (343). He is found to be constipated (289) is restless and demanding at night (271) (269), nursing notes comment that he can be awkward and difficult (242). Waterlow scores are recorded on a number of occasions, all between 19 and 20 suggesting very high risk of further pressure sore development (309 and 310). He is documented to have various urine tract infections including proteus (207) and enterococcus on two occasions (211) (205). On

admission his white cell count is 2.9 neutrophil count 1.4 and platelet count of 97 (201). On 12th August his white count is 3.5 his neutrophil count 1.8 and platelets 135. The blood form states "known myelodysplasia" (193). On admission his albumin is 26 (185) his urea is 6 and his creatinine 59, his prostatic-specific antigen is 6.4 (179) normal is less than 4. This raised level is not investigated any further, it might represent either benign prostate disease or early prostatic cancer.

5.14. During his admission to Mulberry ward he has a fall on the 24th July (70). He is described as quite demanding, wanting staff to come and see him every few minutes (70), he is depressed and tearful on 24th July (71), he is rude and abusive to a member of staff on 26th July (72) and apologises later in the day (73). Dr Lord sees him on 27th July (74) and finds that there were no particular new problems. He is still low in mood on 3rd August (79) calling out for assistance quite a lot (80). He needs a lot more assistance on 10th August (83). On 17th August he became noisy, shouting for help and very abusive, refusing medication (85). He is assessed for a further move to the Thalassa Nursing Home on 17th August (86). He is again confused in the middle of the night on 18th August (87). On 25th August it is noted that he has not passed much urine (90). Blood tests carried out on 26th August (175) find a Sodium 134, Potassium 5.1, Urea 28 and Creatinine 301. He has gone into acute renal failure and is examined and found to have a large palpable bladder (90). He is catheterised. On 28th August there is a significant improvement in his renal function, Sodium 140, Potassium 4.1, Urea 15.6, Creatinine 144 (173). By the time of his discharge to his current usual medication of Sinemet, pain killers and anti-hypertensive drugs; Mirtazapine (an anti-depressant), Carbamazepine 100 mgs nocte, Triclofos 20 mls nocte and Risperidone 0.5 mgs early evening, have all been started as psychotropic medication to help control his mood and agitation (161 and 163).

5.15. He is seen by Dr Lord on Mulberry Ward on 27th August the day before his discharge, the day after he has had a catheter put in. She finds him much better in mood and eating better with a weight of 69.7 kgs (327). There were 2 litres of urine passed after he was catheterised (91). He cannot wheel himself but Dr Lord is happy for him to be discharged to the Thalassa Nursing home with a follow up in the Day Hospital on 14th September. He is then discharged to the Thalassa Nursing Home on 28th August.

5.16. On 11th September (99) he is seen by the Community Psychiatric Nurse who says that he has settled well into the Thalassa Nursing Home and his mood seems good.

5.17. On 14th September he is seen in the Gosport War Memorial Day Hospital his weight is 68.6 kgs (323), brighter and says he is eating not too badly (459). His blood pressure is a little low at 108/58 and his pulse is 90 (323).

There is no comment on his pressure sore although, he is subsequently given a prescription for Metronidazole from " a swab to the sores on your bottom" (317). He is presumably still catheterised.

5.18. He appears to have a routine appointment at the Day Hospital on 17th September (908) for therapist assessment. It is noticed that the pressure sore is exudating markedly. During this session it is recorded that he would not comply with dressings and then would not wake up after bed rest. He was refusing to eat or drink and expressing a wish to die. The nursing notes state that he is seen by Dr Lord (909) who thinks he may need admission on Monday when reviewed again. I have not found any medical notes relating to this.

5.19. On 21st September (642) he is again seen in the Day Hospital by Dr Lord (909). He is recorded to be very frail with his tablets not swallowed and in his mouth. He has a very offensive large necrotic sacral ulcer. His weight is 69 kgs (642). A care plan is made by Dr Lord (643) to stop unneeded drugs, to admit to hospital for treatment of the sacral ulcer, to nurse on the side, for a high protein diet and for Oramorph prn for pain. The notes state the nursing home should keep the bed open for the next three weeks at least and the prognosis is poor (643).

5.20. He is taken to Dryad Ward (645) and seen by Dr Barton who says to make comfortable, give adequate analgesia and that "I am happy for the nursing staff to confirm death". The next medical note (which is out of sequence (644)) on 24th September, states, "remains very poorly, Son has visited again today and is aware of how unwell he is. Analgesia is controlling pain just. I am happy for the nursing staff to confirm death".

5.21. 25th September (Dr ?) Brook writes, "remains very poorly on syringe driver for TLC". There is then a nursing note on 26th September, the patient died at 23.25 on 26th September and the final medical note is on 28th September saying "death certificate discussed with Dr Lord, 1 – Bronchopneumonia, 2 – Parkinson's Disease, Sacral Ulcer".

5.22. The nursing notes are more detailed on 21st September. He is admitted (867) but at 20.30pm is noted to have remained agitated and was pulling off his dressing (880). Syringe driver is commenced "as requested" and he is peaceful. On 22nd September the Son is told that the Diamorphine pump has been "started for pain relief and to allay his anxiety". His Barthel is 0/20 (873) and Waterlow 20, suggesting high risk. The patient is recorded as "stating he had HIV disease" and trying to remove his catheter.

5.23. 23rd September (868) it is recorded that he is chesty overnight and Hyoscine is added. The Son and wife are angry that a syringe driver was commenced and the nurses "explain it was to control pain". He is agitated

at night that evening (876).

5.24. On 24th September the night staff and the day staff report pain and in the notes his Midazolam is increased to 80 mgs a day and his Diamorphine to 40 mgs. The nursing notes record that Dr Barton saw the Son, confirming the medical notes (643).

5.25. On 25th September Midazolam is continued at 80, he is on Diamorphine 60 mgs and is recorded as being peaceful (876). Finally on 26th September the notes record his Diamorphine is increased to 80 mgs and Midazolam to 100 mgs.

5.26. Drug Chart Analysis:

His original drug chart on admission to the ward on 21st September (752) prescribes Oramorphine 2.5 – 10 mgs orally 4 hourly, he receives 5 mgs at 14.50pm on 21st and 10 mgs at 20.15pm. He is also written up (753) for all his current anti-Parkinsonian and anti-psychotic medication but the notes demonstrate that on some dates the drugs are missing and on almost all occasions he is too ill to be able to take the medication on 21st – 24th September.

5.27. Diamorphine is 20 –200 mgs subcutaneously in 24 hours is written up on 21st September (756) and on the 21st at 23.10pm, 20 mgs is started. On 22nd September 20.29pm, 20 mgs is started and on 23rd September at 9.25am, 20 mgs is started. On 24th 40 mgs is started in the syringe driver at 10.55am, on 25th 60mgs is in the syringe driver (837) and on 26th 80 mgs.

5.28. Midazolam 20 – 80 mgs is written up on 21st September (756) and 20 mgs is given on 21st, 22nd and 23rd. On the 23rd though, this is increased to 60 mgs, 80 mgs on the 24th. He receives another 80 mgs on 25th and 100 mgs written up in 24 hours on 26th (837).

5.29. Hyoscine 200 – 800 micrograms sub cut in 24 hours is written up 400 micrograms are given on 22nd and 23rd September and 800 micrograms on 24th. This is then re-prescribed. Hyoscine 80 – 2 grams sub cut in 24 hours (837) and he receives 1,200 micrograms on 25th and 26th.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1. This section will consider if there are any actions so serious they might amount to gross negligence or any unlawful acts or deliberate unlawful killing in the care of Mr Arthur Cunningham. Also if the actions or omissions by the medical team, nursing staff or attendant GP's contributed to the demise of Mr Cunningham, in particular, whether beyond reasonable doubt, actions or admissions more than minimally,

negligently or trivially contributed to death.

6.2. Mr Cunningham's two main problems were lumbar spinal fusion as a result of a war injury, which left him his weakness in his lower legs and his progressive neurological disease, Parkinson's disease. Parkinson's disease is a degenerative disease of the central nervous system, which causes tremor, body rigidity and akinesia (stiffness in movement). It was first noted in 1980 presenting with a tremor, he was certainly on treatment by 1987. The natural history is often a good response to treatment over 5 years and then gradual increasing problems. Late Parkinson's disease becomes increasingly difficult to control with drugs; the patients get difficulty in swallowing, severe constipation, and often in later stages a dementing illness.

