21/2/06
Comments discussed
c Karen Guy.
EMW.
21/2/06.

CORONERS REPORT

This report relates to the death of Margaret Lacey, DOB Code A

Personal Details:

Margaret Lacey

Address: Code A

→ Concerns raised about number of ECT treatments (stated as quite high for a person of this age). Karen will discuss c Martin Brown. Needs qualification in Report.

GP: Dr Brian Ellis
Swan Street Surgery
Petersfield

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 Hants PCT since February 2004

Hampshire

Code B

Knowledge of Patient

I have been the NHS Consultant in Charge of Mrs Lacey's care since the 25th February 2005 when she was referred to me by her GP Dr Brian Ellis of the Swan Street surgery. ~~During this time~~ Since 25 Feb 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 I ~~also~~ reviewed her in the Laurel Day Unit which is our day hospital during her attendance there between hospital admissions.

ab Pbfld Hosp.

~~user~~ referred to whilst writing

Available Documents ~~to write~~ the report

Mrs Lacey

I have had access to her full psychiatric notes dating back to 1992. ~~She~~ 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

First Admission

The initial referral of Margaret 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 ~~this~~ that lady, whom he knew well, had flown 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. The current relapse seemed to have been 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 presentation. 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. She had always 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 symptomatology 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 technically 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 (Electro-Convulsive Therapy) 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 therefore started ECT, which she consented to, on the 16th March 2005.

My first contact with Margaret Lacey was therefore on the 31st March 2005 on my return from holiday. She continued to present as being severely depressed with psychotic symptoms. The ECT was having some effect but she was showing short fit lengths which were not ideal and I therefore suggested increasing the dose of that treatment. I also increased her anti-psychotic medication, Olanzapine, further to a dose of 2.5 mg in the morning and 5 mg 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 Margaret 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 therefore discussed aiming towards discharging her home around that point. She ~~therefore~~ had a total of 6 ECT treatments by the end of March and the ECT treatment was stopped then.

She continued to improve throughout April and as a team we had discussed a planned discharge with Margaret 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 Margaret'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 Margaret with regards to her nutritional needs and helped her with her social needs as well. Margaret was able to manage her own personal care. During the prolonged episodes of leave during April she seemed to be managing reasonably well but ~~there was noted to be~~ an increase in her anxiety levels the more 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. She was becoming increasingly anxious and denying that there had been any improvement since her admission. She began to become preoccupied with a list of physical complaints again, in particular worrying that her bowels were not functioning properly. She ~~also~~ again 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 screen to check for memory deterioration in elderly people and this showed no signs for concern. Unfortunately by the 3rd May 2005 on my 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 you could reassure her they were not true, that she had developed 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 ~~due to the fact~~ 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 on the 13th April. This was gradually increased to a dose of 150 mg by the 3rd May. She had also required a gradual increase in her anti-psychotic medication (Olanzapine) which ~~went up~~ to a dose of 15 mg ~~in total~~ 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 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 and completed Section 62 in order to give her ECT as an emergency procedure the following day on the 23rd May 2005. On the same day I completed my papers to apply for a Section 3 of the Mental Health Act which is an application order to detain and treat her in hospital against her will. The Section 3 was completed on the 23rd May 2005. Margaret 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.

Her second course of ECT therefore began on the 9th June 2005. She had eleven treatments ~~in total on this occasion~~, 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 ~~again~~. Having finished her ECT there was a further investigation which had been outstanding since prior to her hospital admission under my care and I believe that she had a 24 hour heart monitor attached while on the ward. On reviewing her general hospital notes during the preparation of this report it appears this had been arranged much earlier in the year. She had been referred by her GP to the fast access chest pain clinic in January 2005. Following review ~~there they had~~ arranged a 24 hour heart monitoring assessment to be completed and it was this monitoring that happened during this admission. (Although I didn't receive a direct copy of that report to her GP, on reviewing her general medical notes during the preparation of this report, I note a letter from 21st June 2005, saying there were no specific concerns).

Margaret's mental health continued to gradually improve throughout June and July 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.

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 ~~therefore~~ discharged home on the 26th July 2005 under a 117 aftercare package (~~which~~ is a formalized 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 at 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 was expressing concerns as to how she would manage when she returned to Spain and he discussed the situation with her Care Manager and the Welcome Home Care Package was arranged (~~which~~ is a care package which has carers coming in twice a day to monitor the situation for a limited period of 6 weeks ~~then~~ the situation is reviewed). ~~By the time~~ the CPN reviewed Margaret again on the 5th August, ~~again~~ she ~~seemed~~ to be managing ~~OK~~ although she was starting to talk again of 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 analgesia. Throughout August the family were ~~then~~ beginning to raise concerns via telephone calls to the ward and to my office. I ~~therefore~~ reviewed

Margaret 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 again. 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 overall she was doing OK, although there was some disagreement between the 3 children as to how well the situation was going. They encouraged her to attend the Day Hospital which she did on the 31st August 2005.

