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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: LORD, ALTHEA EVERESTA GERADETTE LORD

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: COMMUNITY GERIATRICIAN

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: A.L.G Lord Date: 13/05/2005

I am employed by the East Hants Primary Care Trust as a Community Geriatrician for Fareham and Gosport Primary Care Trust. I have held this position since the 21st June 2004 (21/06/2004).

In 1978 I graduated from the Faculty of Medicine at the University of Sri Lanka, Colombo. I obtained an MB which is a Bachelor of Medicine and a BS which is a Bachelor of Surgery.

In 1983 I obtained a post graduate qualification as a Doctor of Medicine at the University of Sri Lanka.

I have worked at the General Hospital, Colombo as a Senior House Officer and a Registrar in General Medicine up to May 1984.

From May 1984 I was employed as a Registrar in Nephrology under the supervision of Professor H A LEE at the Renal Unit at St Mary's Hospital, Portsmouth, I held this position until October 1985.

Between October 1985 and September 1988 I was employed as a Registrar in Geriatric Medicine at St Mary's and Queen Alexandra Hospitals, Portsmouth.

From October 1988 to March 1992 I was employed as a Senior Registrar on a rotation between Southampton and Portsmouth Hospitals.

From the 31st March 1992 (31/03/1992) until June 2004 I was employed as a Consultant Geriatrician for the Department of Medicine for older people in Portsmouth. During this period I worked at Queen Alexandra , St Mary's and Gosport War Memorial Hospitals .

In 1997 I obtained a F.R.C.P which is the Fellowship of the Royal College of Physicians.

My General Medical Council Registration Number is Code A

In 1998, I was a consultant geriatrician. My responsibilities included, In Patients at Queen Alexandra Hospital, Daedalus Ward at Gosport War Memorial Hospital, Kingsclere Rehabilitation Ward at St. Mary's Hospital. I also conducted a day hospital session at the Amulree Day Hospital located at St. Mary's Hospital and Dolphin Day Hospital at the Gosport War Memorial. The sessions alternated every week.

I also held an out patient sessions weekly at St. Mary's Hospital. On the 1st, 3rd and 5th weeks I held sessions at the Gosport War Memorial Hospital.

I was the Consultant for all these patients who required specialist care for their physical health. All these patients would have been over the age of 65 years.

Firstly I must explain where other departments require an assessment and believe the patient's physical condition requires specialist geriatric assessment a referral is made to the Department of Medicine for Older People.

I have been asked to detail my involvement in the care and treatment of Arthur Brian CUNNINGHAM , Code A

Mr CUNNINGHAM was a 79 year old gentleman living alone in Code A Code A This is a warden assisted flat. He had Parkinson's disease (diagnosed by another specialist) but also a weak pelvic girdle from a war injury. He had predominantly left sided tremor from Parkinson's disease but had peculiar transfers out of bed and chair as he had long

standing weakness of his pelvic muscles which meant that his pelvic girdle was unsteady when he stood up.

In my opinion the dose of Sinemet (Co-careldopa) needed to be reduced as it had resulted in abnormal body movements and subsequently hallucinations. A decline in blood pressure on standing is also a side-effect of Sinemet.

Mr CUNNINGHAM did not accept that his dose of Sinemet needed to be reduced, although this had been explained to him on several occasions he felt he needed a higher dose.

He moved to 3 different homes in the 6 months prior to his death. As he didn't really settle in any one home the Occupational therapists were not able to put in the adaptions that had been available to him in his own flat at Code A

My first assessment/contact with Mr CUNNINGHAM was on 16/09/1997 when I visited him at his home address Code A

As a consultant Geriatrician I carried out domiciliary visits at the request of the patient's GP.

Following my initial visit, Mr CUNNINGHAM subsequently attended the Dolphin Day Unit at Gosport War Memorial hospital as an out patient.

I have been shown the medical notes of Arthur B CUNNINGHAM exhibit BJC/15 . From the medical records I can confirm I saw and assessed Mr CUNNINGHAM on the 10/3/98 (10/03/1998) in my capacity as a consultant Geriatrician.

