CHARLES FARTHING (RE ARTHUR CONNINGHAM)

Hugh Williams

From: Charles Farthing Code A
Sent: 15 August 2008 09:41
To: Hugh Williams
Subject: Portsmouth Health Care Trust
Attachments: HCT-CRSF (11 Nov 98) 3 of 30001.pdf; CRSF-HCT (2 Oct 98) 1 of 30001.pdf; CRSF-HCT (2 Oct 98) 2 of 30001.pdf; CRSF-HCT (2 Oct 98) 3 of 30001.pdf; HCT-CRSF (11 Nov 98) 1 of 30001.pdf; HCT-CRSF (11 Nov 98) 2 of 30001.pdf

Dear Hugh,
Further to our conversation yesterday afternoon, please find attached the second (2) of three packages of information sent separately to keep the contents together and to minimise file size.
They are:
(1) Letters relating to my complaint to Inspector of Nursing Homes
(2) Letters relating to my complaint to the Portsmouth Health Care Trust
(3) Letters relating to my complaint to the General Medical Council
I hold many other related letters concerning (3), written by Eversheds and later Field Fisher Waterhouse.
With kind regards,
Charles Farthing

Code A

2 Oct 98

Chief Executive
Portsmouth Health Care Trust
St James" Hospital
Locksway Road
Portsmouth
PO4 8LD

Dear Sir/Madam,

Re. CUNNINGHAM, Arthur Denis Brian

I am writing in connection with the death of my step-father, Brian Cunningham, at the War Memorial Hospital, Gosport, on Saturday, 26 Sep 98.

The events leading up to his admission into hospital 5 days before, his ~~subsequent~~ subsequent treatment and the content of the Medical Certificate of Cause of Death leave a lot to be desired, and resulted in my requesting a post-mortum examination.

As will be seen from the attached sequence of events, there appears to have been serious negligence on the part of the nursing home, although they have said the responsibility lies with the Day-Care Centre at the hospital into which he was admitted on 21 Sep. This matter is currently under investigation by the Nursing/Residential Care Inspectorate.

Mr Cunningham's treatment in hospital prevented him from communicating with his relatives after the first day, and the Medical Certificate, when issued, did not seem to accurately reflect his medical condition.

My subsequent attempts to discuss the certificate with the doctors who signed it, before the expiry of the 5-day registration time limit, have been thwarted at every turn. Also, it should be noted that the primary signatory on the certificate was Dr Brook, who was unknown to my step-father and that it was Dr Barton who attended him in hospital. Consequently, this has resulted in non-registration of the death to date and the involvement of the Coroner's office.

I am forwarding this letter at this early stage to acquaint you with the facts while they are still fresh, and to hopefully initiate an investigation while notes, etc might still be available.

Yours faithfully,

Code A

C R S Farthing.
Lieutenant Commander
Royal Navy

Copy to: Health Service Commissioner

Encl. Medical Certificate of Cause of Death

SEQUENCE OF EVENTS RELATING TO Mr CUNNINGHAM (Arthur Denis Brian)

21 Sep: Mr Cunningham was admitted to the War Memorial Hospital, Gosport suffering from chronic pressure sores, and I visited him an hour or so later and found him in reasonably good spirits and able to communicate normally. I told him I had an appointment in London the following day and would visit on Wednesday, 23 Sep, on my return.

Before I left the hospital, I was taken aside by the Staff Nurse on duty and told that his condition was extremely serious and something, from her experience, he could not survive. She remarked also that if she had allowed a condition half as serious as this to develop before admission to hospital, she would expect to be dismissed. I then asked for an appointment with the doctor who admitted him, and I was told arrangements would be made as soon as practicable as, in fact, she made only occasional visits to the hospital. Later, I spoke to the Nursing Home Inspectorate and, on their advice, forwarded a letter to them requesting an investigation. This is ongoing at present.

23 Sep: Whilst still in London, I received a telephone call from the hospital in the morning to inform me Mr Cunningham had been very difficult with the staff after I had left, and that his condition had deteriorated very significantly. I returned to Gosport without delay, and visited Mr Cunningham at around lunch-time. To my astonishment he was now in a semi-vegetative state and incapable of communication, eating or drinking which I associated with a shringe-driver which was applying serial morphine. I asked why this was necessary and was told he was in acute pain and that the alternatives would induce discomfort. Realising the seriousness of the situation from past experience, I asked that it be switched off for a brief period to enable me to enquire if he had any last wishes. This was refused on the basis that it needed the authority of a doctor and it would be some time during the next day when one visited. At that time, I was informed that the doctor who admitted Mr Cunningham into hospital had been Dr Lord, and I was given an appointment for Monday, 28 Sep.

24 Sep: My wife and I spent most of the following day at the hospital, and it was not until late in the afternoon that Dr Barton visited the hospital and interviewed me to explain the situation as she saw it. I was told again about the acute pain from the pressure sores and that it was the toxins generated by them that would bring about his death. By now it was also apparent that a bronchial condition had developed. At that point I abandoned any hope of speaking to him again.

25-26 Sep: My wife and I spent most of both days at the hospital but, unfortunately, had returned home a couple of hours before his condition became fatal in the late evening of 26 Sep (outside the time limit for registration of the death).

