East Hampshire, Fareham and Gosport Primary Care Trusts

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4 April 2006

Paul Mant, Coroner's Officer
The Coroner's Office
Room T20, The Guildhall
Guildhall Square
Portsmouth
Hampshire
PO1 2AJ

Dear Code A

Re: Code A

Further to our recent telephone conversation, I am pleased to enclose a signed Report as request. As discussed the report was prepared by Dr Fiona Hogg who has now gone on maternity leave and is therefore unable to sign it. It has been signed on her behalf by the Acting General Manager, Karen Guy.

To further complicate matters, the Elderly Mental Health Service was transferred on 1st April 2006 to the Hampshire Partnership NHS Trust, including the management of Fernhurst Ward, where Mrs Lacey died.

The Hampshire Partnership NHS Trust has provided me with a contact person for this particular case: Code A who can be contacted most easily on his mobile telephone Code A
The address is:

The Hampshire Partnership NHS Trust
The Maples
Horseshoe Drive
Tatchbury Mount
Calmore
Southampton
SO40 2RZ

If I can be of further assistance, please let me know.

Yours sincerely

Elaine Williams
Complaints and Litigation Manager

CORONERS REPORT

This report relates to the death of Code A

Personal Details:

Address: Code A

GP: Dr Brian Ellis
Swan Street Surgery
Petersfield

1. Details of Person Preparing the Report

This report has been prepared by Dr Fiona Michelle Hogg, BM (Bachelor of Medicine), MRCPsych (Member of the Royal College of Psychiatrists). I am a Consultant in Old Age Psychiatry having worked as a Consultant for four years. I have been in this current post, employed by East Hampshire PCT since February 2004.

2. Knowledge of Patient

I have been the NHS Consultant in Charge of Code A care since the 25th February 2005 when she was referred to me by her GP Dr Brian Ellis of the Swan Street surgery. Since 25th February 2005 she has had two in-patient admissions and I have seen her both alone and with other members of the clinical ward team during these periods. I also reviewed her alone at home in a period of discharge between the hospital admissions and reviewed her in the Laurel Day Unit, Petersfield during her attendance there between hospital admissions.

3. Available Documents referred to whilst writing this report

I have had access to her full psychiatric notes dating back to 1992. Code A has been known to the Psychiatric Services since December 1992 and was under the care of Dr Nick Renton, Consultant in Adult Psychiatry between that date and October 1994. She was not seen by the Psychiatric Services between October 1994 and her recent referral to me in February 2005. I have also had the opportunity to review her general hospital records during the preparation of this report.

Chronological Sequence of Events

4. First Admission

The initial referral of Code A to myself was made on the 25th February 2005 by her GP Dr Ellis. I recall a telephone conversation with him in which he described the fact that he knew Code A well and that she had flown back home from Spain over the preceding 24 hours. He explained that she had a history of depression in the past and had made several self-harm attempts during her last depressive episode. One of these was a significant self-harm attempt where she threw herself out of a hospital window. He felt the current relapse was precipitated by the death of her husband in

November 2004. Her family have been attempting to support her since then and she had recently gone to stay with her daughter in Spain in the hope this would help her. Unfortunately the family were describing the fact she was more anxious and agitated in Spain and they were therefore returning to England with the hope of her being admitted to hospital. Having discussed this history with Dr Ellis by phone who clearly knew the patient well, I felt admission that night was appropriate. Unfortunately there were no beds available at St James' Hospital and I therefore arranged her admission to Ark Royal Ward at Gosport War Memorial. Therefore the initial part of her admission from the 25th February 2005 to the 9th March 2005 was under the care of Dr Zia Ul-Haque at Gosport War Memorial Hospital. She was transferred back to St James' Hospital as soon as a bed was available. The other significant medical history that Dr Ellis disclosed to me was that she had had a meningioma (a brain tumour) removed in 1992, this had been the precipitant for the episode of depression resulting in the serious incident of self-harm. She had also had carcinoma of the breast in 1999. She required no treatment for either of these conditions at the time of this admission. Dr Ellis felt that Code A had previously been worrisome about a list of physical complaints and the list of concerns had increased around the time of the death of her husband. He had referred her for further investigations for some of her concerns.

On reviewing the notes made during the admission at Gosport War Memorial she was initially felt to show some mild depressive symptoms and was clearly quite anxious. Her medication at the time of admission was Amitriptyline 75 mg nocte (an anti-depressant) and Nitrazepam 5 mg nocte (a hypnotic). During her admission to Gosport War Memorial it was felt her mental health deteriorated and her depressive symptoms increased. She was very preoccupied with her bowels and appeared to worry incessantly about her constipation. By the 5th March she was noted to be expressing paranoid ideas believing that people on the ward were watching her and spying on her. She was also starting to express some beliefs that she had Alzheimer's disease. She was reviewed on the 7th March by Dr Zia Ul-Haque, her consultant at the time along with the family and her Amitriptyline was increased to 125 mg nocte and an anti-psychotic medication, Olanzapine, was introduced at a small dose of 2.5 mg nocte. Transfer was arranged to Fernhurst Ward at St James' Hospital on the 9th March 2005.

I was on holiday at the time of her admission and Dr Martin Brown was therefore the Consultant in Charge of her care. The ward team were concerned about her presentation from the time of admission. She continued to express psychotic beliefs about people watching her and was concerned somebody was going to try and take her away from the hospital in an ambulance. Although there were no explicit concerns regarding suicidal ideation she was put onto 30 minute observations initially. She was reviewed by Dr Brown on the 14th March 2005 in my absence. He then discussed the situation with the family and recommended ECT as the treatment of choice. She continued to take Amitriptyline 125 mg daily and he suggested increasing her Olanzapine to 2.5 mg bd (twice daily). She started ECT treatment, which she consented to, on the 16th March 2005. Mrs Lacey was consenting to a course of ECT treatment, as she was an informal patient she could withdraw at any time. A course of ECT would vary between 4 and 12 treatments essentially Code A Code A would be recommended for the number of tyreatments to resolve that presenting episode.

