Arthur Cunningham Aged 79 and died on 26.09.1998

He was admitted to Gosport War Memorial Hospital some five days earlier.

Mr Stuart Farthing his stepson gave evidence which is very much at variance with the hospital records and the evidence that you received. He felt that his stepfather had been wrongly treated and did not accept the severity of the bedsore that he had and objected to the use of the syringe driver and required its removal. He made the strongest representations and saw Dr Barton on 24rd September at about 5pm. She told him in no uncertain terms that Mr Cunningham was dieing and that his medication was to ensure that he was not in discomfort and he then said Mr Cunningham died the following evening Saturday 26th September. The death had been certified by Dr Brook who was unknown to Mr Farthing and the cause of death had been given as:
1a Bronchopneumonia

That was unacceptable to Mr Farthing and he required a Post Mortem Examination to be undertaken and through the office of The Coroner that was duly done by Dr Hamid with the cause of death given as:
1a Bilateral Bronchopneumonia.

The statement of **Pamela Gell** was read and she was a nursing director of Thalassa Nursing Home and she told us about Brian Cunningham and his time at the Nursing Home. She confirmed that they agreed to take him on 28th August 1998 but it was noticed that he had a large red sacral area and when she queried that she was told that he had spent the previous night on the floor that may have exacerbated the condition.

Concerns with that sore continued and on 21st September when attending the Dolphin Day Hospital he was admitted to Driad Ward and she was told by them on 23rd September that Brian's condition was quite poorly. She was then informed on 28th September that he had died.

Dr Lord's statement was read and she confirmed that from 1992 she was employed as a Consultant Geriatrician for older people in Portsmouth including Gosport War Memorial Hospital.

She confirmed that Mr Cunningham came under her care, that he was a 79year old man living alone in warden assisted accommodation. He had Parkinson's disease, and a weak pelvic girdle from a war injury. He had predominately a left sided tremor from his Parkinsons disease and was unsteady when he stood. She was concerned at the dose of cinamet he was taking for his Parkinsons disease because it was causing abnormal body movements and subsequently hallucinations.

He had various moves from three different homes in six months prior to his death and found it difficult to settle. Mr Farthing would suggest that was because he felt that the establishments were haunted.

Dr Lord assessed Mr Cunningham on 10th March 1998.

She then sees him again on 19th June 1998 at his home and she is struck by the amount of weight he seems to have lost. She expresses her concern about the level of medication for his Parkinson's disease and the effects that would have on him. She also makes various other observations that he is depressed, has poor short term memory and was having visual hallucinations. She makes the reference to Dolphin Day Hospital for assessment of Mr Cunningham and continues with his overall care and has continuing concerns. She reduced his Parkinsons medication in July 1998 because of hypotension, hallucinations and abnormal movements.

She seems him again on 27th August when he is due to be moved to the nursing home on 28th August and she is concerned about his ability to settle at the nursing home.

She is due to see him on 19th September for a further review and is very concerned at that stage about the large necrotic sacral ulcer which she describes as extremely offensive.

On 21st September she describes seeing Mr Cunningham who was very frail, he has tablets in his mouth some hours after they had been given, the necrotic sacral ulcer is offensive and large and he is developing bed sores on his heels.

She diagnosed at that time that he was suffering from a sacral sore, Parkinsons disease and an old back injury, depression, and an element of dementia, diabetes mellitus and that he was catheterised for urinary retention. She recommended that he should be put on a high protein diet and she prescribed oramorph for the pain from the sore.

Dr Lord suggested that his nursing home bed she could be kept open for him for three weeks. On that basis she admitted him to Gosport. The aim was to maximise the prospect of improvement in his condition although she recognised that his general condition was very poor that he was unlikely to recover.

The statement of **Gillian Hamlyn** was read and she remembered Mr Cunningham to be extremely uncooperative as a patient. She recalls that his sacral area had a deep recess and that he was non compliant with medication and treatment.

She confirms that he was administered variable doses of diamorphine, hyascine and medazalam by a syringe driver.

She says he was administered 20mgs on 21st September 20mgs on 22nd September 20mgs on 23rd September but that was clearly not controlling the pain. He was given 60mgs on 24th September and believes that may have been by the night staff but he was written up for between 20 and 200mgs although increase in dosage would be after consultation with the doctor.

She does record the meeting with Mr and Mrs Farthing when she and Freda Shaw were there and Mr Farthing expressed his anger the syringe driver had been commenced. She declined to remove it without medical advice and she then confirms that Mr and Mrs Farthing are seen by Pastor Mary whether that was fortuitous or planned we cannot say.

She confirms that references to diamorphine in the notes are written in red hence the difference in writing as referred to by Mr Farthing.

She found Mr Farthing quite difficult.

On 24th September she recorded that there had been reports from the night staff that Brian had been in pain when attended to and that was noted by the day staff as well. The syringe driver was renewed at 10.55 that day with 40mgs of diamorphine 80mgs of medazalam and hyascine. She confirmed that Mr Farthing was seen by Dr Barton that day.