28 Sep: I received a telephone call informing me that Dr Lord could not keep my appointment with her, and advising me to contact her Secretary if I wished to arrange for another. This I did, and was given a time on Friday, 2 Oct as the soonest available.

30 Sep: I collected the (sealed) Certificate of Cause of Death from the hospital and proceeded to register the death at Gosport Town Hall. During my interview with the Registrar it became apparent that the cause of

death was given as Bronchopneumonia, with the primary reason for his demise given as a secondary cause. It was agreed that I should contact the certificate signatories before proceeding, especially as the main signature (deciphered by the Registrar as Dr Brook) was completely new to me and certainly not his GP (also, it was not Dr Barton who tended him in hospital).

My attempts to seek an appointment or even speak with Dr Brook on the telephone were deliberately thwarted even though she was prepared to speak to the Undertaker (as she did) on the same day. I was told to ring back on Friday, 2 Oct which, of course, was outside the 5-day limit for registration.

1 Oct: The circumstances were explained to the Coroner's Office and arrangements made for a post-mortum examination.

2 Oct: Coroner's Office informed me that the cause of death was as stated on the Medical Certificate, and said they had not tested for toxins or anything else and had no intention of proceeding further.

PORTSMOUTH
HealthCare
NHS
TRUST

Lieutenant C. R. S. Farthing,

Code A

Our ref
MM/BM/YJM
Your ref

Date
11th November, 1998
Ext
4378

Dear Lieutenant Commander Farthing,

I am writing further to my letters of 6th and 23rd October, 1998 now that I am finally in a position to respond to the matters you raised concerning your stepfather, the late Mr. A. D. B. Cunningham. I do apologise again for taking so long to respond but as Mrs. Frogley has explained to you the production of her report was delayed by staff annual leave and sickness.

I am aware that your concerns about the nursing home care and the Coroner's office are being investigated separately, and will be responding solely to those issues which relate to services provided by this Trust.

As you well know, Mr. Cunningham was admitted to Dryad Ward, Gosport War Memorial Hospital on 21st September, 1998 from the Dolphin Day Hospital which he had been attending since 14th September, 1998. Dr. Lord had been seeing him there, and had given both him and the nursing home advice on his care. On 21st September, 1998 she observed a serious deterioration in his condition and arranged for him to be admitted directly to the ward.

When you visited him later that day the Sister did speak to you about his condition as she was anxious to warn you that he was more seriously ill than might have been apparent to you. In fact, his condition deteriorated quite rapidly, and because he was in a lot of pain he was put onto a low dose of morphine, via a syringe driver, that evening.

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

St. James' Hospital
Locksway Road, Portsmouth, Hants PO4 8LD
Tel: 01705 822444 Fax: 01705 293437

When you returned from London and visited again on 23rd September, 1998 you were obviously, and understandably, very shocked at the deterioration which had occurred. Your request for the syringe driver to be discontinued, so that you could hold final discussions with your stepfather, was carefully considered. I am sorry if you were given the impression that this decision would have to wait until a doctor next visited the ward as, in fact, the situation was fully discussed at the time by telephone with Dr. Lord, who took the view that the pain relief was of paramount importance, and, therefore, did not agree to your request.

When you next visited the ward on 24th September, 1998 you saw Dr. Barton, a local general practitioner who provides some medical cover for the War Memorial Hospital. She recalls the discussion, and confirms that both the acute pain from the pressure sores and the toxins generated from them were discussed, but she thought she had made it clear that Mr. Cunningham was developing a chest infection which would most probably be the cause of his death.

Dr. Barton was on annual leave between 25th September and 2nd October, 1998 and Dr. Brook, one of her partners from the general practitioner practice, was covering her duties in her absence. It was, therefore, absolutely appropriate for the death certificate to have been signed by Dr. Brook - she was acting as Dr. Barton's deputy, and she had seen your stepfather on the ward prior to his death.

It is a matter of regret that the pre-arranged meeting with Dr. Lord on 28th September, 1998 did not take place, although Dr. Lord understood the appointment to have been cancelled because you were going to be in London. She was aware that you cancelled the subsequent appointment but would have gladly made another appointment. I cannot account for the earlier confusion, but believe it would have been most helpful if you and Dr. Lord had been able to meet, as many of the concerns you have expressed might have been resolved at that time. Indeed, this may still be the case and I would be happy to arrange a meeting between you and Dr. Lord should you consider that might be helpful.

With regard to the problems you experienced with registering the death I am afraid there is little I can add, although I can confirm that the post-mortem was requested by Dr. Brook after she had discussed your concerns and your wish to change the certificate cause of death with Dr. Lord. You are already pursuing your concerns about the post-mortem with the Coroner's office, and I am afraid you will need to contact the surgery to clarify why you had such difficulties in contacting Dr. Brook.

I would like to repeat how sorry I am that your distress at this time has been compounded by so many concerns, but hope that I have been able to clarify the position with regard to the Trust's role.

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If you would like to pursue any of these matters further, or would like to meet with Dr. Lord as suggested please contact my secretary within the next month so that we can make the necessary arrangements.

Yours sincerely,

Code A

Max Millett
Chief Executive