I first saw Code A on the 31st March 2005 on my return from holiday. She continued to present as being severely depressed with psychotic symptoms. I therefore suggested increasing the ECT treatment dose. I also increased her anti-psychotic medication, Olanzapine, further to a dose of 2.5 mg in the morning and

5mg at night. Over the next few weeks she was reviewed regularly by the ward team and by myself on the weekly ward rounds. There were significant signs of improvement. By the 31st March during the review with Code A and her family, everyone agreed she was pretty much 70% back to her usual self. She was not expressing any suicidal ideation. She was no longer expressing any psychotic beliefs. We discussed discharge plans at this time. Code A had a total of 7 ECT treatments by the beginning of April and the ECT treatment was stopped then.

She continued to improve throughout April 2005 and as a team we had discussed a planned discharge with Code A and her family. She had increasing periods of leave which she seemed to manage reasonably well. The family started to express concern as to how she was going to be able to manage at home as they told us that Code A husband had effectively been her main carer for many years. Since her treatment for her brain tumour in 1992 he had taken over most of the domestic roles and really prompted Code A with regards to her nutritional needs and helped her with her social needs as well. Code A was able to manage her own personal care. During the prolonged episodes of home leave during April she seemed to be managing reasonably well, it was noted there seemed to be an increase in her anxiety levels during the time she spent at home.

By the time of my review on the 28th April there was a definite deterioration in her mental state again. Code A was becoming increasingly anxious and denying that there had been any improvement since her admission. Once again she began to become preoccupied with a list of physical complaints, in particular worrying that her bowels were not functioning properly. At this time she also became preoccupied that she had a memory problem and was developing an illness such as Alzheimer's. We had checked her Mini Mental State Examination which is a screening tool to check for memory deterioration in elderly people and this showed no signs for concern. By the 3rd May 2005 at the ward review she had deteriorated to such an extent that she was again severely depressed with psychotic symptoms. She was expressing over-valued ideas i.e. ideas held to a level that she was worried about them, but it was possible to reassure her they were not true, for example she thought she had MRSA (a serious hospital-based infection). She was also preoccupied that she had let herself and everybody down, not keeping up with her own personal care or doing her laundry on the ward. Again following discussions with her family it was felt that she was deteriorating rapidly. During this time I had instituted a change of anti-depressant from Amitriptyline which I had gradually been reducing from the middle of April because it did not seem to be maintaining her mental state and also it could have been contributing to her constipation. I had started introducing Sertraline, a different anti-depressant at a dose of 50 mg a day on the 13th April. This was gradually increased to a dose of 150 mg a day by the 3rd May. She had also required a gradual increase in her anti-psychotic medication (Olanzapine) which was increased to a dose of 15 mg a day by the 3rd May.

I reviewed the situation again with her son on the 3rd May and decided that in order to stop further deterioration, ECT again would be the treatment of choice as she'd had such a good response to that previously. She therefore restarted ECT on the 9th May 2005 to which she consented. She remained severely depressed and continued to express psychotic symptoms. She was now also beginning to express more significant concerns regarding physical complaints, in particular regarding pain in her left buttock. I understood from her GP that she had complained of this pain previously and he had arranged some investigations for it but nothing significant had been found. I changed her anti-psychotic medication from Olanzapine to an older generation anti-psychotic medication called Haloperidol on the 16th May initially at a dose of 3 mg bd but again this needed to be increased further throughout May rising

to the highest dose she had of 5 mg bd on the 25th May 2005. By the 20th May she had withdrawn her consent for ECT. This decision seemed to be based on a completely psychotic belief system that she had some inoperable problem with her bowels and nothing we could do was going to cure her and she was going to die. I therefore reviewed her on the 22nd May 2005. I noted a very significant deterioration and was concerned about her poor food and fluid intake. I felt she had to have ECT treatment in order to save her life and so I completed Section 62 in order to give her ECT as an emergency procedure the following day on the 23rd May 2005. On 23rd May 2005 a Section 3 of the Mental Health Act was completed, ECT recommended under a section 62 emergency treatment provision (a section 3 of the mental health act is an application order to detain and treat her in hospital against her will). Code A Code A was unable to give informed consent for ECT at that point due to her illness. I therefore arranged for a SOAD (Second Opinion Approved Doctor) who is a psychiatrist from the Mental Health Act Commission to review her with a view to approving my proposed treatment plan. The SOAD assessed her on 27th May 2005 and agreed to the treatment plan of up to 12 unilateral ECT treatments including those already given in this course from the date of 9th May 2005

Her second course of ECT therefore began on the 9th June 2005. She had eleven treatments ending on the 10th July 2005. Again once the ECT treatment had been started she began to show a gradual improvement in her depressive and psychotic symptoms. She became much less preoccupied with her physical complaints. Code A Code A mental health continued to gradually improve from 9th May to 10th June of 2005. I gradually reduced her Haloperidol medication until at the point of discharge on the 26th July she was taking Haloperidol 1.5 mg nocte, Sertraline 150 mg mane, Nitrazepam 5 mg nocte and Movicol sachet and Lactulose regularly for her bowels.