The notes of my assessment are recorded on pages 633 and 634 detailing Mr CUNNINGHAM's attendance at the Dolphin Day Hospital

On pages 523 and 524 of the medical notes I can confirm there is a letter from me to Mr CUNNINGHAM's GP Dr Stuart MORGAN conveying my assessment which can be

summarised as follows.

My findings were that the patient had episodes of breathlessness. I considered a differential diagnosis of left ventricular failure or anxiety. My clinical examination and investigation did not support left ventricular failure. Mr CUNNINGHAM reported that his breathlessness had improved with diazepam 2mgs taken 3 times a day.

He had involuntary movements of his entire body. In my opinion this was due to the high dosage level of Co-careldopa (Sinemet) which was used to treat his Parkinson's disease.

I recommended that the dose of Co-careldopa be reduced gradually once he had settled in at Solent Cliffs Nursing Home . Mr CUNNINGHAM reported that he was being admitted to this home on 15/03/98

I also arranged for Electro Cardio Graph (ECG), Chest X ray and blood tests to be done.

I wrote to Dr MORGAN as per my letter on page 521 of exhibit BJC/15.

The white cell and platelet count were a little low, but he was not anaemic.

I asked Dr MORGAN to arrange for a repeat full blood count in 2-3 month time and also recommended that Mr CUNNINGHAM be referred to a haematologist if the white blood cell and platelet counts had fallen further.

There is a further letter within the medical notes, page 519 of exhibit BJC/15 refers. This letter confirms that his chest X-ray was normal. Following this attendance on the 5/3/98 Mr CUNNINGHAM was discharged back to the care of his GP Dr Stuart MORGAN.

I next saw and examined Mr CUNNINGHAM at Merlin Park Rest home, Fort Road, Gosport on the 19th June 1998. The record of this assessment is recorded in my letter on page 491 of the medical notes dated 22/6/98.

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I can confirm that I have dictated the following letter dated 22 June 1998 (22/06/1998).

Letter reads:

Dr. J GROCOCK

Code A

Dear Dr. GROCOCK

ARTHUR CUNNINGHAM, **Code A**
HA: MERLIN PARK REST HOME, FORT ROAD, GOSPORT

Dr. Stuart MORGAN requested this domiciliary visit on 16 June following your initial referral on 11 June. I visited Mr. CUNNGINHAM at Merlin Park Rest Home on 19 June.

Walking in I was most struck at the amount of weight Mr. CUNNINGHAM seems to have lost since I last saw him in out-patients on 10 March. He moved to Merlin Park Rest Home at the end of April and understandably felt very low in his spirits and although this is still so, he agrees that he is settling in and also mentioned that he did not feel he would be there much longer and mentioned the possibility of a move to an RAF home. This was certainly mentioned last year and I am uncertain at this stage as to whether this is a realistic option for the future.

Mr. CUNNINGHAM's main functional problem at present is that he finds the bed too soft and misses the monkey pole and rails that he had in his flat which made his transfers much easier. However, he is able to get out of bed with the assistance of one person and although his transfers are extremely unsteady, one carer can usually manage him. He has difficulty turning over in bed at night and feels that the mattress on the bed is too soft, although this has been changed recently. He is able to use a bottle successfully 3-4 times at night to pass water and

denies any difficulty in micturition. He is on a soft diet, his bowels are regular and constipation has not been a particular problem. He is breathless occasionally as before, but denies any definite angina and oedema has not been a problem. He has had 2 falls since moving into the rest home and has not had episodes of loss of consciousness. Dysphagia is not a problem. The staff at the rest home have not noticed periods of shuffling or freezing. Hallucinations have not been a problem in the last few days although this was so quite a few weeks after he moved in.

At present his medication consists of Co-careldopa 250/25 at 6.00 am, 3.00 pm and 12 midnight, Co-careldopa 100/10 at 10.30 am and 7.00 pm, Amlodipine 5 mg mane, Diazepam 0.5 - 5 mg on average once a day and Codanthrusate 2 capsules prn nocte.