6.3. There are complications with the drugs as the disease progresses, as the drugs are harder to keep in an effective therapeutic range. Too much and the patients get marked writhing or shaking movements call dystonias, too little and the patient may cease up completely. The longer-term side effects of the drugs also include postural hypotension (loss of blood pressure when standing, leading to falls) and mental state deterioration, including hallucinations. To try and combat this, complex regimes are used with multiple doses at different times of days, sometimes combined with other drugs. There is no cure for the condition.

6.4. In 1992 he is troubled with kidney stones but has an uneventful operation.

6.5. In 1994 he has a decline in his conditions with reduced mobility. This is a multiple factorial problem caused by his Parkinson's disease, weak legs as a result of his war injury and his obesity of 102 kgs. He is now living alone as his wife had died in 1989. He uses an electric wheelchair effectively and his Barthel is 17 but most of the help he currently needs is with dressing.

6.6. Further problems occur include hypertension, which is treated in 1995, and diabetes mellitus (high blood sugar), which is diagnosed later in the year.

6.7. By September 1987 he is getting considerable problems in managing his mobility as well as his Parkinsonian drug regime with significant dystonic movements. He is now on multiple drugs to treat his various medical conditions. He is referred to the Day Hospital for more physiotherapy to try and support him and to change his drug regime but he cancels further appointments in November 1997 (355).

6.8. By March 1998 (141) when he is seen in the Day Hospital within the Outpatients it mentions that he was now in Solent Cliff Nursing Home, though when seen in June 1998 (345) he has moved to the Merlin Park Residential Home. Throughout this gentleman's last illness there is a pattern of him being persistently dissatisfied with the care he receives, either in hospital or in the various homes he is cared for in, leading to multiple moves. This often complicates assessment as one institution never gets entirely used to him, his management and his behaviour.

6.9. By June 1998 there is now a very marked change in his health. There has been massive weight loss from 102 kgs in 1994 (441), 84 kgs in October 1997 (629) to 68.7 kgs documented by July 1998 (339). He is walking very unsteadily, is having falls in the home, having hallucinations at night, he is depressed and has marked dystonic movements. He is not happy with the suggestion that he actually needs less medication rather than more to help manage his condition.

6.10. Whether the result of genuine unhappiness with the home or depression on top of what is now probably becoming an early dementing illness (his mental test score on 22nd June (343) was 23/29), he refuses to stay at Merlin Park. Social Services become involved and he is seen in the Day Hospital when no new acute problems on top of his known chronic problems are detected. Social Services manage to place him in the Alvestoke Nursing Home (341).

6.11. However, he is not happy at all with this placement when he is seen in the Day Hospital on 6th July 1998 (339). The plan is to investigate his weight loss and to reduce his Sinemet treatment. His Barthel is now 9/20. A further medical complication that has developed, probably since early 1997 (68), is that he has an abnormality of his full blood count with a reduced white cell count and a reduced platelet count. This suggests a problem with his bone marrow. Although the blood film say this is likely to be myelodysplagia (a pre-malignant condition of the bone marrow where there is partial bone marrow failure, but it has not progressed to Leukaemia) no definitive haematological investigations appear to have been undertaken. The main effect of this condition is he is likely to be much more susceptible to infections.

6.12. He is seen by the psychiatric team on 8th July (117) and then is admitted to hospital on 21st July to Mulberry Ward with a primary diagnosis of depression, probably on top of an underlying mild dementing illness (67). For the first time a bed-sore is noted in the nursing notes (293) although this is not commented on in the thorough medical clerking that was undertaken on admission (66).

6.13. There is no doubt that there has been a very significant decline in this gentleman's general health. He has now lost over 40 kgs of weight, including 25% of his body weight in the last year. He had rapidly declining mobility, an early bedsore, he has started to develop mental impairment and his Parkinson's disease has become increasingly difficult to manage.

6.14. Admission is characterised by descriptions of restless and demanding behaviour and occasionally aggression. I suspect he has a low-grade delirium (delirium is acute confusion on top of, in this case, an early underlying dementing illness). Probably being caused by a combination of his drugs and the urinary tract infections that are documented on serial urine samples. He is started on drugs for his (understandable) depressive illness, which in themselves may complicate his drug regime. Finally he is treated with major tranquillisers to try and control his moods and behaviours.

6.15. The outcome of this admission is that he is now on multiple medications to try and control multiple symptoms. Yet there is very little improvement or change in his behaviour, as noted in the nursing cardex.

6.16. He is planned to the Thalassa Nursing home on 28th August as his 4th residential move of the year. However, on the 25th August he is noted to be passing less urine and a blood test on 26th August shows that he has gone into quite significant acute renal failure. On examination he is found to be in retention of urine and is catheterised and two litres of urine is passed (91).

6.17. The retention of urine in itself is likely to have had multi-factorial causes, including the drugs he was on, his proven urinary tract infections and he may also have had an undiagnosed prostatic problems based on a raised PSA (179). However, he responds well to catheterisation and his renal function is dramatically improved by 28th when he is discharged, with a Urea of 15.6 and a Creatinine of 144 (173).

6.18. Following discharge things appear to go not too badly, the CPN seeing him on 11th September (99) states that his mood seems good and he is settled well. On 14th September when he is seen in the Day Hospital, his weight remains unchanged on 68.6 kgs (323) "he is brighter and says eating not too badly" (459). However, his blood pressure is rather low on 14th September at 108/58 (323) and the pressure sore must be causing concern as a swab is sent (317).

6.19. He then has a routine review, for a therapist assessment on 17th September. The nursing notes give a clue that he is quite unwell that day (908 and 909), they refer to the pressure sore now exudating

markedly, he would not comply with his dressings, he would not wake up after bed rest and was refusing to eat or drink. He was apparently expressing a wish to die. This suggests to me he was acutely delirious again and the underlying aetiology could well be sepsis from pressure sore or sepsis (which is very common) from his urinary tract after a recent catheterisation. The nursing notes say that he is seen by the consultant but I was not able to find any medical notes. The nursing notes suggest that Dr Lord considered that she needed to review him on 21st and might need admission at this stage. It is below normal acceptable good medical practice to not make a record when seeing a patient, particularly if there has been a significant change in their condition.

6.20. Mr Cunningham is reviewed again on 21st September (642) when he has rapidly deteriorated, is very ill and very frail. He has an offensive large necrotic sacral ulcer and is not able to swallow with tablets in his mouth. He is admitted to hospital appropriately. Dr Lord asked for a management plan, including nursing him on his side, a high protein diet, Oramorph PRN for pain and writes to the nursing home to keep the bed open for three weeks at least, the prognosis is poor.

6.21. This gentleman is very seriously ill, with multiple problems and has been in decline for at least three months. The consultant has to make a judgement whether these are easily reversible problems, which would need intensive therapy, including drips and surgery to the pressure sore in an acute hospital environment or whether this is likely to be the terminal event of a progressive physical decline.

6.22. In my view the combination of acute problems on top of his known progressive chronic problems, including the large necrotic pressure ulcer would mean that active treatment in an acute DGH was very likely to be futile and therefore inappropriate. It was appropriate to admit him into a caring environment for pain relief and to observe and provide symptomatic support. In my experience it is unusual for a consultant to write "poor prognosis" in the notes unless they believe the patient is terminally ill and death is likely to be imminent.

6.23. He is admitted to the ward, Dr Barton sees him and writes, "make comfortable" in the notes (645). As the patient has just been seen and examined by a consultant who has made a care plan, I think it is reasonable for no further clerking or examination to have been carried out, although many doctors would automatically do that, if briefly, so that they know the baseline of the patient. As suggested Oramorphine is written up and Mr Cunningham receives two doses on 21st.

6.24. However, a syringe driver has also been written up on admission (756) for Diamorphine and Midazolam. There is nothing in the medical notes that specifically explain why was it written up, when the drugs should be started or what dose. It would be normal medical practice to write a comment on such management plan in the notes, but it is not negligent by itself, to fail to do so.

6.25. The nursing notes state that he remains agitated, pulling off his dressings later in the day (880). A decision is made, with the drugs written up (who decides?) to start him on Diamorphine 20 mgs with 20 mgs of Midazolam in a syringe driver.

6.26. The dose of Diamorphine is within an acceptable starting range for patients in pain. Midazolam is also widely used for terminal restlessness; the dose prescribed is from 5 – 80 mgs per 24 hours. The starting dose is within the range of 5 – 20 mgs per 24 hours that is acceptable for older patients (Palliative Care. Chapter 23 in Brocklehurst's Text Book of Geriatric Medicine 6th Edition 2003). Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. As the patient was terminally ill and restless, despite his previous doses of Omnopon, I think this was a reasonable management decision.