5. Time spent in Community between admissions

Due to the significant improvements in her mental health she was discharged from Section 3 of the Mental Health Act on 26th July 2005. She was discharged home on the 26th July 2005 under a section 117 Mental Health Act aftercare package (this is a formalised plan for joint monitoring between health and social services following a period of admission under Section 3 of the Mental Health Act). The follow-up arrangements were for her to continue taking her medication as prescribed. Phil Shaw was allocated as her Community Psychiatric Nurse and Colin Westerby as her Care Manager from Social Services. She was initially reviewed at home by her CPN on the 29th July who documented that she was managing reasonably well although he noted her daughter had been present throughout the time she had been home. Her daughter expressed concerns as to how she would manage when the daughter returned to Spain. The CPN discussed the situation with her Care Manager and it was agreed to arrange Welcome Home Care Package (this is a care package which provides carers to come in twice a day to monitor the situation for a period of 6 weeks at which point the care package is reviewed). When the CPN reviewed Code A Code A on the 5th August, she appeared to be managing at home although she was starting to mention the pain in her left buttock and was concerned about other physical symptoms. She had seen her GP during that week and had been prescribed a different analgesic drug for this. Throughout August the family were beginning to raise concerns via telephone calls to the ward and to my office. I therefore reviewed Code A in an unannounced visit on the 11th August 2005. At the time of my visit I felt she was beginning to struggle in coping with living independently. She was quite preoccupied with the pain in her left buttock and she was finding it increasing difficult to eat and had a poor appetite.

At the time I felt she wasn't significantly depressed but was clearly struggling to cope with living independently and adjusting to life in the house without her husband. This was the first time she'd lived independently at home since his death. I increased her Sertraline to 200 mg daily and encouraged her to attend the Day Hospital. I discussed the situation further with one of her daughters who felt she was coping, although there was some difference of opinion between some family members as to how well she was coping. They encouraged her to attend the Day Hospital which she did on the 31st August 2005.

6. Second Admission

She continued living at home but there were increasing concerns being raised by the family. The CPN had visited her on the 15th September and noted that she was complaining of increased sweats and the CPN was concerned that her weight had decreased by at least 4 pounds since her discharge from hospital. Mrs Lacey was concerned about her memory and beginning to question whether she had Alzheimer's disease. She was readmitted as an informal patient (not under the Mental Health Act) at the request of her GP to Fernhurst Ward on the 16th September 2005. At the time this admission, the Mini Mental State Examination was documented, this stated that she was well-groomed, and not presenting as being depressed, there was no evidence of any psychotic symptoms and the Mini Mental State Examination was 30/30.

I was on holiday at the time of this admission, when I reviewed her on the 19th September 2005 I felt she presented with some mild depressive symptoms but certainly not to the extent that I had seen previously. She didn't feel she should have come back into hospital and as far as I could tell neither did some of her children. We agreed that since she was here we would await a Magnetic Resonance Imaging (MRI) scan which is a specialist X-ray to give a more detailed internal picture, which had previously been arranged by Code A who was one of the Consultants involved in her care prior to this admission. Code A is a lower gastro intestinal surgeon based at QAH. I recall discussing the reason for the MRI scan with her GP by telephone around this time. Apparently Code A had been reviewing Code A for a long time regarding her concerns about her bowels and more recently about her buttock pain. The MRI scan of her lower back and buttocks had been requested by Code A months earlier following his last out-patient review to see whether there was any physical cause for that pain. I felt it was worth reviewing the MRI scan results to see whether this cast any light on whether there was a physical cause for the ongoing complaints regarding her left buttock pain or whether it was related to her depressive episodes. I also reviewed her antidepressant medication again and considered changing her anti-depressant to Venlafaxine. However in light of the current Committee of Safety of Medicines (CSM) guidelines on the use of Venlafaxine in people with a history of cardiac arrythmias I repeated her ECG which showed evidence of a minor abnormality in conduction called Right bundle branch block (which had been previously noted when reviewed earlier in the year by the Chest Pain Clinic). On balance I felt it was better not to start Venlafaxine and opted to use Trazadone which is thought to be generally safer in people with cardiac problems she started Trazadone on 26th September 2005 and discontinued it on 10th October 2005.

I reviewed her a week later on the 26th September 2005 on the ward, despite feeling that she was not significantly depressed at the time of her admission, there was a clear deterioration in her mood. She was much lower in mood and increasingly more anxious. She was also beginning to complain again about the numerous physical problems that she had been concerned about during previous admissions when she was depressed. Her daughter was very concerned that she hadn't had enough

support when she was at home. I spent some considerable time explaining to her daughter that it was a combination of trying to understand whether there were any genuine physical symptoms or whether these were a reflection of her becoming depressed again. I also felt we were seeing a true reflection of Code A trying to cope independently without the support that had been provided by her husband over the many years prior to his death. I explained that I wasn't sure we would ever get Code A well enough to live independently, with her mental state as stable as it had been when she was in a sheltered environment such as the ward. We agreed that the best course of action was to change her anti-depressant again and await the results of the MRI scan. I again discussed the situation with her GP, Dr Ellis on the 28th September 2005.

Having discussed all of the current presentation we agreed it was probably appropriate to ask for an opinion from the Old Age Physicians regarding her ongoing concerns regarding the left buttock pain and also the fact that she was complaining of increased sweating episodes. I felt the sweating episodes was most likely due to anxiety however I repeated biochemistry and haematological investigations to make sure there was no evidence of any infection. All investigations were normal. By the beginning of October she had continued to deteriorate in her mental state. I reviewed the situation again with her son Steven. The MRI scan had shown no significant features to explain the ongoing buttock pain. In particular there was no evidence of any carcinoma which was one of Mrs Lacey's worries although she was not reassured by this. The elderly medicine team medical specialist registrar reviewed Code A on the 3rd October 2005 and could not find any significant medical features of note. However further investigations were suggested including a serum calcium, Bence Jones protein (which is a urine test) and blood test to look at her protein electrophoresis, both of which would be looking for a specific sort of back pain caused by a malignant condition such as myeloma. However, all these tests were reported as normal.

