Dear Tom

We would like to include Unlawful Killing as one of the verdicts. We have done continued reading this weekend and feel quite strongly that the jury should at least be able to consider it.

We have only a few additional points that we wanted to a)make you aware of to include in our arguments b)include were appropriate in your submission document

1) Dudley reports that ED was treated appropriately with strong opiates as a patient with end stage 5, renal failure. However in his own guidelines at "The Richard Bright Renal Unit" Prepared 1 month prior to his expert opinion (http://www.bathgped.co.uk/presentations_from_meetings.htm) it states the following
    a. Patients whose end-stage renal disease is being managed without dialysis or transplantation will usually remain under the care of a renal physician and attend outpatient clinics.
    b. Symptoms associated with ERF vary and include
        i. Nausea and vomiting *(not reported in ED)*
        ii. Anaemia *(not reported in ED)*
        iii. Shortness of Breath *(not reported in ED)*
        iv. Itchy Skin *(not reported in ED)*
        v. Lack of appetite *(not reported in ED)*
        vi. Restless legs *(not reported in ED)*
        vii. Cramps *(not reported in ED)*
        viii. Dry mouth *(not reported in ED)*
        ix. Insomnia *(not reported in ED)*
        x. Lethargy *(not reported in ED)*
        xi. Constipation *(not reported in ED)*
        xii. Loss of sexual function
        xiii. Pain *(not reported in ED)*

        He does not include 'acute confusion' (Because ONLY is an acute confusional state attributed to research related to dialysis discontinuation and the last 24 hours of life)
    c. Where Dr Dudley reports under Pain management in his handbook he states
    d. Pain is NOT usually a symptom in ERF but often relates to co-morbidities (which ED had none). If pain is a symptom he recommends that GP's refer to WHO analgesic ladder modified for ERF patients. (why then when in this case where the GP has fallen so far from the WHO analgesic ladder does he not question it?)
2) He does not mention the Trimethoprim as you state in your submissions; I would also like to add to this that he does not take in to consideration that ED was placed on IV fluids (158) at the QA whilst her creatinine rose to 288 –another good indication as to why her creatinine did not rise to the level of 360 whilst being treated with this antibiotic.
3) I think it needs to be made clearer in the submissions that in Barton's statement she writes that the fentanyl was applied because the creatinine was 360; however when questioned she stated that it was due to increased agitation – a personal recollection, as it is not noted in the file

(because she knew that she didn't not have the blood test results until lunch-time on the 18th)

4) Dr Dudley states that although simple measures may have improved or stabilized ED's clinical condition for a few days, further deterioration culminating in her death was inevitable. Research shows:
   a. survival of elderly patients who have entered Stage 5 of their renal disease showed a 1-2 year survival rate of 68% and 47% respectively. (Dialysis or not? A comparative survival study of patients over 75 years with CKD stage 5; Fliss et al 2007)
   b. in a study of 56 patients managed conservatively with a mean age of 80.5 years 80% were referred to a hospice and after 18months 36% were still alive. Of those that died, 50% died at home, 19% in a hospice, 31% in hospital. (Daniels et al – as delivered at the Renal Association Annual General Meeting 2006– attended by Dr C Dudley)

   I ask then, if Nephrologists specializing in Conservative Renal Management (unlike Dudley who appears to specialize in transplantation) cannot predict length of survival in stage 5 patients how has Dr Dudley managed to define ED's survival as a matter of days? Whilst ED was at the QA and her creatinine was reported at 288 (indicating Stage 5 renal failure) they did not commence palliative/terminal care, even though she was reported as aggressive, confused and refusing medication. They continued with IV fluids and changed her medication to the antibiotic cefaclor and ceased her diuretic Frusemide (272). ED survived another month, until recommenced on Trimethoprim– would Dudley have made the same prognosis if she had been overdosed at the QA? That she was terminal and would only have survived a few more days anyway? (I should like this point raised as part of the submissions)

5) In relation to the diagnosis of Dementia. The mental state examination was performed when ED could not actually hear the questions asked of her, as highlighted by Dr Taylor. The Brain scan (which is no longer available for either the experts or the court) showed involutional changes in accordance with her age and small vessels disease "Extensive MRI evidence of strokes can exist with little clinical evidence of dementia. But it's a poor prognostic sign." (Dr Nick John, Older Persons Unit RUH). Her mental state was never followed up again until the 18th November. How then can it be considered that her underlying dementia contributed to her death.

6) Should it arise we would like to point out that Wilcock was heavily weighted to Dudley's opinion, yet in other cases he was informed that he was on the stand purely for his own opinion and should not speak of others (as in the case of Mr Wilson where the other opinion was damning to Dr Barton)

Many thanks and see you tomorrow morning.