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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.

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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 dissolve the black scab area of the pressure sore, to 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 to the buttock 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 effect, 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 Beverley Turnbull 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

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