On the 17th October 2005 she was noted to have evidence of peripheral oedema and a raised Jugular Venous Pressure (JVP) both of which were a new finding in her. This indicated that she had excess fluid in her body and may have been a sign of early heart failure. This is not an uncommon finding in people of this age. She was commenced on a small dose of Bendrofluazide which is a diuretic (water tablet designed to increase urine output) on the 18th October 2005 to which she responded well. There had been no concerns raised regarding her physical health following her ECT treatments and her physical observations including pulse and blood pressure which are recorded as part of her ECT treatment were all normal on the day of her last ECT on 7th November 2005.

In the middle of October 2005 her mental health continued to slowly deteriorate however I felt she wasn't as ill as she had been earlier in the year when I had to use the Mental Health Act section 3. I decided to change her medication to a newer anti-depressant called Duloxetine starting at an initial dose of 30 mg which was prescribed on the 10th October 2005, increasing to 60 mg per day (normal maintenance dose) on the 19th October 2005. My rationale for prescribing this was that it was reported to be good at controlling somatic symptoms of depression (concerns regarding physical symptoms) this had always been one of the major problems with Mrs Lacey when she became depressed. It was also less likely to cause problems of constipation. It also appeared from the literature available to have a safer profile for use in people with a variety of mild to more severe cardiac problems. Her family were all keen that she should have ECT treatment at this time and although Code A wasn't initially keen to do so, after discussing it further with all of her children she decided she would have further ECT treatment as she had

responded so well to it in the past. She started a course of ECT on the 24th October 2005 and by the time of her death she had received 5 treatments with the last ECT being on the 7th November 2005.

I reviewed her on the ward round on the 7th November, she had just had an ECT treatment. Although she was complaining of a swollen tongue and some throat irritation, nothing was found on investigation. In light of some concerns as to whether she had a fungal infection in her month. Fluconazole was also introduced on the 3rd November 2005. She had three doses of this at 100 mg mane on the 5th, 6th and 8th of November. She also had Miconazole mouthwash which she was taking from the 10th October 2005. We had started her on a course of anti-fungal agents in case she had a fungal infection. Although she still had some physical complaints this was not to the extent of previous level. The ward felt that she was beginning to show signs of improvement. Code A agreed that she was less anxious about her physical complaints but didn't feel her mood was particularly improving. We therefore agreed a plan to continue with the current medication as prescribed and to continue with the ECT treatment.

I have clearly discussed Code A on the ward with the ward staff in particular with ward manager Jan Johnson. The ward staff had no reason to be more concerned about Code A mental or physical health since ward round review on the 7th November 2005.

7. Circumstances at the time of death

Sadly Code A was found dead on the morning of 9th November 2005 at approx 0730am on Fernhurst Ward in her bed. She was lying on her side curled up and looked as if she was asleep.

7. Psychiatric Summary

This lady was known to my team from the 25th February 2005. She had had a prolonged hospital admission on the first occasion from the 25th February to the 9th March in Ark Royal Ward at Gosport War Memorial and then transferred to my care on the 9th March 2005, finally being discharged home on the 26th July 2005.

During the course of that admission she required a variety of changes of anti-depressant medication and anti-psychotic medications as already documented. She had two courses of ECT treatment and was 'Sectioned' using Section 3 of the Mental Health Act. The first course of ECT beginning on the 16th March, comprising of seven treatments and ending on the 6th April 2005. The second period of ECT treatment began on the 9th May 2005 and ended on the 10th June 2005 comprising of 11 treatments. During her first admission she had 18 ECT treatments.

She was discharged from the ward with follow-up from both the Psychiatric Services from the point of view of input from a Community Psychiatric Nurse and the Laurel Day Unit. She also had an allocated care manager from social services who had allocated a care package in place during her time at home. I reviewed her on one occasion myself at home. She continued to be compliant with all of her prescribed medication throughout her discharge.

She was then readmitted on the 16th September 2005, following concerns raised by the family that she was not coping very well at home and was also beginning to express more concerns regarding her physical well-being. Her mental health deteriorated during the course of this admission despite a further change in anti-depressant medication. She also consented to a further course of ECT treatment

which began on the 24th October 2005 and she had five treatments prior to her death on the 9th November 2005, the last ECT treatment being the 7th November 2005.

Throughout this entire period a variety of changes in both her antidepressant medication and antipsychotic medication occurred as documented.

8. Physical Health Summary
There had been longstanding concerns regarding this lady's physical health. As stated previously she had significant medical problems over the years including a brain tumour and breast cancer. These conditions had both been followed up over the years by the specialists involved and were not relevant to the current problems.

During her first admission she was routinely reviewed by Mr Lees, Neurosurgeon in Southampton April 2005. He was not concerned by her presentation. Mr Lees had removed Code A original tumour in 1992 and had routinely reviewed her regularly afterwards.

The concerns regarding her bowels and constipation, buttock pain and chest pain all predated the latest admission. Some of the investigations completed during this admission were prearranged by her GP or other hospital specialists involved in her care. None of the investigations revealed any information to explain her physical concerns, which appeared to become a more predominant feature when she was depressed.

In January 2005 Code A had been seen in the rapid access chest pain clinic and a 24 hour heart monitoring was ordered. This was performed in May 2005 and results showed no significant abnormalities.