Mr. CUNNINGHAM was seen at 4.35 pm (an hour and a half after his previous dose of Levodopa) and was extremely dystonic, the dystonia affecting his entire body and right upper and lower limbs. He had a mild tremor in the left upper limb but had no rigidity in his limbs at all, was not particularly bradykinetic, there was no seborrhoea or sialorrhoea. Transfers were extremely hazardous and he was lurching even more than before and he had to be steadied by 2 people, although he used a stick. His voice was soft as before, but there was reasonable modulation. His pulse was 80 a minute and regular, blood pressure was 140/80 sitting, venous pressure was not raised, heart sounds were normal and his chest was clear. I could not feel any masses or tenderness in his abdomen., He was very weak around the hips with a left foot drop as before.

Overall I feel that Mr. CUNNINGHAM is on too much Levodopa and this has been my opinion since October last year. Unfortunately Mr. CUNNINGHAM has never agreed with this and our previous attempts at dosage reduction were unsuccessful. I feel that his unsteadiness at present is a result of too much Levodopa which has resulted in dystonia as well as likely severe postural hypotension (he was too unsteady to check a standing blood pressure today). I feel that the Diazepam leads to hypotonia which renders his unstable lumbosacral spine more so. I agree that Mr. CUNNINGHAM is depressed at the move into Merlin Park Rest Home and felt that his short term memory was worse than before as he was quite repetitive. In addition, functionally things are difficult for him as the flat was well adapted to his needs. He had quite a few

implements that he could use. He still has his electric wheelchair but I gather that this is downstairs.

I have taken the liberty of reducing his Levodopa further and have also phased out the timings to regular 4 hourly dosing during the day so that this would provide us with a baseline from which to make further adjustments. His therapeutic regimen now consists of Co-careldopa 250/25 at 6.00 am and 10.00 pm, Co-careldopa 100/10 at 10.00 am, 2.00 pm and 6.00 pm, Amlodipine 5mg daily and Co-danthrusate as before. I have asked the rest home to offer 2.5 mg of Diazepam if he requests it. I hope that the Diazepam could be reduced gradually in the future. Mr. CUNNINGHAM has agreed to these changes to his medication.

As you mention that his records have been misplaced I am sending you a copy of my out-patient letter of 10 March which mentions the dose of Levodopa he was then taking, and also his reluctance to reduce the dose further. If you wish further copies of the correspondence please let me know and I would be happy to send them on to you.

We will need to ascertain as to whether Mr. CUNNINGHAM is going to remain at Merlin Park over the next few months as it would be rather pointless fitting rails if he is to move in the near future. I agree that Mr. CUNNINGHAM is depressed but feel that referral to Dr. BANKS for an assessment of his mental state could be deferred until the dose of Levodopa is reduced as much as possible as it is the excessive Levodopa that has caused his hallucinations.

Mr. CUNNINGHAM has agreed to day hospital attendances and I hope we are able to help him this time around.

Yours Sincerely

(signed) Althea Lord
Dr. A LORD FRCP
Consultant Physician in Geriatrics

Enc.

My assessment can be summarised as follows.

I observed that he had lost weight. He was depressed and had a poor short term memory and had reported visual hallucinations.

He had involuntary movements affecting his entire trunk, right upper and lower limbs with a mild Parkinsonian tremor in the left upper limb.

Mr CUNNINGHAM now required the assistance of two people to transfer safely out of the bed.

I have also recorded the fact that in my opinion the dose of Co-careldopa (Sinemet) was too high and was leading to the involuntary body movements. I also felt that it was likely that he had severe postural hypotension. He was too unsteady to obtain a blood pressure reading when standing.

I was concerned that the Diazepam may have led to a reduction in the tone of the Pelvic girdle muscles. A further contributory factor as to why he was unsteady on his feet.

I agreed with Mr CUNNINGHAM to a reduction of Co-carledopa as detailed in my letter on page 493 paragraph 3 of the medical records.

I also recommended that the dose of Diazepam be reduced gradually.

Mr CUNNINGHAM mentioned to me that he intended to move to an RAF home. As such it was not possible to be certain whether he would be remaining at Merlin Park Rest home.