6.27. By 29th he is clearly delirious and is now totally dependent with a Barthel of 0/20. There does not appear to have been very good communication with the Son as anxieties are raised about his management (868). The dose of Diamorphine and Midazolam remain unchanged on 22nd and 23rd, although he is a little agitated at night on 23rd (876) and both day and night staff report pain on 24th (869). At this stage Diamorphine is increased to 40m mgs and the Midazolam to 80 mgs. In my view, the dose of Diamorphine prescribed was appropriate, however the four-fold increase in Midazolam 20 mgs on the 23rd to 80 mgs on the 24th appears excessive.

6.28. After the pain on 24th there is no further distress noted in either the medical notes (645) or the nursing notes (869). Despite this, the Diamorphine is increased to 60 mgs a day on 25th and 80 mgs on the 26th and the Midazolam is put up to 100 mgs a day on the 26th. In my view it was reasonable to increase the palliative care regime of Diamorphine and Midazolam on both 23rd and 24th September. He was in pain and he was agitated. It might well have been better to increase the Diamorphine (as pain does seem to be a major issue here with the bed-sore) rather than the Midazolam to ensure that this dying man was symptom free and did require an increase in medication on the 24th.

6.29. The dose of Diamorphine is then increased on both the 25th and 26th to 60 then 80 mgs (837) and Midazolam is increased again on 26th September to 100 mgs. There is no justification given for this in either the nursing or the medical notes, nor at any stage is it possible to tell from the notes whether the decision to change the drug dosages was a medical or a nursing decision or which doctor or nurse made that decision.

6.30. In my view the dose of Diamorphine and Midazolam was excessive on 25th and 26th and the medication may have slightly shortened life. However, I cannot find evidence to satisfy myself to the standard 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.

7. OPINION

7.1. 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 to stop trying to deal with each individual problem or crisis, to an acceptance the patient is now dying and that symptom control is appropriate.

7.2. 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.

7.3. 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".

8 LITERATURE/REFERENCES

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5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129
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9. EXPERTS' DECLARATION

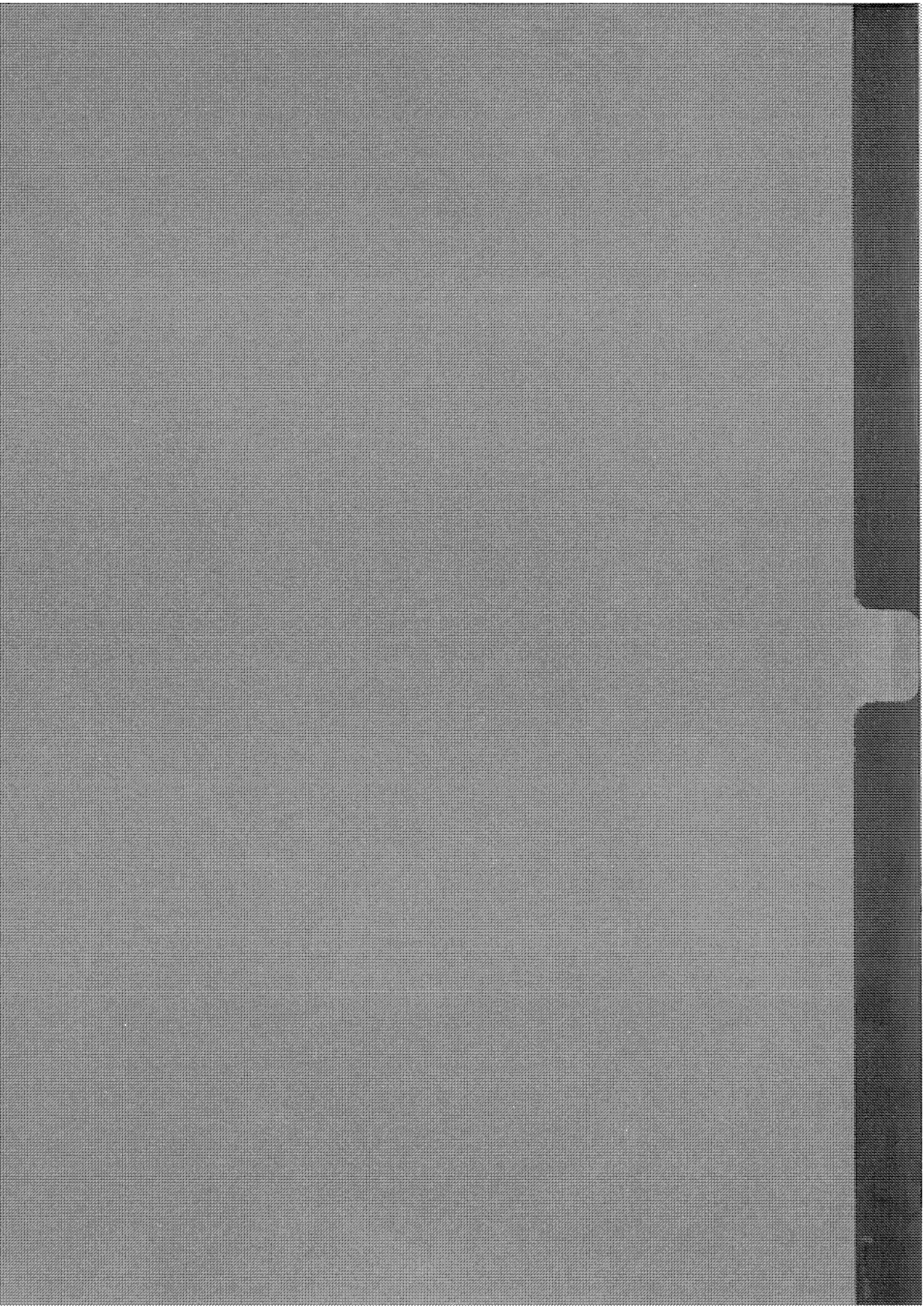
1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Version 2 of complete report 11th July 2005 – Arthur Cunningham

Signature:_____ **Code A** _____ Date: 12/7/05



Form MG15(T)

RESTRICTED

RECORD OF INTERVIEW

Enter type: ROT

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(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FRAUD SQUAD OFFICE NETLEY

Date of interview: 21/04/2005

Time commenced: 0902 Time concluded: 0932

Duration of interview: 30 MINS Tape reference nos. (→) CSY/JAB/6

Interviewer(s): DC2479 YATES & DC1162 QUADE

Other persons present: Mr BARKER Solicitor

Police Exhibit No: CSY/JAB/6A Number of Pages: 24

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded, I'm DC2479 Chris YATES. My colleague is –
DC QUADE	DC1162 Geoff QUADE.
DC YATES	I'm interviewing Doctor Jane BARTON, Doctor could you please give your full name and your date of birth.
BARTON	Jane Anne BARTON, **Code A**

RESTRICTED

DC YATES — Thank you. Also present is Mr BARKER who's Doctor BARTON'S Solicitor. Can you please introduce yourself with your full name.

SOLICITOR — Gladly. Ian Stephen Petrie BARKER and I am indeed Doctor BARTON'S Solicitor.

DC YATES — And have you got a statement about your role here today.

SOLICITOR — No just that I'm Doctor BARTON'S Solicitor.

DC YATES — This interviews being conducted in an office within the Fraud Squad at Netley, Support Headquarters in Hampshire, the time is two minutes past 9, 09:02 hours and the date is the 21st of April 2005. At the conclusion of the interview Doctor I'll give you a notice explaining what will happen to the tapes. I must remind you as well Doctor that you're still entitled to free legal advice. I know Mr BARKER is here as your legal advisor but have you had enough time to consult with Mr BARKER in private or would you like further time.

BARTON — I've had enough time thank you.

DC YATES — If at any time during the interview you wish to take legal advice just say and we'll stop the interview and find somewhere, where you can consult in private. I'd also like to point that you have attended voluntarily, you're not under arrest you've come here of your own freewill and this means that if at any time you wish to leave your completely free to do so okay.

BARTON Okay.

DC YATES I also Caution you. You do not have to say anything but it may harm your defence if you do not mention when questioned something, which you later rely on in Court. Anything you do say maybe given in evidence. Do you understand that Caution.

BARTON I do.

DC YATES I normally ask you for our peace of mind of your understanding of the Caution but it always comes back to me to, to break it down so.

SOLICITOR Just testing you.

DC YATES Just so that, just so that we know that, that it is understood it's broke into three sections. The first bit's very easy, you don't have to say anything and the last bit is very simple in that this interview is being tape recorded and should the matter go to Court then a transcript can be read or the tapes can be played. It's the middle bit that needs a little bit of explanation, should this matter go to Court it may and it is a may harm your defence if you don't mention something while your being questioned but then come up with an alibi or some form of answer at Court, the Court may think well why didn't you say that earlier. Okay. Everybody happy with that explanation.