Following discussions with her GP by telephone during her second admission I had arranged for a review of her physical health which was completed on the 30th October 2005 by Dr Chakrabati, Specialist Registrar in Elderly Medicine. Following this review no concerns were highlighted regarding her physical health.

9. Medication at the time of her death
Fluconazole 100 mg mane (only given on three occasions).
Co-codamol 8/500 qds
Miconazole oral gel 10 mls qds
Duloxetine 60 mg mane
Bendrofluazide 2.5 mg mane

10. Ward observations at the time of her death
At the time of her death Code A was on Level One Observations which is the minimal level of observation for all patients. This means the nursing team on the ward have to be aware of her location on an hourly basis throughout the shift. This was in accordance with Trust protocols at the time of her death. There were no concerns raised in the weeks prior to her death regarding any suicidal ideation or intent. Therefore the formal purpose of the observation was to make sure ward staff were aware of her location and safety and well-being. We would not routinely carry out physical examination such as monitoring temperature, pulse and blood pressure as part of this level of observation on a psychiatric ward. However, as previously stated these observations were all monitored during her last ECT treatment on 7th November 2005.

Date of Report **30th March 2006**

Signature: **Code A** **Acting General Manager**

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CORONERS REPORT

This report relates to the death of Code A DOB 18/10/1930

Personal Details:

Address: **Code A**

GP: Dr Brian Ellis
Swan Street Surgery
Petersfield

1. Details of Person Preparing the Report

This report has been prepared by Dr Fiona Michelle Hogg, BM (Bachelor of Medicine), MRCPsych (Member of the Royal College of Psychiatrists). I am a Consultant in Old Age Psychiatry having worked as a Consultant for four years. I have been in this current post, employed by East Hampshire PCT since February 2004.

2. Knowledge of Patient

I have been the NHS Consultant in Charge of **Code A** care since the 25th February 2005 when she was referred to me by her GP Dr Brian Ellis of the Swan Street surgery. Since 25th February 2005 she has had two in-patient admissions and I have seen her both alone and with other members of the clinical ward team during these periods. I also reviewed her alone at home in a period of discharge between the hospital admissions and reviewed her in the Laurel Day Unit, Petersfield during her attendance there between hospital admissions.

3. Available Documents referred to whilst writing this report

I have had access to her full psychiatric notes dating back to 1992. Mrs Lacey has been known to the Psychiatric Services since December 1992 and was under the care of Dr Nick Renton, Consultant in Adult Psychiatry between that date and October 1994. She was not seen by the Psychiatric Services between October 1994 and her recent referral to me in February 2005. I have also had the opportunity to review her general hospital records during the preparation of this report.

Chronological Sequence of Events

4. First Admission

The initial referral of Mrs Lacey to myself was made on the 25th February 2005 by her GP Dr Ellis. I recall a telephone conversation with him in which he described the fact that he knew Mrs Lacey well and that she had flown back home from Spain over the preceding 24 hours. He explained that she had a history of depression in the past and had made several self-harm attempts during her last depressive episode. One of these was a significant self-harm attempt where she threw herself out of a hospital window. He felt the current relapse was precipitated by the death of her husband in

November 2004. Her family have been attempting to support her since then and she had recently gone to stay with her daughter in Spain in the hope this would help her. Unfortunately the family were describing the fact she was more anxious and agitated in Spain and they were therefore returning to England with the hope of her being admitted to hospital. Having discussed this history with Dr Ellis by phone who clearly knew the patient well, I felt admission that night was appropriate. Unfortunately there were no beds available at St James' Hospital and I therefore arranged her admission to Ark Royal Ward at Gosport War Memorial. Therefore the initial part of her admission from the 25th February 2005 to the 9th March 2005 was under the care of Dr Zia Ul-Haque at Gosport War Memorial Hospital. She was transferred back to St James' Hospital as soon as a bed was available. The other significant medical history that Dr Ellis disclosed to me was that she had had a meningioma (a brain tumour) removed in 1992, this had been the precipitant for the episode of depression resulting in the serious incident of self-harm. She had also had carcinoma of the breast in 1999. She required no treatment for either of these conditions at the time of this admission. Dr Ellis felt that Mrs Lacey had previously been worrisome about a list of physical complaints and the list of concerns had increased around the time of the death of her husband. He had referred her for further investigations for some of her concerns.

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5mg at night. Over the next few weeks she was reviewed regularly by the ward team and by myself on the weekly ward rounds. There were significant signs of improvement. By the 31st March during the review with Mrs Lacey and her family, everyone agreed she was pretty much 70% back to her usual self. She was not expressing any suicidal ideation. She was no longer expressing any psychotic beliefs. We discussed discharge plans at this time. Mrs Lacey had a total of 7 ECT treatments by the beginning of April and the ECT treatment was stopped then.

She continued to improve throughout April 2005 and as a team we had discussed a planned discharge with Mrs Lacey and her family. She had increasing periods of leave which she seemed to manage reasonably well. The family started to express concern as to how she was going to be able to manage at home as they told us that Mrs Lacey's husband had effectively been her main carer for many years. Since her treatment for her brain tumour in 1992 he had taken over most of the domestic roles and really prompted Mrs Lacey with regards to her nutritional needs and helped her with her social needs as well. Mrs Lacey was able to manage her own personal care. During the prolonged episodes of home leave during April she seemed to be managing reasonably well, it was noted there seemed to be an increase in her anxiety levels during the time she spent at home.