Notwithstanding Mr Farthing statements she did not believe that he had any difficulty with the question of the syringe driver and his concern was that he couldn't talk to his stepfather while he had it in position.

The statement of **Freda Shaw** was read and she confirms that Mr Cunningham's condition was deteriorating and details the various nursing care plans that were put in position for him and that she administered 60mgs of diamorphine 80mg of medazalam and hyascine through a syringe driver on 25th September 1998 at 10.15.

The statement of **Barbara Ring** was read. She had worked at Thalassa Nursing Home but from 1991 she worked at Gosport. She confirms that in 1998 she was concerned with Arthur Cunningham and that on 26th September she administered diamorphine, hyascine and medazalam to Mr Cunningham. His prescription had been written up by Dr Barton for diamorphine 40 to 200mgs hyascine 800 to 2mgs and medazalam 20 to 200mgs.

She says that at 11.50 on 26th September she administered 80mgs of diamorphine 1200mgs of hyascine and 100mgs of medazalam. She notes from the records that his condition was deteriorating slowly and confirms that any change in medication would have been discussed with the doctor unless she was not available in which case decisions would be made by the staff in accordance with experience and qualifications.

She confirmed specifically that the decision to increase the dosage would have been taken by the doctor or by two trained members of staff who knew the patient and could make that decision provided always that it was within prescribed parameters.

Beverly Turnbull gave evidence.

She had worked at Gosport for many years and she expressed concerns that in the early 1990's syringe drivers were being used and that apparently patients were becoming heavily sedated, unrousable and died. Meetings took place in 1991 to address those issues with the Hospital Manager, training in syringe drivers was then arranged and concerns were addressed and by the mid 1990's she said that she had no ongoing worries about the practice.

Specifically she did not have any concerns in respect of Mr Cunningham and she noted that on the 26th September 1998 his entry confirms that his condition continued to deteriorate and he died at 23.15 hours.

Dr Hamid was the pathologist and instructed by the Portsmouth Coroner to undertake the Post Mortem Examination on Mr Cunningham and it is

he who certified: 1a: Bilateral Bronchopneumonia. A copy of his report is available.

Dr Barton gave evidence to confirm her dealings with Mr Cunningham and confirms his admission to Driad ward on 21st September. The concerns are confirmed that he is frail with an offensive large necrotic sacral ulcer and that he had Parkinson's Disease, an old back injury, depression with an element of dementia, diabetes and that he was catheterised for retention of urine.

Dr Barton actually goes with Sister Hamlyn to Dolphin Day Hospital to collect Mr Cunningham and once at Dryad Ward she examines him. She also photographs the pressure sore.

She agrees with Dr Lord the prognosis is poor and her note on admission is transfer to Driad Ward, make comfortable, give adequate analgesia, I am happy for nursing staff to confirm death.

Mr Cunningham had been prescribed oramorph 2.5 to 10mgs four hourly. However she was concerned that although the oramorph would assist with pain relief it might become inadequate with a such a significant sacral sore which was causing him pain and distress. Accordingly she wrote up diamorphine on a proactive basis with a range of 20 to 200mgs. She also prescribed hyascine and medazalam 20 to 80mgs. She is quite clear that these were prescribed purely with the aim of alleviating Mr Cunningham's significant pain, distress and agitation. She was aware that Dr Lord had noted that he had tablets in his mouth some hours after they had been given to him and she was concerned that he may not swallow.

On 21st September he confirms that Mr Cunningham was given 5mgs of oramorph at 2.50pm and that a further 10mgs were given later in the day.

Mr Cunningham's condition is said to be very agitated at 5.30pm and that he remains agitated until about 8.30pm when the incident occurs with him pulling of the dressing. The syringe driver is established later that evening and he is given 20mgs of diamorphine and 20mgs of medazalam. She has no particular recollection of that but it was in accordance with her prescription. She confirms that Mr Cunningham's barthell score was nil.

Dr Barton then goes on to refer to the meeting between Mr & Mrs Farthing, Sister Hamlyn and Staff Nurse Shaw and the explanation is given about the syringe driver. She deals with the increase in dosage of diamorphine and medazalam and on 24th September 1998 she noted in her

own notes, remains unwell, son has visited again today and is aware of how unwell she is. Subcutaneous analgesia is controlling the pain just, I am happy for nursing staff to confirm death.

On 25th September she writes a further prescription for diamorphine 40 to 200mgs hyascine 800mgs to 2gs medazalam 20 to 200mgs.

Dr Barton's partner Dr Sarah Brook was on call for the evening of 25th September and she sees him and notes that he remains very poorly and was for TLC. The following morning medication is increased diamorphine to 800mgs medazalam to 100mg and hyascine to 1020mgs. Whilst Dr Barton is not able to confirm she presumes that Dr Brook would have agreed with this and would have done so on the basis of his increased pain. Again she confirms medication at all times was given to alleviate pain, stress and anxiety.

