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**Report on the Care and Death of Arthur Cunningham  
26<sup>th</sup> September 1998**

**Draft Report 19<sup>th</sup> 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:**

- 1.1. 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.
- 1.2. 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.
- 1.3. 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.
- 1.4. 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).
- 1.5. 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 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).

- 1.6. 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.
- 1.7. 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).
- 1.8. In June 2998 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 hypotensive 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).
- 1.9. On 22<sup>nd</sup> 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).
- 1.10. On 6<sup>th</sup> 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.

- 1.11. On 8<sup>th</sup> 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).
- 1.12. On 20<sup>th</sup> 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 27<sup>th</sup> 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.
- 1.13. On 21<sup>st</sup> 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 12<sup>th</sup> 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.
- 1.14. During his admission to Mulberry ward he has a fall on the 24<sup>th</sup> 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 24<sup>th</sup> July (71), he is rude and abusive to a member of staff on 26<sup>th</sup> July (72) and apologises later in the day (73). Dr Lord sees him on 27<sup>th</sup> July (74) and finds that there were no particular new problems. He is still low in mood on 3<sup>rd</sup> August (79) calling out for assistance quite a lot (80). He needs a lot more assistance on 10<sup>th</sup> August (83). On 17<sup>th</sup> 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 17<sup>th</sup> August (86). He is again confused in the middle of the night on 18<sup>th</sup> August (87). On 25<sup>th</sup> August it is noted that he has not passed much urine (90). Blood tests carried out on 26<sup>th</sup> 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 28<sup>th</sup> 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).

- 1.15. He is seen by Dr Lord on Mulberry Ward on 27<sup>th</sup> 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 14<sup>th</sup> September. He is then discharged to the Thalassa Nursing Home on 28<sup>th</sup> August.
- 1.16. On 11<sup>th</sup> September (99) he is seen by the Community Psychiatric Nurse who says that he has settle well into the Thalassa Nursing Home and his mood seems good.
- 1.17. On 14<sup>th</sup> 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.
- 1.18. He appears to have a routine appointment at the Day Hospital on 17<sup>th</sup> 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.
- 1.19. On 21<sup>st</sup> 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).

- 1.20. 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 24<sup>th</sup> 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".
- 1.21. 25<sup>th</sup> September (Dr ?) Brook writes "remains very poorly on syringe driver for TLC". There is then a nursing note on 26<sup>th</sup> September, the patient died at 23.25 on 26<sup>th</sup> September and the final medical note is on 28<sup>th</sup> September saying "death certificate discussed with Dr Lord, 1 – Bronchopneumonia, 2 – Parkinson's Disease, Sacral Ulcer".
- 1.22. The nursing notes are more detailed on 21<sup>st</sup> 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 22<sup>nd</sup> 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.
- 1.23. 23<sup>rd</sup> 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).
- 1.24. On 24<sup>th</sup> 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).
- 1.25. On 25<sup>th</sup> September Midazolam is continued at 80, he is on Diamorphine 60 mgs and is recorded as being peaceful (876). Finally on 26<sup>th</sup> September the notes record his Diamorphine is increased to 80 mgs and Midazolam to 100 mgs.
- 1.26. Drug Chart Analysis:

His original drug chart on admission to the ward on 21<sup>st</sup> September (752) prescribes Oramorphine 2.5 – 10 mgs orally 4 hourly, he receives 5 mgs at 14.50pm on 21<sup>st</sup> 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 21<sup>st</sup> – 24<sup>th</sup> September.