By the time of my review on the 28th April there was a definite deterioration in her mental state again. Mrs Lacey was becoming increasingly anxious and denying that there had been any improvement since her admission. Once again she began to become preoccupied with a list of physical complaints, in particular worrying that her bowels were not functioning properly. At this time she also became preoccupied that she had a memory problem and was developing an illness such as Alzheimer's. We had checked her Mini Mental State Examination which is a screening tool to check for memory deterioration in elderly people and this showed no signs for concern. By the 3rd May 2005 at the ward review she had deteriorated to such an extent that she was again severely depressed with psychotic symptoms. She was expressing over-valued ideas i.e. ideas held to a level that she was worried about them, but it was possible to reassure her they were not true, for example she thought she had MRSA (a serious hospital-based infection). She was also preoccupied that she had let herself and everybody down, not keeping up with her own personal care or doing her laundry on the ward. Again following discussions with her family it was felt that she was deteriorating rapidly. During this time I had instituted a change of anti-depressant from Amitriptyline which I had gradually been reducing from the middle of April because it did not seem to be maintaining her mental state and also it could have been contributing to her constipation. I had started introducing Sertraline, a different anti-depressant at a dose of 50 mg a day on the 13th April. This was gradually increased to a dose of 150 mg a day by the 3rd May. She had also required a gradual increase in her anti-psychotic medication (Olanzapine) which was increased to a dose of 15 mg a day by the 3rd May.

I reviewed the situation again with her son on the 3rd May and decided that in order to stop further deterioration, ECT again would be the treatment of choice as she'd had such a good response to that previously. She therefore restarted ECT on the 9th May 2005 to which she consented. She remained severely depressed and continued to express psychotic symptoms. She was now also beginning to express more significant concerns regarding physical complaints, in particular regarding pain in her left buttock. I understood from her GP that she had complained of this pain previously and he had arranged some investigations for it but nothing significant had been found. I changed her anti-psychotic medication from Olanzapine to an older generation anti-psychotic medication called Haloperidol on the 16th May initially at a dose of 3 mg bd but again this needed to be increased further throughout May rising

to the highest dose she had of 5 mg bd on the 25th May 2005. By the 20th May she had withdrawn her consent for ECT. This decision seemed to be based on a completely psychotic belief system that she had some inoperable problem with her bowels and nothing we could do was going to cure her and she was going to die. I therefore reviewed her on the 22nd May 2005. I noted a very significant deterioration and was concerned about her poor food and fluid intake. I felt she had to have ECT treatment in order to save her life and so I completed Section 62 in order to give her ECT as an emergency procedure the following day on the 23rd May 2005. On 23rd May 2005 a Section 3 of the Mental Health Act was completed, ECT recommended under a section 62 emergency treatment provision (a section 3 of the mental health act is an application order to detain and treat her in hospital against her will). Mrs Lacey was unable to give informed consent for ECT at that point due to her illness. I therefore arranged for a SOAD (Second Opinion Approved Doctor) who is a psychiatrist from the Mental Health Act Commission to review her with a view to approving my proposed treatment plan. The SOAD assessed her on 27th May 2005 and agreed to the treatment plan of up to 12 unilateral ECT treatments including those already given in this course from the date of 9th May 2005

Her second course of ECT therefore began on the 9th June 2005. She had eleven treatments ending on the 10th July 2005. Again once the ECT treatment had been started she began to show a gradual improvement in her depressive and psychotic symptoms. She became much less preoccupied with her physical complaints. Mrs Lacey's mental health continued to gradually improve from 9th May to 10th June of 2005. I gradually reduced her Haloperidol medication until at the point of discharge on the 26th July she was taking Haloperidol 1.5 mg nocte, Sertraline 150 mg mane, Nitrazepam 5 mg nocte and Movicol sachet and Lactulose regularly for her bowels.

5. Time spent in Community between admissions

Due to the significant improvements in her mental health she was discharged from Section 3 of the Mental Health Act on 26th July 2005. She was discharged home on the 26th July 2005 under a section 117 Mental Health Act aftercare package (this is a formalised plan for joint monitoring between health and social services following a period of admission under Section 3 of the Mental Health Act). The follow-up arrangements were for her to continue taking her medication as prescribed. Phil Shaw was allocated as her Community Psychiatric Nurse and Colin Westerby as her Care Manager from Social Services. She was initially reviewed at home by her CPN on the 29th July who documented that she was managing reasonably well although he noted her daughter had been present throughout the time she had been home. Her daughter expressed concerns as to how she would manage when the daughter returned to Spain. The CPN discussed the situation with her Care Manager and it was agreed to arrange Welcome Home Care Package (this is a care package which provides carers to come in twice a day to monitor the situation for a period of 6 weeks at which point the care package is reviewed). When the CPN reviewed Mrs Lacey on the 5th August, she appeared to be managing at home although she was starting to mention the pain in her left buttock and was concerned about other physical symptoms. She had seen her GP during that week and had been prescribed a different analgesic drug for this. Throughout August the family were beginning to raise concerns via telephone calls to the ward and to my office. I therefore reviewed Mrs Lacey in an unannounced visit on the 11th August 2005. At the time of my visit I felt she was beginning to struggle in coping with living independently. She was quite preoccupied with the pain in her left buttock and she was finding it increasing difficult to eat and had a poor appetite.

At the time I felt she wasn't significantly depressed but was clearly struggling to cope with living independently and adjusting to life in the house without her husband. This was the first time she'd lived independently at home since his death. I increased her Sertraline to 200 mg daily and encouraged her to attend the Day Hospital. I discussed the situation further with one of her daughters who felt she was coping, although there was some difference of opinion between some family members as to how well she was coping. They encouraged her to attend the Day Hospital which she did on the 31st August 2005.

