# ARTHUR CUNNINGHAM

# SUMMARY OF EVIDENCE

# CASE OF ARTHUR CUNNINGHAM

## Background/Family Observations

Arthur CUNNINGHAM was born on Code A. 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 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 Code A (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 ' Code A Code A 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. Code A (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 Code A and DC Code A.

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.

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 Code A Code A 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.

Code A 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'.

Code A 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 Code A on 21st September.

Comments that Diamorphine administered by Nurses, Code A Code A

Nurses Code A Code A 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.

HAMPSHIRE CONSTABULARY

C.51 1/99

Identification Ref. No. DB/2015

Court Exhibit No.

R - v -

Description

A certified copy of a death certificate (CUNNINGHAM)

Time/Date Seized/Produced

19TH May 2005

Where Seized/Produced

Office for National Statistics

Seized/Produced by D. Burgess

Signed

Incident/Crime No. Operation Rochester

Major Incident Item No. x 622

Laboratory Ref:

**PLEASE ATTACH WITH TAPE**

**GLOUCESTERSHIRE CONSTABULARY**

Station.

J1 No. Item No.

O.I.C.

Identification Ref No.

Court Exhibit No. DB 2015

R-v-

Description

A CERTIFIED COPY OF A DEATH CERTIFICATE

Time / Date Seized / Produced

19TH May 2005

Where seized / Produced

Office for National Statistics

Seized/ Produced By

DAVID BURGESS

Signed Code A

Incident Crime No. Operation Rochester

Major incident item No.

Laboratory Ref

P27B (Rev 2/02)

# Code A

**Note (1) Births and Deaths.**

This certificate is issued in pursuance of the Births and Deaths Registration Act 1953. Section 34 provides that any certified copy of an entry purporting to be sealed or stamped with the seal of the General Register Office shall be received as evidence of the birth or death to which it relates without any further or other proof of the entry, and no certified copy purporting to have been given in the said Office shall be of any force or effect unless it is sealed or stamped as aforesaid.

**Note (2) Births.**

A name given to a child (whether in baptism or otherwise) before the expiration of twelve months from the date of registration of its birth, may be inserted in Space 17 of the entry in the birth register under the procedure provided by Section13 of the Births and Deaths Registration Act 1953. If the parents or guardians wish to avail themselves of this facility at any time, they must deliver a certificate of baptism or of naming to the registrar or superintendent registrar having the custody of the register in which the birth was registered. This certificate must be in the prescribed form and can be obtained on application to any registrar.

# 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 Code A 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 Code A 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 Code A 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 PC Code A

Code A 21-4-05 Code A