SOLICITOR I'm happy with that certainly.

DC YATES — On this occasion the room again it's not being monitored as you know on the occasion it was monitored there's a little box that sits on top there with a red light, it's not being monitored. As before it will be me speaking to you the majority of time and DC QUADE will be taking notes during the interview. One thing I would like to cover with you Mr BARKER the last time we met was Thursday, I can't remember the date now. The last time we met we gave you some disclosure, advance disclosure which was the medical notes of Arthur CUNNINGHAM and a brief synopsis. Is that correct.

SOLICITOR — That is indeed correct.

DC YATES — Doctor as you are aware this is an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital and that's between 1990 and 2000, a ten year period. No decision has been made as to whether an offence or any offence has been committed. But it's important to be aware that the offence range being investigated runs from murder to assault, there's a very wide range. Part of the ongoing enquiries to interview witnesses who were involved in the care and treatment of the patients during that period. You were a Clinical Assistant working at the hospital at the time of these deaths, your knowledge is for the working of the hospital and the care and treatment of the patients is very central to our enquiry. The interview today will concentrate on the care and treatment of Arthur Brian David CUNNINGHAM, who was I think often mainly

known as Brian CUNNINGHAM. Mr CUNNINGHAM was a 78 year old man who was admitted to Dryad Ward on 21st September 1998 with bed sores. He had a history of Parkinson's Disease and he died five days later on the 26th September 1998 cause being given as bronchial pneumonia and Parkinson's Disease, now perhaps Doctor in your own words you can tell me what you recollect, recollect of Mr CUNNINGHAM'S treatment and care at the Hospital on Dryad Ward. Now I know that you've got a prepared statement is that what you wish to read.

BARTON — Thank you.

DC YATES — It is is it. Can I ask you the normal question is that your statement did you make that statement.

BARTON — I did.

DC YATES — Okay. Then feel free to read it.

BARTON — I am Dr Jane BARTON of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital.

I understand you are concerned to interview me in relation to a patient at the Gosport War Memorial Hospital, Mr Arthur CUNNINGHAM. As you are aware, I provided you with a statement on the 4th November 2004 (04/11/2004), which gave information about my practice generally, both

in relation to my role as a General Practitioner and as the clinical assistant at the Gosport War Memorial Hospital. I adopt that statement now in relation to general issues insofar as they relate to Mr CUNNINGHAM.

In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. I confirm that these comments are indeed a fair and accurate summary of the position in 1998 when I was involved in the care of Mr CUNNINGHAM.

Arthur CUNNINGHAM was a retired gentleman of 79 who had been under the care both of Elderly Medicine and Elderly Mental Health for some time. He suffered from Parkinson's disease, and features of this degenerative disease had apparently been present since the mid 1980's. In addition, Mr CUNNINGHAM had an old spinal injury from a plane crash during the second world war with associated chronic back pain, and diet controlled type 2 diabetes mellitus.

Mr CUNNINGHAM was referred to Dr LORD by his GP in early 1998 with complaints of breathlessness. Dr LORD saw him in March and considered that he might have problems with intermittent left ventricular failure. She also gave advice about the level of his medication for his Parkinson's disease.

At that time Mr CUNNINGHAM was living in sheltered accommodation, where he had been for a number of years. It appears that he was then admitted to the Merlin Park rest home shortly after he saw Dr LORD. It appears that Mr CUNNINGHAM attended at the Dolphin Day Hospital on a number of occasions before being referred once more to Dr LORD by his GP in June 1998. Mr CUNNINGHAM had apparently developed quite marked dystonic movements involving his face trunk and arms, and he had been experiencing hallucinations which the GP thought might be due to the amount of medication for his Parkinson's.

Dr LORD saw Mr CUNNINGHAM at a domiciliary visit on 19th June. When she wrote back to his GP several days later she said that she was most struck at the amount of weight Mr CUNNINGHAM seemed to have lost since she had last seen him. She felt he was indeed taking too much Levodopa for his Parkinson's, and that he was depressed at the move to the rest home. Mr CUNNINGHAM apparently agreed to attend at the day hospital.

However, even before that arrangement could be put into effect, on 22nd June, Mr CUNNINGHAM was then brought by a Social Worker to the Phoenix Day Hospital, which was located in the same building at Gosport War Memorial Hospital. Mr CUNNINGHAM had apparently stayed the previous night with friends and was refusing to return to the Merlin Park rest home. In addition to Parkinson's disease, he was felt to be suffering from with dementia, hallucinations from his medication, and from depression.

The medical records suggest that a place was then found at Alverstoke nursing home. He was reviewed at the Dolphin Day Hospital on 6th July, when his Barthel score was 9 having been 17 the previous year, and he was then seen the following day at Alverstoke at a domiciliary visit by staff grade psychiatrist Dr Mary SCOTT-BROWN. Dr SCOTT-BROWN felt that Mr CUNNINGHAM was clinically depressed and prescribed Sertraline, an anti-depressant.

Mr CUNNINGHAM was then seen again at the Dolphin Day Hospital, where concern was raised about him having problems with a myeloproliferative disorder and it appears that the Sertraline may have been discontinued in consequence. It seems that Mr CUNNINGHAM continued to be depressed and arrangements were then made for him to be admitted to the Mulberry Ward at the Gosport War Memorial Hospital on 21st July. He was assessed on admission when his problems were considered to include dementia, Parkinson's disease, depression, and myelodysplasia. The latter was demonstrated by

thrombocytopaenia – a low platelet count, and meutropaenia – a low white cell count. It was felt that this had been a chronic problem since February the previous year, and that he was more susceptible to infection. At the time of admission he was considered to be "quite physically frail".

Mr CUNNINGHAM was seen by Dr LORD on 27th July when she noted that he had low albumin and white cells counts. By this time he was receiving Mirtrazapine as an alternative anti depressant to the Sertraline.

Mr CUNNINGHAM remained on Mulberry Ward for a period slightly in excess of a month. His notes show that he was reviewed by Dr LORD on the 27th August. Dr LORD noted that Mr CUNNINGHAM had been catheterised as he had been retaining urine, and 1900 mls were produced on catheterisation. A nursing note the same day indicates that granuflex dressing continued to be applied to the sacral area, and indeed 6 days previously there had been a note indicating that the area was sore and cream had been applied. Dr LORD felt that the Parkinson's disease had deteriorated and Mr CUNNINGHAM was now not really mobile. Dr LORD decided to continue with the same dose of L-Dopa for his Parkinson's disease as increasing this might worsen Mr CUNNINGHAM'S mental state. She felt Mr CUNNINGHAM should be transferred to the Thalassa Nursing Home the following day, and follow-up was to be arranged at the Dolphin Day Hospital, with Mr CUNNINGHAM to be seen there on the 14th September.

The Waterlow pressure score at that time was measured at 20, constituting a very high risk.

Mr CUNNINGHAM was actually discharged two days later, on the 29th August. A placement had by that stage been found at the Thalassa Nursing Home. The discharge note records that Mr CUNNINGHAM'S myelodysplasia was stable, and that his creatinine following the urinary retention was abnormally high at 301.

Mr CUNNINGHAM was then duly seen at the Dolphin Day Hospital on the 14th September, and by this stage the area on the sacrum had deteriorated. The nursing assessment indicates that pressure sores were broken on the sacrum and that Mr CUNNINGHAM required pressure relieving cushions. It seems from the subsequent nursing note that a swab would have been taken from the sacral sore at the attendance on the 14th September.

He was seen at the Day Hospital by Dr ROSS, and his current medication was noted to be Amlodipine 5mg marne for hypertension, Magnesium Hydroxide 10mls twice a day for constipation, Codanthrusate 2 capsules nocte for severe constipation, Sinamet 110 1 four times a day and and Sinamet CR 1 at night both for Parkinson's disease, Co-proxamol 2 four times a day for pain relief, Mirtazapine 30 mgs at night as an anti-depressant, Senna 2 nocte for constipation, Triclosfos 20 mls nocte as sedation to assist sleep, Risperidone 0.5 mgs at 6 p.m. also for sedation, and Carbamazepine 100 mgs nocte as sedation and pain relief from neuralgia.

Mr CUNNINGHAM attended again at the Day Hospital 3 days later on the 17th September, when the swab was noted to have had a positive result, and an anti-biotic, Metronidazole was commenced. The nursing notes record that Dr LORD saw Mr CUNNINGHAM that day and there was a possibility he would be admitted the following Monday. Mr CUNNINGHAM was also noted as having expressed a wish to die.