Second Admission

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

I was on holiday at the time of her admission; by the time 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 her 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 MRI scan which had previously been arranged by Mr Thompson who was one of the consultants involved in her care prior to this admission. I recall discussing the reason for the MRI scan with her GP by telephone around this time. Apparently Mr Thompson had been reviewing Margaret 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 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 therefore 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 Margaret trying to cope independently without the support that had been offered by her husband over the many years prior to his death. I explained that I wasn't sure we would ever get her well enough to live independently with her mental state as stable as it was when she was in a sheltered environment such as the ward. We therefore 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, but did repeat biochemistry and haematological investigations to make sure there was no evidence of any infection and all investigations were again normal. By the beginning of October she had continued to deteriorate in her mental state. I reviewed the situation again with her son Steven who felt that hospital admission on this occasion wasn't likely to achieve anything. 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 Margaret's worries although she was not reassured by this. The medical specialist registrar reviewed this lady on the 3rd October 2005 and could not find any significant medical features of note. However they suggested further investigations, 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 these were all reported as normal.

By the middle of October her mental health was still slowly deteriorating although I felt she wasn't as ill as she had been earlier in the year when I had to use the Mental Health Act. I decided to change her to a newer anti-depressant called Duloxetine starting at an initial dose of 30 mg prescribed on the 10th October 2005, increasing to 60 mg, the normal maintenance dose, on the 19th October 2005. My rationale for prescribing this was that it was supposed to be very good at controlling somatic symptoms of depression (by somatic symptoms I mean concerns regarding physical symptoms) this had always been one of the major problems with Margaret when she became depressed. It was also less likely to cause problems with regards to 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 at this time and although Margaret 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. She had had five ECT treatments by the time of her death, 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 then. Although she was complaining of a swollen tongue and some throat irritation there had been nothing found on investigation. We had started her on a course of anti-fungal agents in case she had a fungal infection. However generally she still had some physical complaints but not to the extent she had been concerned about a few weeks earlier. The staff on the ward felt that there was beginning to

show signs of improvement again. Margaret 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 with the ECT treatment.

She was found dead on the morning of 9th November 2005.

I have clearly discussed her presentation on the ward with the ward staff in particular with ward manager Jan Johnson. The staff on the ward had no reason to be concerned about Margaret's mental or physical health in the time since the ward round review on the 7th November 2005 and her being found dead on the morning of the 9th November 2005 at approximately 7.30 am.

Summary
Psychiatric
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. Therefore in total during her first admission she had 18 ECT treatments. This is probably a higher than average amount of treatment for a lady of this age.

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 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.

Physical Health
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 had both been followed up for years by the specialists involved and neither seemed relevant to the current problems. In fact she was reviewed by the Neurosurgeon in Southampton during this admission.

The concerns regarding her bowels and constipation, buttock pain and chest pain all predated this 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 showed any result to explain her physical concerns, which did seem to become a more predominant feature when she was depressed.

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, ~~one of the~~ Specialist Registrars in Elderly Medicine. ~~Again~~ following this review there were no concerns highlighted regarding her physical health.

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 be 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 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

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

Observations at the time of her death

At the time of her death she 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 observed according to the Trust protocols at the time of her death. There was no concern raised in the weeks prior to her death regarding any suicidal ideation or intent. Therefore the purpose of the observation was to make sure we were aware of her location and that she was not in any danger of harming herself or others. 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 they were all monitored during her last ECT treatment on 7th November 2005.

Date of Report: .....

Signature: .....

CONFIDENTIAL

Dictated: 25/01/06
Typed: 30/01/06

Our Ref: SH/HLW/J058427

Elderly Mental Health Department
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Elaine Williams
Complaints and Litigation Manager
East Hampshire PCT
Raebarn House, 3rd Floor
Hulbert Road
Waterlooville
PO7 7GP

Dear Elaine,

I am really sorry for the delay in getting this report out to you.

I didn't actually manage to get the notes until a week or so before Christmas, as a set was missing between here and the QAH. By that time I was in the final stages of trying to tidy up my work before my maternity leave started in January and it was all a bit hectic. I felt it was more appropriate that I did the report rather than delegating it to somebody else who clearly had no knowledge of the sequence of events prior to this lady's death.

Once again apologies for the delay.

Yours sincerely,

Dr Shelly Hogg
Consultant in Old Age Psychiatry

Elaine Williams - Complaints and Litigation Manager

From: Code A - Clerical Officer
Sent: 21 February 2006 10:14
To: Elaine Williams - Complaints and Litigation Manager
Cc: Karen Guy - Locality Manager
Subject: FW: Coroners Report

Elaine

Karen has a hard copy of this report and will go through it with you to make any amendments

Thanks

Code A
Secretary to Alistair Macnaughton/Karen Guy
Code A

-----Original Message-----
From: Code A - Medical Secretary
Sent: 21 February 2006 10:09
To: Code A - Clerical Officer
Subject: Coroners Report

Hi Code A

Please find attached report for the Coroner as requested.

I will check with Dr Martin Brown to see if he still wants to add a note about why he was signing on Shelly's behalf. He doesn't want to be called to give in evidence in Court as it wasn't his patient.

Kind regards,

Code A

300106.doc

Coronors
t M Lacey 250