- 1.27. Diamorphine is 20 – 200 mgs subcutaneously in 24 hours is written up on 21<sup>st</sup> September (756) and on the 21<sup>st</sup> at 23.10pm, 20 mgs is started. On 22<sup>nd</sup> September 20.29pm, 20 mgs is started and on 23<sup>rd</sup> September at 9.25am, 20 mgs is started. On 24<sup>th</sup> 40 mgs is started in the pump at 10.55am, on 25<sup>th</sup> 60mgs is in the pump 9837) and on 26<sup>th</sup> 80 mgs.
- 1.28. Midazolam 20 – 80 mgs is written up on 21<sup>st</sup> September (756) and 20 mgs is given on 21<sup>st</sup>, 22<sup>nd</sup> and 23<sup>rd</sup>. On the 23<sup>rd</sup> though, this is increased to 60 mgs, 80 mgs on the 24<sup>th</sup>. He receives another 80 mgs on 25<sup>th</sup> and 100 mgs written up in 24 hours on 26<sup>th</sup> (837).
- 1.29. Hyoscine 200 – 800 micrograms sub cut in 24 hours is written up 400 micrograms are given on 22<sup>nd</sup> and 23<sup>rd</sup> September and 800 micrograms on 24<sup>th</sup>. This is then re-prescribed. Hyoscine 80 – 2 grams sub cut in 24 hours (837) and he receives 1,200 micrograms on 25<sup>th</sup> and 26<sup>th</sup>.

## **2. Expert Opinion:**

- 2.1. 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.
- 2.2. 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 stage a dementing illness.

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.

- 2.3. In 1992 he is troubled with kidney stones but has an uneventful operation.
- 2.4. 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.
- 2.5. Further problems occur include hypertension, which is treated in 1995, and diabetes mellitus (high blood sugar), which is diagnosed later in the year.
- 2.6. 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).
- 2.7. 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.
- 2.8. 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.

- 2.9. 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 22<sup>nd</sup> 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).
- 2.10. However, he is not happy at all with this placement when he is seen in the Day Hospital on 6<sup>th</sup> 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 myelodysplasia (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.
- 2.11. He is seen by the psychiatric team on 8<sup>th</sup> July (117) and then is admitted to hospital on 21<sup>st</sup> 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).
- 2.12. There is no doubt that there has been a very significant decline in this gentleman's general health. He has now lost over 45 kgs of weight, including 25% of his body weight in the last year. He had rapidly declining mobility, an early bed-sore, he has started to develop mental impairment and his Parkinson's disease has become increasingly difficult to manage.
- 2.13. 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.

- 2.14. 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.
- 2.15. He is planned to the Thalassa Nursing home on 28<sup>th</sup> August as his 4<sup>th</sup> residential move of the year. However, on the 25<sup>th</sup> August he is noted to be passing less urine and a blood test on 26<sup>th</sup> 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).
- 2.16. 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 28<sup>th</sup> when he is discharged, with a Urea of 15.6 and a Creatinine of 144 (173).
- 2.17. Following discharge things appear to go not too badly, the CPN seeing him on 11<sup>th</sup> September (99) states that his mood seems good and he is settled well. On 14<sup>th</sup> 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 14<sup>th</sup> September at 108/58 (323) and the pressure sore must be causing concern as a swab is sent (317).
- 2.18. He then has a routine review, for a therapist assessment on 17<sup>th</sup> 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 21<sup>st</sup> 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.
- 2.19. Mr Cunningham is reviewed again on 21<sup>st</sup> 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.

- 2.20. 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.
- 2.21. 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.
- 2.22. 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 21<sup>st</sup>.
- 2.23. 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.
- 2.24. 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 an infusion pump.
- 2.25. 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 6<sup>th</sup> 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.

- 2.26. By 29<sup>th</sup> 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 22<sup>nd</sup> and 23<sup>rd</sup>, although he is a little agitated at night on 23<sup>rd</sup> (876) and both day and night staff report pain on 24<sup>th</sup> (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 23<sup>rd</sup> to 80 mgs on the 24<sup>th</sup> appears excessive.
- 2.27. After the pain on 24<sup>th</sup> 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 25<sup>th</sup> and 80 mgs on the 26<sup>th</sup> and the Midazolam is put up to 100 mgs a day on the 26<sup>th</sup>. In my view it was reasonable to increase the palliative care regime of Diamorphine and Midazolam on both 23<sup>rd</sup> and 24<sup>th</sup> 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 24<sup>th</sup>.
- 2.28. The dose of Diamorphine is then increased on both the 25<sup>th</sup> and 26<sup>th</sup> to 60 then 80 mgs (837) and Midazolam is increased again on 26<sup>th</sup> 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.
- 2.29. In my view the dose of Diamorphine and Midazolam was excessive on 25<sup>th</sup> and 26<sup>th</sup> 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.