Dr LORD duly reviewed Mr CUNNINGHAM again at the Dolphin Day Hospital on the Monday 21st September. She noted that he was now very frail with an offensive large necrotic sacral ulcer with a thick black scar. She noted his medical problems to be the sacral sore, Parkinson's disease, his old back injury, depression with an element of dementia, diabetes, and that he had been catheterised for retention of urine. The decision was made to admit Mr CUNNINGHAM to Dryad Ward at the Gosport War Memorial Hospital. A note written by a member of the nursing staff on the 24th September, but seemingly relating to about this time recorded that there had been a physical decline and the pressure sore had developed. Mr CUNNINGHAM was said to be 'terminally ill' and not expected to live past the weekend according to the sister on the ward.

Dr LORD wrote to Mr CUNNINGHAM'S General Practitioner the same day, reporting that he had been reviewed at the Dolphin Day Hospital and that he had a "large necrotic sacral ulcer which was extremely offensive.

There was some grazing of the skin around the necrotic area, and also a reddened area with a black centre on the left lateral malleolus". Dr LORD said that she was admitting him to the Dryad Ward with a view to more aggressive treatment on the sacral ulcer as she felt that this would now need Aserbine. This is a medication which Dr LORD probably hoped would dissolve the black scab area of the pressure sore, to help with healing. In Dr LORD'S entry in the medical records, she noted the plan to administer Aserbine, recorded that Mr CUNNINGHAM should be nursed on his side, should have a high protein diet, and that Oramorph should be given if required for the pain. In concluding her note, she recorded that the prognosis was poor. By that, Dr LORD would have felt that Mr CUNNINGHAM was probably dying.

I recall that prior to Mr CUNNINGHAM being moved to Dryad Ward, I went to see him at the Day Hospital together with Sister HAMBLIN. He was clearly upset, distressed and in pain when we then took him down to Dryad Ward. Once at Dryad Ward I examined him. A photograph was taken of the pressure sore which was very extensive. As Dr LORD had previously produced a detailed note by way of review at the Day Hospital, and as we had a photographic record of the pressure sore, my note on this occasion was more limited. Given Mr CUNNINGHAM'S very frail condition and Dr LORD'S assessment of the prognosis, I included within my note the entry that I was happy for the nursing staff to confirm death. That would have the effect of ensuring that it was not necessary for a duty Doctor to be

asked to attend specifically for that purpose if Mr CUNNINGHAM were then to die.

I assessed Mr CUNNINGHAM the same day, and my note reads as follows:

"21-9-98 Transfer to Dryad Ward
Make comfortable
Give adequate analgesia
I am happy for nursing staff to confirm death".

The drug chart which had been available at the Dolphin Day Hospital was brought to the ward, and the medication continued – as per the drugs which had been set out by Dr ROSS in her record of the 14th September. Dr LORD added the prescription for Oramorph, 2.5-10 mls to be available four hourly as required. I also later prescribed Actrapid for Mr CUNNINGHAM'S diabetes, at 10 units if the blood sugar was in excess of 15, and 5 units if it was in excess of 10.

Having assessed Mr CUNNINGHAM personally, I was concerned that although the Oramorph would assist in providing pain relief, this might become inadequate. The sacral sore was very significant, being the size of a fist, and the second largest I have ever seen. It was clearly causing Mr CUNNINGHAM significant pain and distress at the time when I assessed him. Accordingly, I decided to write up Diamorphine on a proactive basis and a dose range of 20 to 200 mgs. This was a wide range, but I was conscious that inevitably the medication would be commenced at the

bottom end of this range, if given at all. Any increase would then ordinarily be with reference to me or another practitioner.

In addition to the Diamorphine I prescribed 200 – 800 mcgs of Hyoscine and Midazolam, 20 – 80 mgs. These medications were prescribed by me purely with the aim of alleviating Mr CUNNINGHAM'S significant pain, distress and agitation. It was also apparent to me that Mr CUNNINGHAM might have a problem with swallowing Dr LORD'S note for earlier that day indicated that tablets had been found in his mouth, and this gave rise to a concern that Mr CUNNINGHAM would not be able to take tablets, including the Carbamazepine, Mirtazapine, Risperidone, and Triclofos, the lack or reduction in which would cause corresponding increase in his agitation.

The nursing records for the 21st September record the admission and that I saw Mr CUNNINGHAM. The nursing record and the drug chart also indicate that at 2.50 p.m. Mr CUNNINGHAM was given 5 mgs of Oramorph prior to the dressing of his wound. It appears that a further 10 mgs of Oramorph was given later in the day.

A further nursing record indicates that Mr CUNNINGHAM was said to very agitated at 5.30. A dressing was applied to the buttock at 6.30 p.m, with Asberine cream to the necrotic area, together with Zinc and Caster Oil to the surrounding skin. Further Oramorph, 10 mgs, was given later at about 8.15 to 8.20 p.m. A further nursing entry indicates that Mr CUNNINGHAM remained agitated until

approximately 8.30. It seems then that Mr CUNNINGHAM pulled off the dressing to the sacral area.

Later that evening at about 11 p.m. the syringe driver was established, with 20 mgs of Diamorphine and 20 mgs of Midazolam. I have no specific recollection, but I anticipate that the second dose of Oramorph had been insufficient in relieving the pain and anxiety, and in the circumstances, to ensure that Mr CUNNINGHAM was free from pain and anxiety, and had a settled and an uninterrupted night, the Diamorphine was then commenced, providing continuous pain relief for what was most was clearly a most unpleasant ulcerated wound. A subsequent entry in the nursing notes suggest that Mr CUNNINGHAM had been distressed and anxious at about this time, and no doubt he would have been in pain.

I cannot now say if I was specifically contacted about the institution of the Diamorphine. Ordinarily I would have been contacted, but the administration was at the lowest end of the dose range, and its provision had been agreed with me and the nursing staff earlier, so it is possible that specific reference was not made. In any event, the nurses noted that Mr CUNNINGHAM was peaceful following the institution of the Diamorphine and Midazolam, and slept soundly. He was said to have had two glasses of milk, taken when he was awake, and in the morning was much calmer. A further nursing entry the following morning records that he had had a very settled night.

Although I made no record of it, I would have seen Mr CUNNINGHAM again the following morning and reviewed his condition. A Barthel assessment was carried out the same day, Mr CUNNINGHAM'S Barthel score being nil, in other words he was totally dependent by this time. Again, my ability to complete the notes at this stage would have been significantly hampered by my workload, with the large number of patients to be reviewed.

The nursing notes indicate that Mr CUNNINGHAM'S step-son phoned in the course of the day, and it was explained to him that a syringe driver with Diamorphine and Midazolam had been commenced the previous evening for pain relief and to allay his anxiety following an episode when Mr CUNNINGHAM had tried to wipe sputum on a nurse saying that he had HIV and was going to give it to her. This is the episode of distress and anxiety to which I made reference above. He had apparently also tried to remove his catheter and empty the bag, and remove his sacral dressing, throwing it across the room.

The syringe driver was noted to have been charged at 8.20 p.m. on 22nd September with a further 20 mgs of Diamorphine and Midazolam, Mr CUNNINGHAM was noted to appear less agitated that evening. It seems therefore that the Diamorphine and Midazolam had had the appropriate affect, though the agitation was only less, and had not apparently resolved completely.

I saw Mr CUNNINGHAM again the following morning, 23rd September which is recorded in the nursing record.

Again I was unable to make a note in Mr CUNNINGHAM'S records. The nurses indicated that Mr CUNNINGHAM had become chesty overnight and was now to have Hyoscine added to the syringe driver. That would have been a decision made by me following my assessment of him. Mr CUNNINGHAM'S step-son, Mr FARTHING, was contacted and informed of Mr CUNNINGHAM'S deterioration. The step-son asked if this was due to the commencement of the syringe driver, and was apparently told by the nursing staff that Mr CUNNINGHAM was on a small dose which he needed. I would agree that the dose involved was both small and necessary.

Later that day Mr and Mrs FARTHING came to the hospital and were seen by Sister Gill HAMBLIN, together with staff nurse Freda SHAW. They were apparently very angry that the driver had been commenced, but Sister HAMBLIN noted that she explained again the contents of the syringe driver were to control Mr CUNNINGHAM'S pain, and if discontinued we would need an alternative method of giving pain relief. Sister HAMBLIN noted that Mr FARTHING was now fully aware Mr CUNNINGHAM was dying and needed to be made comfortable. It would appear from her note and from the nature of the explanation given to Mr FARTHING, that Sister HAMBLIN agreed this medication was necessary to relieve Mr CUNNINGHAM'S pain and distress.