Professor Black gave evidence that Arthur Cunningham was an example of a complex and challenging problem in geriatric medicine. He had chronic multiple diseases and he identified one of the problems as being when the clinician should stop trying to deal with each individual problem or crisis and except that a patient is dying and that symptom control is appropriate.

He concluded that Mr Cunningham was managed appropriately including an appropriate decision to start the syringe driver and his one concern is the increase in the dose of diamorphine on 25th and 26th September for which he was unable to find any justification. However he was not the treating clinician and he was at pains to say that the increase to 60 and then 80mgs on 25th and 26th September 1998 is not documented and therefore he cannot find that justification. Perhaps in particular significance in this case is that Dr Barton was not on duty at that time and therefore any discussion that took place would not have been with her. It would have been with Dr Brook.

As the cause of death he gave me:
1a Sepsis
1b End Stage Parkinsonism
II Myelodysplasia & Diabetes Mellitus

In response to Mr Leper he said that throughout his prognosis was poor and he would not have expected the patient to go home. He did say that the increase in dose from 25th and 26th September was excessive and there was no justification for it in the notes. He would have accepted an

increase from 20 to 40mgs. He could not understand why oramorph prn was not solving his problem.

He could accept that it was palliative care and that the syringe driver would enable the relief of pain and anxiety.

It was accepted by Professor Black that bronchopneumonia can occur as a result of opiate overdose and the intention in administering diamorphine must be to relieve pain without sedating the patient to unconsciousness.

It was put to Professor Black that Mr Cunningham was fully conscious but he did not accept that and referred to him being in an acute confusional state.

On the transfer from oramorph to diamorphine the appropriate transfer would have been to 10mgs of diamorphine and there should have be a reason documented to exceed that but no such record existed.

He is in no doubt that Mr Cunningham is in an acute confusional state and that the administration of medazalam is entirely appropriate. Similarly if he is pain there is no reason not to use morphine.

There should have been a proper assessment of his pain and latterly there is and increase of five times the morphine and four times the medazalam.

However he did feel that the confusion was unlikely to be as a result of the diamorphine.

Particularly he was convinced that the respiratory problem was as a result of the bronchopneumonia and not as a result of any hypoxic injury from opiate overdose. His view was that the increase in medication 'may have slightly shortened life'.

However he remained quite adamant that diamorphine would have been his drug of choice.

In response to Mr Jenkins he did point out that Mr Cunningham may have had swallowing problems and in particular he was found with tablets in his mouth some considerable time after they had been administered.

His sacral sore would have caused considerable pain and he himself was a serious management problem.

Professor Black did point out that on 24th September 1998 Mr Cunningham was in pain when being attended to and had trouble with his knees. On 25th September he has a peaceful night his position is changed but he does not like being moved. At that stage he was not unconscious.

Dr Wilcock gave evidence and recountered a brief history. In particular Mr Cunningham required maximal doses of weak opioids because of back pain as a result of an old standing war injury.

He was on antidepressants, mood stabiliser, antipsychotic and a sedative and these seemed to improve his mood and sleep pattern. After an initial admission to hospital he then returns to his Nursing Home and is followed up at the Dolphin Day Hospital. It is from there that he is admitted directly on to Driad Ward for treatment of his pressure sore which you may remember Dr Barton described as the second worst she had seen. His prognosis was poor but notwithstanding Dr Lord who had arranged the admission said that the Nursing Home place should be kept open for three weeks.

Dr Wilcock felt that the dosage of diamorphine was excessive and that he would have looked at other strategies for managing Mr Cunningham's pain.

In response to Mr Leper he said that he considered there was palliative care too early and excessive analgesia. He was questioned about why he would think that Mr Cunningham was never given the high protein diet and he said that it was probably impossible but in the absence of notes was unable to say why.

He did say that this was a patient who was probably drowsy, had a problem with swallowing, a sacral sore and whilst there may be scope for some improvement the prognosis was poor. He was very poorly, had a chest infection and it was not appropriate to pursue treatment aggressively.

It was put to him that Mr Cunningham had asked for chocolates and that was prima facie evidence that he was able to swallow. I took the point that asking for chocolate and him being able to swallow it are completely different matters.

On any assessment there had to be a benefit/risk assessment.

He said that Mr Cunningham had benefited from 5mgs of oramorph in the past and if that were the case he would have gone on to try that again and if it did not work then increase it. He felt that the medication he received was quite justifiable.

He was concerned that Mr Cunningham did not continue to have his psychiatric medication on 21st September and that those drugs should have been restarted. However in his words it was all coming to a head and Mr Cunningham was dying.

Again he said that if there was pain the cause of the pain needs to be analysed and appropriately treated.

He dismissed the question of hypoxia and respiratory depression as a result of drug overdose and said that was far more likely to be as a result of the bronchopneumonia.