As a result of this uncertainty the Occupational Therapists had not yet fitted the equipment that had been installed at his home address at Code A This equipment had been specially designed for Mr CUNNINGHAM to enable the safe transfers and mobility around his flat.

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I referred him to Dolphin day hospital for a multi disciplinary assessment of his functional needs and further adjustment of his medication.

However I note that it is recorded in the letter page 341 of the medical notes show that on the 25/6/98 (25/06/1998) Mr CUNNINGHAM had moved to Alverstoke House, Somervell Close, Gosport.

This letter of the 22/6/98 (22/06/1998) sets out my recommendations to the staff at Dolphin Day Hospital.

Letter reads:

22 June 1998 (22/06/1`998)

Sister A STEWART
Dolphin Day Hospital
Gosport War Memorial Hospital
Bury Road
Gosport

Dear Anne

ARTHUR CUNNINGHAM, Code A [redacted]

(Added in handwriting):
Tel. Code A Alverstoke House N/H Somervell Close, Gosport.

I would be grateful if Mr. CUNNINGHAM could please attend once a week. He is extremely dystonic now and has lost a lot of weight. I would like the following done please:

1 Us& Es, liver function tests, calcium, glucose, thyroid function tests and full blood count.

2 Lying and standing blood pressure done at each visit.

3 If severe dystonias are a problem, reduce the 6.00 am (0600) dose of Co-careldopa from 250 to 110 in the first instance, but also check with the rest home as to whether there are episodes of shuffling, freezing and rigidity.

4 Check with the rest home as to the frequency of Diazepam. They are documenting this in a book which Mr. CUNNINGHAM signs as he has phoned his relatives saying he is being 'drugged up'.

5 Could the physiotherapist please assess him.

6 Could the occupational therapist please see him at Merlin Park Rest Home with a view to a more suitable bed and rails. Mr. CUNNINGHAM himself is unsure as to whether he will stay at Merlin Park and we will need to check this with the Social Worker before adaptations are put in.

7 If his mood remains low, he may need assessment by Dr. BANKS.

With many thanks and best wishes.

Yours sincerely
(signed) Althea
Dr. A LORD FRCP
Consultant Physician in Geriatrics

Added in handwriting:
PS Please phone GP to find out current address and if DDH is still required.
Thanks, Althea. 23/6
25/6 in Alverstoke N/H 2/52.
I was going to book him DDH in from 6/7/98 (06/07/1998) but will wait to hear from SPW S.GOLDING pm today.

My next contact with Mr Cunningham was on the 20/7/98 (20/07/1998) when I reviewed him

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at Dolphin day hospital.

I can confirm that I have written the entries recorded on pages 637 and 638 of the medical notes (Exhibit BJC/15).

The letter that I dictated on the 22/7/98 pages 478 and 479 of the medical notes relate to Mr CUNNINGHAM's attendance of the 20/7/98 (20/07/1998).

I can confirm that I have dictated the following letter dated 22 July 1998 (22/07/1998):

Letter reads:

Dr. J GROCOCK

Code A

Dear Dr. GROCOCK

Re: Arthur CUNNINGHAM, Alverstoke House Nursing Home, Somervell Close, Gosport PO12 2BX D.O.B. **Code A**

Diagnosis:

1. Parkinson's Disease - stable
2. Weak pelvic girdle from old injury - stable
3. Low white cells and platelets - likely Myelodysplasia
4. Weight loss
5. Element of depression with deteriorating memory - has not been able to settle in Rest and Nursing Homes in the last couple of months.

Mr. CUNNINGHAM attended Dolphin Day Hospital today. He has been doing so since 6th

July and the opinion from the Therapists and Nursing Staff is that both his Parkinson's disease and transfers are stable overall, he is able to do this with one. He still tends to jack-knife on transferring from the sitting or lying down position, but overall his stability does not seem to have deteriorated very much. His weight today was even lower at 67.2 kg blood pressure was 130/65 lying down, 180/110 on standing. He was low in mood and his short term memory is certainly much worse. He was dysphonic as before, tremors were a problem of the left upper limb more than the right and he had mild moderate cogwheel rigidity in the upper limbs. There was no dystonia and Mr. CUNNINGHAM himself denies hallucinations now. He mentioned a difficulty with his swallowing, but is able to feed himself at the day hospital and usually finishes his main meal as well as a pudding without any observed difficulty.