The driver was then renewed at 8 p.m. with 20 mgs of Diamorphine, but with an increase in the level of

Midazolam to 60 mgs, together with 400 mcgs of Hyoscine. I anticipate that Mr CUNNINGHAM'S agitation might have been increasing, hence the increase in the level of Midazolam, and indeed in spite of that, the notes go on to record that Mr CUNNINGHAM became a little agitated at 11 p.m. with the syringe driver being boosted with effect. The nursing staff recorded that Mr CUNNIGHAM seemed to be in some discomfort when moved, and the driver was boosted prior to changing position.

Again, I anticipate that I would have been contacted about the increase in the medication and agreed with it, although I have got no recollection of this.

I anticipate, though I have made no specific note of it, that I would have again seen Mr CUNNINGHAM the following morning, 24th September in order to review his condition.

On the 24th September, Sister HAMBLIN recorded a report from the night staff that Mr CUNNINGHAM was in pain when being attended to, and was also in pain with the day staff, though it was suggested that this was especially in his knees. In any event, the syringe driver was increased to 40 mgs of Diamorphine, and the Midazolam to 80 mgs, together with 800 mcgs of Hyoscine. The dressing was reviewed in the afternoon and Sister HAMBLIN went on to record that Mr FARTHING had been seen by me that afternoon and was fully aware of Mr CUNNINGHAM'S condition.

I have no recollection of meeting Mr FARTHING, but clearly I did so and indeed that is recorded in my own note in Mr CUNNINGHAM'S records which reads as follows:-

> "24-9-98 Remains unwell
> Son has visited again today and
> is aware of how unwell he is
> subcutaneous analgesia is controlling the
> pain – just
> I am happy for nursing staff to confirm
> death".

I anticipate that I would have explained Mr CUNNINGHAM'S condition to his step-son, that we were endeavouring to keep him free from pain distress and agitation, and that sadly he was dying. My note indicates that although the subcutaneous analgesia was controlling the pain, this was "just", and clearly I envisaged that Mr CUNNINGHAM'S condition was such that it might become necessary to increase the medication.

The nursing records indicate for the night of the 24th September Mr CUNNINGHAM was aware of being moved it being necessary periodically to alternate the position in which he was lying, but he was felt to have had a peaceful night sleep though sounding chesty in the morning.

I anticipate that in the usual way I would have seen Mr CUNNINGHAM again that morning, 25th September. I wrote a further prescription for the Diamorphine, Hyoscine

and Midazolam, this time with the ranges being 40 – 200, 800 mcgs – 2 grammes, and 20 – 200 mgs respectively.

It appears then that the Diamorphine was then increased to 60 mgs, with 80 mgs of Midazolam and 1200 mcgs of Hyoscine at 10.15 that morning. My expectation is that this increase was necessary to relieve Mr CUNNINGHAM'S pain and distress. It is likely that by this time Mr CUNNINGHAM would have become been becoming tolerant to opiates, and that might have added to the need to increase the doses of medication. It appears from the previous drug chart that an error was made by the nurse on the 25th September, when she started to record the 60 mgs as if for the previous day 24th September, but she has gone on then to complete the entry on the new chart, and it seems clear from the nursing notes that this increase in the dose of medication was indeed instituted on the morning of 25th September.

It appears that my partner, Dr Sarah BROOK, was on duty over the course of the weekend, and so would have been on call from the evening of Friday 25th September. I anticipate that I might have informed her of Mr CUNNINGHAM'S condition, and the fact that he was likely to die soon. It is possible that in consequence of this Dr BROOK decided to review Mr CUNNINGHAM and it is clear she attended to see him, noting in the record that he remained very poorly, that he was on a syringe driver and was for "TLC", meaning tender loving care. Dr BROOK would have appreciated that he was likely to die soon and that keeping

him free from pain and distress was all that could be reasonably achieved in the circumstances.

Sadly and inevitably, Mr CUNNINGHAM continued to deteriorate. It appears that he had a peaceful night, but the nursing records record specifically that his condition was deteriorating slowly, with all care being given.

The following morning, at about 11.50 a.m., the medication was increased again, with Diamorphine at 80 mgs, Midazolam at 100 mgs, and the Hyoscine maintained at 1200 mcgs. I anticipate that Mr CUNNINGHAM was experiencing further pain and distress, necessitating the increase, and that Dr BROOK would have agreed with it, though it is also possible that I might have been contacted prior to the increase by the nursing staff instead. In view of Mr CUNNINGHAM'S condition, with the significant pain from the large sacral sore, and the fact that he would have been becoming inured to the medication, that increase would have been necessary.

Sadly, Mr CUNNINGHAM continued to deteriorate. There is no record that Mr CUNNINGHAM was experiencing pain in the course of the day, and it appears therefore that the medication was successful in relieving pain, distress and anxiety at that time. Mr CUNNINGHAM died that evening at 11.15 p.m., death being confirmed by nurses Beverley TURNBULL and Anita TUBBRITT.

At all times the medication given to Mr CUNNINGHAM and as authorised by me was provided solely with the aim of relieving his pain, distress and anxiety in accordance with my duty of care to Mr CUNNINGHAM.

SOLICITOR — Can I say at this point that my advice to Dr BARTON is that she should make 'no comment' to any further questions which you might wish to put to her and I adopt as the reason for that advice the reasons I have given previously.

DC YATES — Okay. Thank you for the prepared statement Doctor. Can I ask you as before do you mind sign, signing it dating it and note it that you've handed it to me DC YATES.

BARTON — This one. On the front page or the back page.

DC YATES — Back page will be great please.

SOLICITOR — As Doctor BARTON'S doing that can I suggest that she might want to mark in an amendment on paragraph 15. Showing the second part there after the first drug it was Marne.

BARTON — Said.

SOLICITOR — You said it yeah.

DC YATES — You said it yeah.

RESTRICTED

BARTON Signed and handed to DC YATES, signature and the date.

DC YATES Could you initial the correction.

BARTON Yes.

DC YATES Yeah lovely. Do you mind and sign that.

SOLICITOR Not at all.

DC YATES Any questions you'd like to ask Geoff.

DC QUADE No thank you.

DC YATES As before Doctor we'll call a stop to the interview at the moment so that we can go away and actually go through this slowly in our own time, there may well be some questions that I want to ask, I fully accept what your Solicitor's said you will not be answering any questions I may put to you, we'll have to see where we are once I've digested all this information. Is there anything you wish to clarify or add at the moment though.

BARTON No thank you.

DC YATES Okay. Well we'll give you a notice explaining what will happen to the tapes. The time is 9:32 and we'll turn the recorder off.

RESTRICTED

STATEMENT OF DR JANE BARTON - RE ARTHUR CUNNINGHAM

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Arthur Cunningham. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Cunningham.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. I confirm that these comments are indeed a fair and accurate summary of the position in 1998 when I was involved in the care of Mr Cunningham.

4. Arthur Cunningham was a retired gentleman of 79 who had been under the care both of Elderly Medicine and of Elderly Mental Health for some time. He suffered from Parkinson's disease, and features of this degenerative disease had apparently been present since the mid 1980's. In addition, Mr Cunningham had an old spinal injury from a plane crash during the second world war - with associated chronic back pain, and diet controlled type 2 diabetes mellitus.

5. Mr Cunningham was referred to Dr Lord by his GP in early 1998 with complaints of breathlessness. Dr Lord saw him in March and considered that he might have problems with intermittent left ventricular failure. She also gave advice about the level of his medication for his Parkinson's disease.

6. At that time Mr Cunningham was living in sheltered accommodation, where he had been for a number of years. It appears that he was then admitted to the Merlin Park rest home shortly after he saw Dr Lord. It appears that Mr Cunningham attended at the Dolphin Day Hospital on a number of occasions before being referred once more to Dr Lord by his GP in June 1998. Mr Cunningham had apparently developed quite marked dystonic movements involving his face trunk and arms, and he had been experiencing hallucinations which the GP thought might be due to the amount of medication for his Parkinson's.

7. Dr Lord saw Mr Cunningham at a domiciliary visit on 19th June. When she wrote back to his GP several days later she said that she was most struck at the amount of weight Mr Cunningham seemed to have lost since she had last seen him. She felt he was indeed taking too much Levopoda for

his Parkinson's, and that he was depressed at the move to the rest home. Mr Cunningham apparently agreed to attend at the day hospital.

