ARTHUR CUNNINGHAM

OPERATION ROCHESTER

Report summarising screening assessment of first 61 cases analysed

This report is compiled from the annotations made during the initial screening of each case. No subsequent editing or amendment is included in this report. However, it should be noted that only the first 20 cases were screened truly blind. In assessing the first 20, I applied the same standards as I would to my own practice, ie that of an experienced medical practitioner in the specialty of palliative medicine. It is my personal belief that excellent clinical practice, ie the best possible decision making given the clinical information available and the patient's preferences, should be the same in all settings, whether specialist or generalist.

However, during the conference after the screening of the first 20 cases it was made clear to me that I was setting an unrealistically high standard for practice in a rehabilitation/continuing care setting. My assessments of all subsequent cases were influenced, therefore, by the views of the other members of the clinical team. There will not be complete consistency in my assessments between the first 20 cases and the subsequent ones.

The screening matrix used for scoring in all cases was as follows:

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B				
Unexplained By Illness C				

In each case the screening assessment was made contemporaneously with the study of that case record. It was not made retrospectively at a later date from my handwritten notes, although they informed my judgement by summarising the important points I abstracted when going through each record.

The following table brings together the assessment notes made on each patient and my own screening assessment score, prior to discussion with other members of the clinical team.

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/15	Cunningham, Arthur	Code A	B4

OPERATION ROCHESTER
ADDITIONAL NOTES 3.4.04

ID	NOTES	GRADING CHANGE?
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	No change
BJC/15 CUNNINGHAM Arthur	[illegible]	No change
[illegible]	[illegible]	[illegible]

Code A

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
A(B)C 084598 S.518104 A. Cunningham

Exhibit number
BJC-15

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Code A	CONSENSUS WAS 3B	
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

8. OPINION

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

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

9. LITERATURE/REFERENCES

British National Formulary 35 (March 1998).

Prescribing in Terminal Care, pages 12–15.

British National Formulary 47 (March 2004).

Good Medical Practice, General Medical Council, October 1995, pages 2–3.

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition

'Wessex Protocol' Salisbury Palliative Care Services May 1995.

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: _____

Report on the Care and Death of Arthur Cunningham 26th September 1998

Draft Report 19th November 2004

This report has been provided by Dr David A Black, MA MB BCHIR (Cantab) FRCP, Consultant Physician at Queen Mary's Sidcup NHS Trust. This report is in two parts, a factual summary of the timeline including important investigations and in the second part an opinion on the events that occurred. The numbers in brackets referred to the page of the evidence to support the statements:

1. Timeline:

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A