He should continue with Sinemet 110, 5 times a day (6.00 am, 10.00 am, 2.00 pm, 6.00 pm and 10.00pm) Amlodipine 5 mg daily, Co-danthrusate 2 capsules nocte, Solpadol 2 prn qds and Diazepam 2.5 mg prn.

I have arranged for a Speech and Language Therapist to assess his swallow, as I wonder if he is safe with liquids. Following Mr. CUNNINGHAM's consultation with me, I have had a phone conversation with Dr. V BANKS, Consultant in Old Age Psychiatry and was informed that he is being admitted to Mulberry A Ward on 21st July. I will be happy to review him there and will let the Speech Therapist know of his admission so that he could be seen on the ward.

I have discussed with Mr. CUNNINGHAM today that it was in his interest to try and settle in a new Nursing Home that was found for him, although this may not be called 'perfect' in his eyes. He continues to mention the RAF Home in East Sussex as his preferred option for placement and I am not too sure as to why he was unable to go there.

Mr. CUNNINGHAM will need the house and furniture to be adapted for him and will also need regular help with his transfers, but unfortunately this cannot be put in place until we have a permanent place of residence. This has been explained to Mr. CUNNINGHAM today.

With best wishes,

Yours sincerely

(signed) Althea Lord

Dr. A LORD

Consultant Geriatrician

Dolphin Day Hospital

c.c. EHU (QAH)

Dr. V BANKS, Consultant in Old Age Psychiatry

The notes of my assessment are set out in this letter to Dr GROCOCK which can be summarised as follows;

Mr CUNNINGHAM's problems were as listed in the letter, he was transferring with the assistance of one person.

His mood remained low. His short term memory was poor.

He was on a lower dose of Co-careldopa but with no deterioration in function.

I was informed by Dr BANKS (the Consultant Psychiatrist) that Mr CUNNINGHAM was being admitted to Mulberry A ward on the 21/7/98 for assessment.

Mr CUNNINGHAM remained keen to move to the RAF home in East Sussex.

I note there is an entry in the clinical records at page 70 at 3-15pm on 24/7/98 recording a telephone conversation between me and Dr Childs which is recorded as follows;.

24.7.98. 3.15 pm D/W A LORD. His Parkinson's is very stable at present. He gets a lot of problems ĉ dystonia and hallucinations and also hypotension if the dose is increased. He has always wanted more Dopa but we should continue at the current dose. Dr. LORD will

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24.7.98 cont. see him on Monday.

Mr CUNNINGHAM informed

(W.Childs) SHO

This accord's with my preceding and subsequent contacts with the patient.

I can confirm that I have written the following entry on page 74 of the medical notes as follows:

27.7.98. 0845 Seen on Mulberry A.

He is sitting at table eating porridge on his own. Subsequently observed to be buttering and eating toast.

A bit slow and some tremor but no particular problems observed.

From 20/7/98

- S/ Alb 27 (47 in March)
- Hb 14

WBC 2.9 - (N) 1.4

Platelets 97.

His mobility problems are mainly due to his weak pelvic girdle from an old spinal injury - PD is stable overall.

Suggest

1) High Protein diet.
2) Weekly FBC
3) Ct. same dose of L-DOPA.

If however night-time stiffness persists → try Sinemet CR (250) at 10 pm instead of 110 -

(watch for dystonia & hallucinations)

Signed A. Lord

On pages 105 to 107 in the medical notes there is a letter from me to Dr BANKS detailing my ward visit of the 27/7/98. I can confirm that I have dictated the following letter dated 28th July 1998 (28/07/1998):

Letter reads:

Dr. V BANKS
Consultant in Old Age Psychiatry
Gosport War Memorial Hospital
Bury Road
Gosport

Dear Vicky

WARD VISIT - MULBERRY A, GWMH
ARTHUR CUNNINGHAM, Code A
HA: ALVERSTOKE HOUSE NURSING HOME,
SOMERVELL CLOSE, GOSPORT

Mr. CUNNINGHAM was reviewed on Mulberry A on 27 July at Dr. CHILD's request as he wished the dose of Levodopa to be increased. I visited at 8.45 am and he was at the breakfast table with two other gentlemen, was observed to be eating his porridge on his own, subsequently buttered his toast which he was able to swallow without any obvious dysphagia, or bradykinesia.