8. However, even before that arrangement could be put into effect, on 22nd June, Mr Cunningham was then brought by a social worker to the Phoenix Day Hospital, which was located in the same building as GWMH. Mr Cunningham had apparently stayed the previous night with friends and was refusing to return to the Merlin Park rest home. In addition to Parkinson's disease, he was felt to be suffering with dementia, hallucinations from his medication, and from depression.

9. The medical records suggest that a place was then found at Alverstoke nursing home. He was reviewed at the Dolphin Day Hospital on 6th July, when his Barthel score was 9 (having been 17 the previous year), and he was then seen the following day at Alverstoke at a domiciliary visit by staff grade psychiatrist Dr Mary Scott-Brown. Dr Scott-Brown felt that Mr Cunningham was clinically depressed and prescribed Sertraline, an anti-depressant.

10. Mr Cunningham was then seen again at the Dolphin Day Hospital, where concern was raised about him having problems with a myeloproliferative disorder and it appears that the Sertraline may have been discontinued in consequence. It seems that Mr Cunningham continued to be depressed and arrangements were then made for him to be admitted to the Mulberry Ward at the GWMH on 21st July. He was assessed on admission when his problems were considered to include dementia, Parkinson's disease, depression, and myelodysplasia. The latter was demonstrated by thrombocytopaenia - a low platelet count, and neutropaenia - a low white cell count. It was felt that this had been a chronic problem since February the previous year, and that he was more susceptible to

infection. At the time of admission he was considered to be "quite physically frail".

11. Mr Cunningham was seen by Dr Lord on 27th July when she noted that he had low albumin and white cell counts. By this stage he was receiving Mirtrazapine as an alternative anti depressant to the Sertraline.

12. Mr Cunningham remained on Mulberry Ward for a period slightly in excess of a month. His notes show that he was reviewed by Dr Lord on the 27th August. Dr Lord noted that Mr Cunningham had been catheterised as he had been retaining urine, and 1900 mls were produced on catheterisation. A nursing note the same day indicates that granuflex dressing continued to be applied to the sacral area, and indeed 6 days previously there had been a note indicating that the area was sore and cream had been applied. Dr Lord felt that the Parkinson's disease had deteriorated and Mr Cunningham was now not really mobile. Dr Lord decided to continue with the same dose of L-Dopa for his Parkinson's disease as increasing this might worsen Mr Cunningham's mental state. She felt Mr Cunningham should be transferred to the Thalassa Nursing Home the following day, and follow-up was to be arranged at the Dolphin Day Hospital, with Mr Cunningham to be seen there on the 14th September. The Waterlow pressure score at that time was measured at 20, constituting a very high risk.

13. Mr Cunningham was actually discharged two days later, on the 29th August. A placement had by that stage been found at the Thalassa Nursing Home. The discharge note records that Mr Cunningham's myelodysplasia was stable, and that his creatinine following the urinary retention was abnormally high at 301.

14. Mr Cunningham was then duly seen at the Dolphin Day Hospital on the 14th September, and by this stage the area on the sacrum had deteriorated. The nursing assessment indicates that pressure areas were broken on the sacrum and that Mr Cunningham required pressure relieving cushions. It seems from the subsequent nursing note that a swab would have been taken from the sacral sore at the attendance on the 14th September.

15. He was seen at the Day Hospital by Dr Ross, and his current medication was noted to be Amlodipine 5mg mane for hypertension, Magnesium Hydroxide 10mls bd for constipation, Codanthrusate 2 capsules nocte for severe constipation, Sinamet 110 I qds and Sinamet CR I nocte both for Parkinson's disease, Co-proxamol 2 qds for pain relief, Mirtazapine 30 mgs nocte as an anti-depressant, Senna 2 nocte for constipation, Triclofos 20 mls nocte as sedation to assist sleep, Risperidone 0.5 mgs at 6pm also for sedation, and Carbamazepine 100 mgs nocte as sedation and pain relief from neuralgia.

16. Mr Cunningham attended again at the Day Hospital 3 days later on the 17th September, when the swab was noted to have had a positive result, and an anti-biotic, Metronidazole was commenced. The nursing notes record that Dr Lord saw Mr Cunningham that day and there was a possibility he would be admitted the following Monday. Mr Cunningham was also noted as having expressed a wish to die.

17. Dr Lord duly reviewed Mr Cunningham again at the Dolphin Day Hospital on the Monday 21st September. She noted that he was now very frail with an offensive large necrotic sacral ulcer with a thick black scar. She noted his medical problems to be the sacral sore, Parkinson's disease, his old back injury, depression with an element of dementia,

diabetes, and that he had been catheterised for retention of urine. The decision was made to admit Mr Cunningham to Dryad Ward at the GWMH. A note written by a member of the nursing staff on the 24th September, but seemingly relating to about this time recorded that there had been a physical decline and the pressure sore had developed. Mr Cunningham was said to be 'terminally ill and not expected to live past the weekend according to the sister on the ward'.

18. Dr Lord wrote to Mr Cunningham's General Practitioner the same day, reporting that he had been reviewed at the Dolphin Day Hospital, and that he had a "large necrotic sacral ulcer which was extremely offensive. There was some grazing of the skin around the necrotic area, and also a reddened area with a black centre on the left lateral malleolus." Dr Lord said that she was admitting him to the Dryad Ward with a view to more aggressive treatment on the sacral ulcer as she felt that this would now need Aserbine. This is a medication which Dr Lord probably hoped would dissolve the black scab area of the pressure sore, to help with healing. In Dr Lord's entry in the medical records, she noted the plan to administer Aserbine, recorded that Mr Cunningham should be nursed on his side, should have a high protein diet, and that Oramorph should be given if required for the pain. In concluding her note, she recorded that the prognosis was poor. By that, Dr Lord would have felt that Mr Cunningham was probably dying.

19. I recall that prior to Mr Cunningham being moved to Dryad Ward, I went to see him at the Day Hospital together with Sister Hamblin. He was clearly upset, distressed and in pain when we then took him down to Dryad Ward. Once at Dryad Ward I examined him. A photograph was taken of the pressure sore which was very extensive. As Dr Lord had previously produced a detailed note by way of review at the Day

Hospital, and as we had a photographic record of the pressure sore, my note on this occasion was more limited. Given Mr Cunningham's very frail condition and Dr Lord's assessment of the prognosis, I included within my note the entry that I was happy for the nursing staff to confirm death. That would have the effect of ensuring that it was not necessary for a duty doctor to be asked to attend specifically for that purpose if Mr Cunningham were then to die.

20. I assessed Mr Cunningham the same day, and my note reads as follows:

"21-9-98 Transfer to Dryad Ward
Make comfortable
give adequate analgesia
I am happy for nursing staff to confirm death."

21. The drug chart which had been available at the Dolphin Day Hospital was brought to the ward, and the medication continued - as per the drugs which had been set out by Dr Ross in her record of the 14th September. Dr Lord added the prescription for Oramorph, 2.5 - 10 mls to be available four hourly as required. I also later prescribed Actrapid for Mr Cunningham's diabetes, at 10 units if the blood sugar was in excess of 15, and 5 units if it was in excess of 10.

22. Having assessed Mr Cunningham personally, I was concerned that although the Oramorph would assist in providing pain relief, this might become inadequate. The sacral sore was very significant, being the size of a fist, and the second largest I have ever seen. It was clearly causing Mr Cunningham significant pain and distress at the time when I assessed him. Accordingly, I decided to write up Diamorphine on a proactive basis and a dose range of 20 to 200 mgs. This was a wide

range, but I was conscious that inevitably the medication would be commenced at the bottom end of this range, if given at all. Any increase would then ordinarily be with reference to me or another practitioner.

23. In addition to the Diamorphine I prescribed 200 - 800 mcgs of Hyoscine and Midazolam, 20 - 80 mgs. These medications were prescribed by me purely with the aim of alleviating Mr Cunningham's significant pain, distress and agitation. It was also apparent to me that Mr Cunningham might have a problem with swallowing - Dr Lord's note for earlier that day indicated that tablets had been found in his mouth, and this gave rise to a concern that Mr Cunningham would not be able to take tablets, including the Carbamazepine, Mirtazapine, Risperidone, and Triclofos, the lack or reduction in which would cause corresponding increase in his agitation.

24. The nursing records for the 21st September record the admission and that I saw Mr Cunningham. The nursing record and the drug chart also indicate that at 2.50pm Mr Cunningham was given 5 mgs of Oramorph prior to the dressing of his wound. It appears that a further 10 mgs of Oramorph was given later in the day.