6. Second Admission

She continued living at home but there were increasing concerns being raised by the family. The CPN had visited her on the 15th September and noted that she was complaining of increased sweats and the CPN was concerned that her weight had decreased by at least 4 pounds since her discharge from hospital. Mrs Lacey was concerned about her memory and beginning to question whether she had Alzheimer's disease. She was readmitted as an informal patient (not under the Mental Health Act) at the request of her GP to Fernhurst Ward on the 16th September 2005. At the time this admission, the Mini Mental State Examination was documented, this stated that she was well-groomed, and not presenting as being depressed, there was no evidence of any psychotic symptoms and the Mini Mental State Examination was 30/30.

I was on holiday at the time of this admission, when I reviewed her on the 19th September 2005 I felt she presented with some mild depressive symptoms but certainly not to the extent that I had seen previously. She didn't feel she should have come back into hospital and as far as I could tell neither did some of her children. We agreed that since she was here we would await a Magnetic Resonance Imaging (MRI) scan which is a specialist X-ray to give a more detailed internal picture, which had previously been arranged by Mr Thompson who was one of the Consultants involved in her care prior to this admission. Mrs Thompson is a lower gastro intestinal surgeon based at QAH. I recall discussing the reason for the MRI scan with her GP by telephone around this time. Apparently Mr Thompson had been reviewing Mrs Lacey for a long time regarding her concerns about her bowels and more recently about her buttock pain. The MRI scan of her lower back and buttocks had been requested by Mr Thompson months earlier following his last out-patient review to see whether there was any physical cause for that pain. I felt it was worth reviewing the MRI scan results to see whether this cast any light on whether there was a physical cause for the ongoing complaints regarding her left buttock pain or whether it was related to her depressive episodes. I also reviewed her antidepressant medication again and considered changing her anti-depressant to Venlafaxine. However in light of the current Committee of Safety of Medicines (CSM) guidelines on the use of Venlafaxine in people with a history of cardiac arrythmias I repeated her ECG which showed evidence of a minor abnormality in conduction called Right bundle branch block (which had been previously noted when reviewed earlier in the year by the Chest Pain Clinic). On balance I felt it was better not to start Venlafaxine and opted to use Trazadone which is thought to be generally safer in people with cardiac problems she started Trazadone on 26th September 2005 and discontinued it on 10th October 2005.

I reviewed her a week later on the 26th September 2005 on the ward, despite feeling that she was not significantly depressed at the time of her admission, there was a clear deterioration in her mood. She was much lower in mood and increasingly more anxious. She was also beginning to complain again about the numerous physical problems that she had been concerned about during previous admissions when she was depressed. Her daughter was very concerned that she hadn't had enough

support when she was at home. I spent some considerable time explaining to her daughter that it was a combination of trying to understand whether there were any genuine physical symptoms or whether these were a reflection of her becoming depressed again. I also felt we were seeing a true reflection of Mrs Lacey trying to cope independently without the support that had been provided by her husband over the many years prior to his death. I explained that I wasn't sure we would ever get Mrs Lacey well enough to live independently, with her mental state as stable as it had been when she was in a sheltered environment such as the ward. We agreed that the best course of action was to change her anti-depressant again and await the results of the MRI scan. I again discussed the situation with her GP, Dr Ellis on the 28th September 2005.

Having discussed all of the current presentation we agreed it was probably appropriate to ask for an opinion from the Old Age Physicians regarding her ongoing concerns regarding the left buttock pain and also the fact that she was complaining of increased sweating episodes. I felt the sweating episodes was most likely due to anxiety however I repeated biochemistry and haematological investigations to make sure there was no evidence of any infection. All investigations were normal. By the beginning of October she had continued to deteriorate in her mental state. I reviewed the situation again with her son Steven. The MRI scan had shown no significant features to explain the ongoing buttock pain. In particular there was no evidence of any carcinoma which was one of Mrs Lacey's worries although she was not reassured by this. The elderly medicine team medical specialist registrar reviewed Mrs Lacey on the 3rd October 2005 and could not find any significant medical features of note. However further investigations were suggested including a serum calcium, Bence Jones protein (which is a urine test) and blood test to look at her protein electrophoresis, both of which would be looking for a specific sort of back pain caused by a malignant condition such as myeloma. However, all these tests were reported as normal.

On the 17th October 2005 she was noted to have evidence of peripheral oedema and a raised Jugular Venous Pressure (JVP) both of which were a new finding in her. This indicated that she had excess fluid in her body and may have been a sign of early heart failure. This is not an uncommon finding in people of this age. She was commenced on a small dose of Bendrofluazide which is a diuretic (water tablet designed to increase urine output) on the 18th October 2005 to which she responded well. There had been no concerns raised regarding her physical health following her ECT treatments and her physical observations including pulse and blood pressure which are recorded as part of her ECT treatment were all normal on the day of her last ECT on 7th November 2005.

In the middle of October 2005 her mental health continued to slowly deteriorate however I felt she wasn't as ill as she had been earlier in the year when I had to use the Mental Health Act section 3. I decided to change her medication to a newer anti-depressant called Duloxetine starting at an initial dose of 30 mg which was prescribed on the 10th October 2005, increasing to 60 mg per day (normal maintenance dose) on the 19th October 2005. My rationale for prescribing this was that it was reported to be good at controlling somatic symptoms of depression (concerns regarding physical symptoms) this had always been one of the major problems with Mrs Lacey when she became depressed. It was also less likely to cause problems of constipation. It also appeared from the literature available to have a safer profile for use in people with a variety of mild to more severe cardiac problems. Her family were all keen that she should have ECT treatment at this time and although Mrs Lacey wasn't initially keen to do so, after discussing it further with all of her children she decided she would have further ECT treatment as she had

responded so well to it in the past. She started a course of ECT on the 24th October 2005 and by the time of her death she had received 5 treatments with the last ECT being on the 7th November 2005.