Mr. CUNNINGHAM has not been observed to have any particular day-time stiffness, but I note from his medical notes that there has been some stiffness at night although this seems to be improving. Clinically he had mild cogwheel rigidity in the left upper limb, a tremor on the left

more than the right, was not dystonic, dysphonia as before, but there was no evidence of any stuttering or freezing. The dose of Levodopa had been reduced as he had problems with sever postural hypotension, hallucinations and dystonia on a higher dose.

Investigations early last week confirm normal renal function with a very low serum albumin of 26. However, a couple of days later (22 July) his urea has risen to 11, creatinine 101, electrolytes are normal and the albumin is spuriously raised at 47. Thyroid function tests are normal. His white count remains low but stable at 2.9, haemoglobin is normal at 14, MCV 93.5 and platelets stable around 100. ESR is 18.

I do not feel that further action need be taken about his neutropenia and thrombocytopenia but feel that he will need weekly full blood counts for the present. I feel his fluid input should be increased, aiming for 2 litres a day. I have also mentioned him to Ruth DEVERILL , Speech and Language Therapist so that his swallow could be formally assessed as he may benefit from thickened fluids rather than thin fluids if this is difficult. I feel that his present dose of Co-careldopa 110 should be maintained at 5 a day, but if night-time stiffness is still a problem towards the end of the week I would suggest that this is increased to Co-careldopa CR 250 at 10.00 pm and the 110 omitted. If this does cause more problems with hallucinations the dose will need to be reduced back again.

Overall Mr. CUNNINGHAM's Parkinson's Disease is no worse and his transfers continue to be difficult mostly due to an old war injury which has resulted in considerable weakness of the pelvic girdle.

I would be happy to review him as appropriate.

With best wishes,

Yours sincerely,
(signed) Althea Lord
Dr. A LORD FRCP

Consultant Physician in Geriatrics

This letter can be summarised as follows ;

Mr CUNNINGHAM was observed by me eating his breakfast without difficulty.

His Co-caredolpa dose had been reduced because of the previously reported hypotension, hallucinations and abnormal movements.

His blood tests showed low Albumin indicating poor nutrition and a mild reduction in white cells and Platelets.

I recommended that we increase his daily liquid intake aiming for 2 litres a day.

I referred him to the speech and language therapists in connection with his swallow.

I also recommended weekly full blood counts. I left the Co-careldopa unchanged during the day time with a recommendation that the night time dose be increased from 110 to 250.

Mr CUNNINGHAM's Parkinson's symptoms had not worsened.

I can confirm that I have written the following entry as follows:

27/8/98 ELDERLY MEDICINE

Reviewed

1) Catheterised today for retention of urine - RV 1900 mls initially + bag full now.
2) Parkinson's Disease - has deteriorated.Cannot comment without review of medical notes. Transfers ĉ 1 - 2.

Not really mobile.

Won't wheel himself in chair.

3) Eating better.

Weight 69.7 kg (8/8/98) (08/08/1998)

Plan

1) Ct. same dose L-dopa an ↑ dose may be required but I feel this carries a sig't risk of worsening his mental state.
2) Could OT here please liaise ĉ Eileen KETTLEWELL OT, as Mr. CUNNIGNHAM will require rails by his bed - will need post-discharge visit to N/home.
3) Leave catheter in for now.
4) I'll arrange F/U at DDH on 14/9/98 (14/09/1998) to monitor PD, FBC, U/Es and weight.
5) I feel he should be discharged to Thalassa Nursing Home tomorrow.
6) Document Wt before D.

(signed) Althea Lord

(Geriatrician)

I would like to explain the following medical abbreviations within this entry.

