LESLIE PITTOCK

PITTOCK NO ADDITIONAL

HAMPSHIRE CONSTABULARY

SUMMARY OF EVIDENCE

CASE OF LESLIE PITTOCK

Background/Family Observations

Leslie Charles PITTOCK was born in Hemel Hempstead on Code A. He was a sub-mariner in the Royal Navy and met his wife in Canada. They had three children and settled in England in 1947.

Mr PITTOCK suffered depression for a great deal of his life end even attempted suicide on a number of occasions. He was admitted to Knowle Hospital a number times throughout the 60's, 70's and 80's. He returned from the Navy after 22 years service and worked as a Nautical Instructor on the River Hamble. He loved sailing but when the Nautical Training School closed he lost his purpose in life and withdrew into himself. His wife died in 2001.

In about 1993/1994 Mr PITTOCK was admitted again to Knowle Hospital with depression. This time when he was discharged, due to the strain of caring for him at home he was discharged to Hazledene Rest Home where he lived until he died at the Gosport War Memorial Hospital on 24th January 1996.

Whilst at the Rest Home Mr PITTOCK became progressively worse, not socialising, refusing to eat or drink. He was then admitted to Mulberry Ward, a psychiatric ward at Gosport War Memorial Hospital. Again here he continued to deteriorate and didn't respond to treatment. Mr PITTOCK contracted a chest infection and was moved to Dryad Ward for terminal care. He was refusing to eat or drink. He became extremely frail and lost the will to live.

Mr PITTOCK was turned regularly by the nursing staff to prevent bed sores as his skin was breaking down. This caused him pain. He was therefore given morphine via a syringe driver to relieve this pain when turned. The family consider this treatment to be totally appropriate.

Mr PITTOCK died on 24th January 1996; his death was certified by Dr BARTON, the cause of death given as bronchopneumonia.

Police Investigation

Following the publicity in respect of the Police investigation of the case of Gladys RICHARDS who died at the Gosport War Memorial hospital in, a number of relatives of other patients who died at the same hospital reported to the Police that they had concerns in respect of the medical treatment of their relatives and requested Police investigations. Amongst these relatives were those of Mr PITTOCK.

The medical records of Mr PITTOCK were obtained by the Police, copied and submitted to the key clinical team for review. The key clinical team considered that Mr PITTOCK'S treatment at the Gosport War Memorial hospital was negligent and the cause of death was unclear.

As a result of the key clinical team's findings the medical records of Mr PITTOCK have been examined by Police in order to identify all persons who were concerned in her medical and nursing treatment. All medical and nursing staff identified have made statements explaining those entries, in the medical records of Mr PITTOCK, made by them or to which they made some contribution.

Case papers and the medical records of Mr PITTOCK have been analysed by a further set of independent experts, Dr's WILCOCK and BLACK.

Medical history of Leslie PITTOCK.

(References to page numbers are in respect of the file of medical records reviewed by the key clinical team and the set of independent experts.)

Mr Leslie Pittock had a very long history of depression as clearly set out in a summary (13). In 1959 he had reactive depression, it occurred again in 1967. In

1979 he had agitation and in 1988 agitated depression.

He had a further long admission with agitated depression in 1992 (8) complicated by an episode of cellulitis (30). This culminated in an admission to long-term residential care in January 1993 (34). He had further admissions to hospital under the care of the psychiatric team including June 1993 (37) when some impaired cognition was noted. In 1995 there was a home visit for further psychiatric problems (42).

In 1995 (44) there was a change in behaviour; loss of weight and increased frailty was noted. He was falling at the residential home. He was expressing grief, frustrations and aggression. At this time his psychiatric medications included Diazepam, Temazepam, Thioridazine, Sertraline, Lithium, and Codanthrusate for constipation. His other problems were hypothyroidism and Parkinsonism with a tremor. (Note: this was not Parkinson's disease but tremor, rigidity and akinesia which occurs similar to Parkinson's disease but as a result of long-term anti-psychotic medication).

On 29th November 1995 he was admitted under the psychiatrist Dr Banks (46) to Gosport War Memorial Elderly Mental Health beds. His mental test score was documented at 8/10 (50). He was discharged back to residential home on 24th October (46) with a continued diagnosis of depression (56). However, his very poor mobility and shuffling gate was noted (57).

On 13th December 1995 he was re-admitted (62) to mental health beds at the Gosport War Memorial under Dr Banks stating "everything is horrible". He was verbally aggressive to the staff and was not mobilising and staying in bed all day. He felt hopeless and suicidal. (62).

On 22nd December, Code A he also had chest symptoms. It was thought he had a chest infection, and was treated with Erythromycin (64). On 27th December he was "chesty, not himself", and his bowels were causing concern. The physiotherapist noted that he had signs in his chest (65). A second course of a different antibiotic (Cephalosporin) was prescribed (81). Code A

Code A

Code A It is also noted that by 1st January (147) he was drowsy with very poor fluid intake.

On 2nd January 1996 Dr Lord, consultant geriatrician was asked to see (66) and on 3rd January he was noted to be clinically deteriorating with poor food intake (66), albumin of 27 (67). An abdominal x-ray on 27th December describes possible "pseudo-obstruction" (116). This is a condition when the large bowel fails to work and starts to dilate, usually in patients who have multiple illnesses including Parkinsonism, electrolyte imbalance, infections, antibiotics and other drugs. Prognosis is often poor and depends on resolving the underlying causes.