25. A further nursing record indicates that Mr Cunningham was said to very agitated at 5.30pm. A dressing was applied to the buttock at 6.30pm, with Asberine cream to the necrotic area, together with Zinc and Caster Oil to the surrounding skin. Further Oramorph, 10 mgs, was given later at around 8.15 - 8.20pm. A further nursing entry indicates that Mr Cunningham remained agitated until approximately 8.30pm. It seems then that Mr Cunningham pulled off the dressing to the sacral area.

26. Later that evening at about 11pm the syringe driver was established, with 20 mgs of Diamorphine and 20 mgs of Midazolam. I have no specific recollection, but I anticipate that the second dose of Oramorph had been insufficient in relieving the pain and anxiety, and in the circumstances, to ensure that Mr Cunningham was free from pain and anxiety, and had a settled and an uninterrupted night, the Diamorphine was then commenced, providing continuous pain relief for what was clearly a most unpleasant ulcerated wound. A subsequent entry in the nursing notes suggest that Mr Cunningham had been distressed and anxious at about this time, and no doubt he would also have been in pain.

27. I cannot now say if I was specifically contacted about the institution of the Diamorphine. Ordinarily I would have been contacted, but the administration was at the lowest end of the dose range, and its provision had been agreed with me and the nursing staff earlier, so it is possible that specific reference was not made. In any event, the nurses noted that Mr Cunningham was peaceful following the institution of the Diamorphine and Midazolam, and slept soundly. He was said to have had two glasses of milk, taken when he was awake, and in the morning was much calmer. A further nursing entry the following morning records that he had had a very settled night.

28. Although I made no record of it, I would have seen Mr Cunningham again the following morning and reviewed his condition. A Barthel assessment was carried out the same day, Mr Cunningham's Barthel score being nil, in other words he was totally dependent by this time. Again, my ability to complete notes at this stage would have been significantly hampered by my workload, with the large number of patients to be reviewed.

29. The nursing records indicate that Mr Cunningham's step-son telephoned in the course of the day, and it was explained to him that a syringe driver with Diamorphine and Midazolam had been commenced the previous evening for pain relief and to allay his anxiety following an episode when Mr Cunningham had tried to wipe sputum on a nurse saying that he had HIV and he was going to give it to her. This is the episode of distress and anxiety to which I made reference above. He had apparently also tried to remove his catheter and empty the bag, and remove his sacral dressing, throwing it across the room.

30. The syringe driver was noted to have been charged at 8.20pm on 22nd September with a further 20 mgs of Diamorphine and Midazolam, Mr Cunningham noted to appear less agitated that evening. It seems therefore that the Diamorphine and Midazolam had had the appropriate affect, though the agitation was only 'less', and had not apparently resolved completely.

31. I saw Mr Cunningham again the following morning, 23rd September, which is recorded in the nursing record. Again I was unable to make a note in Mr Cunningham's records. The nurses indicated that Mr Cunningham had become chesty overnight and was now to have Hyoscine added to the syringe driver. That would have been a decision made by me following my assessment of him. Mr Cunningham's step-son, Mr Farthing, was contacted and informed of Mr Cunningham's deterioration. The step-son asked if this was due to the commencement of the syringe driver, and was apparently told by the nursing staff that Mr Cunningham was on a small dose which he needed. I would agree that the dose involved was both small and necessary.

32. Later that day Mr and Mrs Farthing came to the hospital and were seen by Sister Gill Hamblin, together with staff nurse Freda Shaw. They were apparently very angry that the driver had been commenced, but Sister Hamblin noted that she explained again the contents of the syringe driver were to control Mr Cunningham's pain, and if discontinued we would need an alternative method of giving pain relief. Sister Hamblin noted that Mr Farthing was now fully aware Mr Cunningham was dying and needed to be made comfortable. It would appear from her note and from the nature of the explanation given to Mr Farthing, that Sister Hamblin agreed this medication was necessary to relieve Mr Cunningham's pain and distress.

33. The driver was then renewed at 8pm with 20 mgs of Diamorphine, but with an increase in the level of Midazolam to 60 mgs, together with 400 mcgs of Hyoscine. I anticipate that Mr Cunningham's agitation might have been increasing, hence the increase in the level of Midazolam, and indeed in spite of that, the notes go on to record that Mr Cunningham became a little agitated at 11pm with the syringe driver being boosted with effect. The nursing staff recorded that Mr Cunningham seemed to be in some discomfort when moved, and the driver was boosted prior to changing position.

34. Again, I anticipate that I would have been contacted about the increase in the medication and agreed with it, though I have got no recollection of this.

35. I anticipate, though I have made no specific note of it, that I would have again seen Mr Cunningham the following morning, 24th September in order to review his condition.

36. On the 24th September, Sister Hamblin recorded a report from the night staff that Mr Cunningham was in pain when being attended to, and was also in pain with the day staff, though it was suggested that this was especially in his knees. In any event, the syringe driver was increased to 40 mgs of Diamorphine, and the Midazolam to 80 mgs, together with 800 mcgs of Hyoscine. The dressing was reviewed in the afternoon, and Sister Hamblin went on to record that Mr Farthing had been seen by me that afternoon and was fully aware of Mr Cunningham's condition.

37. I have no recollection of meeting Mr Farthing, but clearly I did so and indeed that is recorded in my own note in Mr Cunningham's records which reads as follows:-

> "24-9-98 Remains unwell
> Son has visited again today and
> is aware of how unwell he is
> sc analgesia is controlling the pain - just
> I am happy for nursing staff to confirm death"

38. I anticipate that I would have explained Mr Cunningham's condition to his step-son, that we were endeavouring to keep him free of pain distress and agitation, and that sadly he was dying. My note indicates that although the subcutaneous analgesia was controlling the pain, this was "just", and clearly I envisaged that Mr Cunningham's condition was such that it might become necessary to increase the medication.

39. The nursing records indicate for the night of the 24th September Mr Cunningham was aware of being moved - it being necessary periodically to

alternate the position in which he was lying, but he was felt to have had a peaceful night sleep though sounding chesty in the morning.

40. I anticipate that in the usual way I would have seen Mr Cunningham again that morning, 25th September. I wrote a further prescription for the Diamorphine, Hyoscine and Midazolam, this time with the ranges being 40 - 200 mgs, 800 mcgs - 2 grammes, and 20 - 200 mgs respectively.

41. It appears then that the Diamorphine was increased to 60 mgs, with 80 mgs of Midazolam and 1200 mcgs of Hyoscine at 10.15 that morning. My expectation is that this increase was necessary to relieve Mr Cunningham's pain and distress. It is likely that by this time Mr Cunningham would have been becoming tolerant to opiates, and that might have added to the need to increase the doses of medication. It appears from the previous drug chart that an error was made by the nurse on the 25th September, where she started to record the 60 mgs as if for the previous day 24th September, but she has gone on then to complete the entry on the new chart, and it seems clear from the nursing notes that this increase in the dose of medication was indeed instituted on the morning of 25th September.

42. It appears that my partner, Dr Sarah Brook, was on duty over the course of the weekend, and so would have been on call from the evening of Friday 25th September. I anticipate that I might have informed her of Mr Cunningham's condition, and the fact that he was likely to die soon. It is possible that in consequence of this Dr Brook decided to review Mr Cunningham and it is clear she attended to see him, noting in the record that he remained very poorly, that he was on a syringe driver and was for "TLC", meaning tender loving care. Dr Brook would have appreciated that he was likely to die soon and that keeping him free

from pain and distress was all that could be reasonable achieved in the circumstances.

43. Sadly and inevitably, Mr Cunningham continued to deteriorate. It appears that he had a peaceful night, but the nursing records record specifically that his condition was deteriorating slowly, with all care being given.

44. The following morning, at about 11.50am, the medication was increased again, with Diamorphine at 80 mgs, Midazolam at 100 mgs, and the Hyoscine maintained at 1200 mcgs. I anticipate that Mr Cunningham was experiencing further pain and distress, necessitating the increase, and that Dr Brook would have agreed with it, though it is also possible that I might have been contacted prior to the increase by the nursing staff instead. In view of Mr Cunningham's condition, with the significant pain from the large sacral sore, and the fact that he would have been becoming inured to the medication, that increase would have been necessary.

45. Sadly, Mr Cunningham continued to deteriorate. There is no record that Mr Cunningham was experiencing pain in the course of the day, and it appears therefore that the medication was successful in relieving pain, distress and anxiety at that time. Mr Cunningham died that evening at 11.15pm, death being confirmed by nurses Beverley Turnbull and Anita Tubbritt.

46. At all times the medication given to Mr Cunningham and as authorised by me was provided solely with the aim of relieving his pain, distress and anxiety in accordance with my duty of care to Mr Cunningham.

Signed and Handed to DC Yates

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