RV = Residual Volume and refers to the volume of Urine drained when the Catheter is just inserted. In this case there was just under 2 litres.

Transfers æ 1-2 = When moving from bed or chair he requires the assistance of 1 or 2 carers.

Æ = with

Ct = Continue

↑D = Increased

Ldopa = levodopa which is the main constituent of Co-careldopa

Sigt = Significant

OT = Occupational Therapist

N/Home = Nursing Home

F/U = Follow Up

DDH = Dolphin Day Hospital

PD =Parkinsons Disease

FBC = Full Blood Count

U&E's = Urea and Electrolytes

D = Discharge

Wt = Weight

I can confirm that I have dictated the following letter dated 1st September 1998 (01/09/1998).

Letter reads:

Dr. V BANKS
Consultant in Old Age Psychiatry
Gosport War Memorial Hospital
Bury Road
Gosport

Dear Vicky

WARD VISIT - MULBERRY A, GWMH
ARTHUR CUNNINGHAM, Code A
HA: ALVERSTOKE HOUSE NURSING HOME,
SOMERVELL CLOSE, GOSPORT

I reviewed Mr. CUNNINGHAM on Mulberry A on 27 August. I gather that he is due to be discharged to Thalassa Nursing Home on 28 August, but had problems today with retention of urine and had a residual volume of 1900 mls, and a further 800 mls was emptied this afternoon as well. He denies constipation, he is eating better and his weight in early August had improved to 69.7. kg. He is much better in his mood although apprehensive about the discharge tomorrow. His Parkinson's disease seems a little worse, he had a little increase in stiffness but I gather he now takes 1 or 2 people to transfer and is not really mobile. Although he releases the

brakes on his wheelchair he does not wheel himself either.

In the long term he may require more Levodopa but I am not keen to do this at this stage as I feel it would upset his mental state and may make settling down at Thalassa more difficult. I feel that discharge tomorrow could go ahead as planned and feel that the deterioration in renal function is due to his retention of urine.

I hope to contact the occupational therapists as regards assessment at Thalassa Nursing Home on discharge as I feel he will need adequate rails to help with his transfers. I also hope to review him in Dolphin Day Hospital on 14 September to monitor his Parkinson's Disease, weight, urinary retention, full blood count and renal function.

With best wishes,

Yours sincerely,
(signed) Althea
Dr. A LORD FRCP
Consultant Physician in Geriatrics

This letter details my assessment of my visit to Mr CUNNINGHAM on Mulberry A ward on the 27/8/98 (27/08/1998) which can be summarised as follows;

Mr CUNNINGHAM had been catheterised for urinary retention with a residual urine volume of 1900mls- This is a significantly large volume of urine to be retained within the bladder.

His nutrition and weight had improved to 69.7kg.

His mood was better although he was apprehensive about his discharge to the Thalassa Nursing Home.

I recommended continuation of the existing dose of Co-careldopa, as a higher dose could

worsen his mental state

I recommended that the Occupational therapists review him for rails by his bed following his discharge.

The catheter was to remain in for the time being and that his weight should be documented on discharge.

I advised that he should be discharged to the Thalassa Nursing Home on 28/8/98 (28/08/1998) and that I should see him in the Dolphin Day Hospital on the 14/9/98 (14/09/1998) to review him.

I can confirm that I have dictated the following letter dated 23 September 1998 (23/09/1998):

Letter reads:

Dr. J GROCOCK

Code A

Dear Dr. GROCOCK,

Re: Arthur CUNNINGHAM, Thalassa Nursing Home, 79 Western Way, Alverstoke, Gosport. PO12 2NF

Code A

Mr. CUNNINGHAM was reviewed in Dolphin Day Hospital today and has 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. His Parkinson's disease doesn't seem any worse and mentally he was less depressed but continues to be very frail. I have taking the liberty of admitting him to Dryad Ward at Gosport War Memorial Hospital with a view to more aggressive treatment on the sacral ulcer as I feel that this will now need Aserbine in the first instance. The social worker is being contacted so that his place at the Thalassa nursing home can be kept open for the next three weeks. Mr. CUNNINGHAM has agreed to the admission. We shall let you know how he gets on.