I reviewed her on the ward round on the 7th November, she had just had an ECT treatment. Although she was complaining of a swollen tongue and some throat irritation, nothing was found on investigation. In light of some concerns as to whether she had a fungal infection in her month. Fluconazole was also introduced on the 3rd November 2005. She had three doses of this at 100 mg mane on the 5th, 6th and 8th of November. She also had Miconazole mouthwash which she was taking from the 10th October 2005. We had started her on a course of anti-fungal agents in case she had a fungal infection. Although she still had some physical complaints this was not to the extent of previous level. The ward felt that she was beginning to show signs of improvement. Mrs Lacey agreed that she was less anxious about her physical complaints but didn't feel her mood was particularly improving. We therefore agreed a plan to continue with the current medication as prescribed and to continue with the ECT treatment.

I have clearly discussed Mrs Lacey on the ward with the ward staff in particular with ward manager Jan Johnson. The ward staff had no reason to be more concerned about Mrs Lacey's mental or physical health since ward round review on the 7th November 2005.

7. Circumstances at the time of death

Sadly Mrs Lacey was found dead on the morning of 9th November 2005 at approx 0730am on Fernhurst Ward in her bed. She was lying on her side curled up and looked as if she was asleep.

7. Psychiatric Summary

This lady was known to my team from the 25th February 2005. She had had a prolonged hospital admission on the first occasion from the 25th February to the 9th March in Ark Royal Ward at Gosport War Memorial and then transferred to my care on the 9th March 2005, finally being discharged home on the 26th July 2005.

During the course of that admission she required a variety of changes of anti-depressant medication and anti-psychotic medications as already documented. She had two courses of ECT treatment and was 'Sectioned' using Section 3 of the Mental Health Act. The first course of ECT beginning on the 16th March, comprising of seven treatments and ending on the 6th April 2005. The second period of ECT treatment began on the 9th May 2005 and ended on the 10th June 2005 comprising of 11 treatments. During her first admission she had 18 ECT treatments.

She was discharged from the ward with follow-up from both the Psychiatric Services from the point of view of input from a Community Psychiatric Nurse and the Laurel Day Unit. She also had an allocated care manager from social services who had allocated a care package in place during her time at home. I reviewed her on one occasion myself at home. She continued to be compliant with all of her prescribed medication throughout her discharge.

She was then readmitted on the 16th September 2005, following concerns raised by the family that she was not coping very well at home and was also beginning to express more concerns regarding her physical well-being. Her mental health deteriorated during the course of this admission despite a further change in anti-depressant medication. She also consented to a further course of ECT treatment

which began on the 24th October 2005 and she had five treatments prior to her death on the 9th November 2005, the last ECT treatment being the 7th November 2005.

Throughout this entire period a variety of changes in both her antidepressant medication and antipsychotic medication occurred as documented.

8. Physical Health Summary
There had been longstanding concerns regarding this lady's physical health. As stated previously she had significant medical problems over the years including a brain tumour and breast cancer. These conditions had both been followed up over the years by the specialists involved and were not relevant to the current problems.

During her first admission she was routinely reviewed by Mr Lees, Neurosurgeon in Southampton April 2005. He was not concerned by her presentation. Mr Lees had removed Mrs Lacey's original tumour in 1992 and had routinely reviewed her regularly afterwards.

The concerns regarding her bowels and constipation, buttock pain and chest pain all predated the latest admission. Some of the investigations completed during this admission were prearranged by her GP or other hospital specialists involved in her care. None of the investigations revealed any information to explain her physical concerns, which appeared to become a more predominant feature when she was depressed.

In January 2005 Mrs Lacey had been seen in the rapid access chest pain clinic and a 24 hour heart monitoring was ordered. This was performed in May 2005 and results showed no significant abnormalities.

Following discussions with her GP by telephone during her second admission I had arranged for a review of her physical health which was completed on the 30th October 2005 by Dr Chakrabati, Specialist Registrar in Elderly Medicine. Following this review no concerns were highlighted regarding her physical health.

9. Medication at the time of her death
Fluconazole 100 mg mane (only given on three occasions).
Co-codamol 8/500 qds
Miconazole oral gel 10 mls qds
Duloxetine 60 mg mane
Bendrofluazide 2.5 mg mane

10. Ward observations at the time of her death
At the time of her death Mrs Lacey was on Level One Observations which is the minimal level of observation for all patients. This means the nursing team on the ward have to be aware of her location on an hourly basis throughout the shift. This was in accordance with Trust protocols at the time of her death. There were no concerns raised in the weeks prior to her death regarding any suicidal ideation or intent. Therefore the formal purpose of the observation was to make sure ward staff were aware of her location and safety and well-being. We would not routinely carry out physical examination such as monitoring temperature, pulse and blood pressure as part of this level of observation on a psychiatric ward. However, as previously stated these observations were all monitored during her last ECT treatment on 7th November 2005.

Date of Report **30th March 2006**

Signature: **Code A** ... **Acting General Manager**

Code A. → HP NHS Trust.

Mob. Code A.

ML Coroner's Report.

→ When signed copy received from Karen Guy send to Code A explaining Code A on maternity leave + therefore cannot sign it.
K.G signed on her behalf.

Service transferred 1/4/06 → HP
+ give Code A
contact phone no.

EMD. 30/3/06