With best wishes

Yours sincerely

(unsigned)

Dr. A LORD
Consultant Geriatrician
Dolphin Day Hospital

c.c. FHU (QAH)
Dr. V BANKS, Cons. Old Age Psychiatry

I can confirm that I have written the following entry as follows:

21/9/98	DDH BP → 110/70 p - 84
69 kg	Very frail
	Tablets found in mouth - some hrs. after they've given
	Offensive large necrotic Sacral ulcer ĉ thick Black scar
	Diagram of grazes
	(L)Lateral malleolus - small Black scar + reddened

PD no worse

Ä= Diagnosis

(1) sacral sore (in N/home)

(2) PD

(3) Old back injury

(4) Depression + element of dementia

(5) Diabetes Mellitus - diet

(6) Catheterise for Retention

Plan:

1) Stop Co-danthrusate + Metronidazole + Amlodipine

2) TCI - Dryad today
   - Aserbine for sacral ulcer
   - nurse on side
   - high protein diet
   - Oramorph prn if pain

N/Home to keep bed open for next 3/52 at least.

Pt informed of admission - agrees.

Inform N/Home, Dr. BANKS - Social Worker

Prognosis poor.

(signed) A Lord

I can explain my notes as recorded on pages 642 and 643 of the medical notes as follows;

Mr CUNNINGHAM was seen at Dolphin Day hospital. His blood pressure lying down was 110/70. (which was a relatively low reading for Mr CUNNINGHAM)

His pulse (P) was 84 beats per minute which was a normal reading.

His weight was documented as 69 kilograms.

I have observed that he is very frail. I have examined his mouth and found evidence of unswallowed tablets which I had ascertained had been given earlier.

I also noted that he had a large Necrotic sacral sore (that is it was foul smelling). Necrotic means it is basically dead tissue, in this case, it was covered with a thick black scar.
There were also grazes noted on both buttocks which I illustrated.

L. Lateral Malleolus refers to the outer aspect of the left ankle. He had a small black scar on this side and there was some surrounding redness.

PD- no worse- I did not feel his Parkinson disease had worsened.

My Diagnosis Ä was as follows

1) Sacral sore sustained in a nursing home
2) Parkinsons Disease (PD)
3) Old back Injury
4) Depression and an element of Dementia
5) Diabetes, Mellitus - This condition was controlled by diet alone.
6) Catheterised for urinary retention.

My plan was as follows

1) Stop Co-danthramer (which is a laxative) and metronidazole which he was taking orally. It was unlikely this would have adequately penetrated the necrotic tissue in the sacral ulcer.

The Amilodipine was discontinued as his blood pressure was low.

2) Admission was arranged to Dryad ward at Gosport War memorial hospital where a bed was available.

TCI = To Come In

3) I recommended Aserbine cream for topical use on the sacral ulcer and that he be nursed on his side to relieve the pressure on the ulcer.

I recommended he be put on a high protein diet to help improve his nutrition and help wound healing.

As the ulcer was extensive he would have a significant degree of pain for which I recommended Oramorph . I prescribed 2.5mgs to 10mgs to be given orally as required at intervals of 4 hours.

I have documented this prescription on page 752 which is the prescription drug chart.

I felt that the Nursing Home bed should be kept open for the next 3 weeks in order to establish whether Mr CUNNINGHAM would become well enough to return there.

Mr CUNNINGHAM formally agreed to the admission. The day hospital staff were also instructed to inform the nursing home, Dr BANKS (Consultant psychiatrist) and his social worker of the admission

I have noted that his prognosis was poor.

Whilst the treatment plan was aimed at maximising the prospect of an improvement in Mr CUNNINGHAM's condition I recognised that his general condition was very poor and had contributed to the development of the large pressure sore. I felt that he was unlikely to recover.

I cannot find any further entries by me in this patient's records that I had any further contact in relation to Mr CUNNINGHAM's clinical care.

If there is a change in the patient's condition then medical staff can alter the patient's medication and dosage as necessary without reference to the Consultant unless in the opinion of the medical and or nursing staff, further consultant input is required