On 4th January 1996 Mr Pittock is seen by Dr Lord, Consultant Geriatrician who noted severe depression, total dependency, catheterisation, lateral hip pressure sores

and hypoproteinaemia. (67) He states that the patient should be moved to a long-stay bed at the Gosport War Memorial Hospital and that his residential home place should be given up as he was unlikely to return. On 5th January he is transferred to Dryad Ward for "long-term care" (151). Dr Lord also states (5M) "Mrs Pittock is aware of the poor prognosis".

Gosport War Memorial Hospital

On 5th January a basic summary of the transfer is recorded, on the 9th January increasing anxiety and agitation is noted and the possibility of needing opiods is raised. The nurses cardex on 9th said that he is sweaty and has "generalised pain" (25M). On 10th January a medical decision is recorded "for TLC". In the medical discussion (13M) with the wife also apparently agrees "for TLC". I am not sure of the signature of 10th January in the medical notes (13M). The nursing cardex records they commenced Oramorph and that Mrs Pittock is aware of the poor outcome (25M).

The 15th January the nursing notes document that a syringe driver has been commenced (25M) and by the evening the patient is unresponsive (26M). However on 16th January there is some agitation when being attended to and Haloperidol is added to the syringe driver (26M). On the 17th the patient remains tense and agitated, (27M) the nursing cardex states that Dr Barton attended, reviewed and altered the dosage of medication. The syringe driver is removed at 15.30 hours and the notes say "two drivers" (27M).

The next medical note is on 18th January, eight days after previous note on 10th January. This states further deterioration, subcut analgesia continues..... try Nozinan.

On 20th January the nursing notes state that Dr Briggs was contacted regarding the drug regime and there was a verbal order to double the Nozinan and omit the Haloperidol (28M). This is confirmed in the medical notes on 20th January (15M).

On 21st January the nursing notes state "much more settled", respiratory rate of 6 per minute, not distressed.

On 24th January the date of death is verified by Staff Nurse Martin in the medical notes at 0145hrs. (15M).

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Mr PITTOCK was a Clinical Assistant, Dr Jane BARTON. As such her role in caring for patients is

governed by Standards of Practice and Care as outlined by the General Medical Council. This advice is sent to all doctors on a yearly basis and includes the following statements

- good clinical care must include an adequate assessment of the patients condition, based on the history and clinical signs and, if necessary, an appropriate examination
- in providing care you must keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs or appliances that serve the patient's needs.

In reviewing the medical records of Mr PITTOCK it is apparent that Dr BARTON has not made entries in the medical records when she has visited her patient. There is lack of explanation as to the treatment being offered to Mr PITTOCK and the reasoning behind the various prescriptions of drugs. Ranges of drugs are prescribed which appear to fall outside recognised parameters.

Expert analysis

Dr Andrew WILCOCK

Dr WILCOCK is an expert in Palliative Medicine and Medical Oncology. He has produced two reports in respect of the cases of Mr PITTOCK. His first report comments on the standard of care afforded to Mr PITTOCK and his second report comments on the first statement of Dr Jane BARTON (referred to later).

Dr WILCOCK in his review of Dr BARTON's care of Mr PITTOCK reported specifically:-

i) The notes relating to Mr Pittock's transfer to Dryad Ward are inadequate. On transfer from one service to another, a patient is usually reclerked highlighting in particular the relevant history, examination findings and any planned investigations to be carried out.

ii) Pain is the most likely reason for prescribing the non-steroidal anti-inflammatory drug (Arthrotec). However, pain was not documented in the notes, nor was any pain assessed.

iii) Mr Pittock's painful right hand held in flexion does not appear to have been appropriately assessed. From its description it may have been tetany causing carpopedal spasm and the common causes of this should have been considered, e.g. a low serum calcium or magnesium deficiency. Less likely is a dystonia but given that some of his medications could cause extrapyramidal effects (see technical background) this possibility should also have been considered. As hypocalcaemia is reported to cause mood disturbance such as anxiety and agitation, it would have been particularly relevant to consider.

iv) It should be clarified why Dr Barton felt Mr Pittock needed opioids. From the medical notes, it appears to relate to his increasing anxiety and agitation. This is not an appropriate indication for the use of opioids. If opioids were being suggested for his painful hand, this would also be inappropriate. The medical notes state no other pain. The nursing notes do state he had generalised pain, but the lack of a full pain assessment makes it difficult to

know what pain this represented; for example, was it related to muscle and/or joint stiffness from immobility, his pressure sores or abdomen?

v) It is not clear from the medical notes the indication for which the morphine was commenced. If it was for pain then this should have been documented and assessed. It was a reasonable starting dose for someone of his age and morphine is used in palliative care for generalised pain related to muscle or joint stiffness due to immobility or painful pressure sores.

vi) It is not clear what the indications were for prescribing the syringe driver on the 10th January 1996 and for the medications it contained. It is not usually necessary to utilise the SC route unless a patient is unwilling or unable or to take medications orally (e.g. difficulty swallowing, nausea and vomiting). From the drug chart Mr Pittock did not appear to have these problems (page 18 of 49). No instructions were given on the drug chart on when the syringe driver should be commenced, how this would be decided and by whom. The dose of diamorphine was initially written as a dose range of 40–80mg, only to be subsequently rewritten the next day as 80–120mg without explanation of why a higher dose range was necessary. Based on Mr Pittock's existing opioid dose, all of the doses of diamorphine are likely to be excessive for his needs. Given his total dose of oramorph (morphine solution) of 30mg in 24hours, an appropriate dose of diamorphine using a 1:2 or the more usual 1:3 dose conversion ratio, would have been 10–15mg in 24hours. There is no justification given for this in the medical notes. Similarly, the

indications for including the hyoscine hydrobromide and midazolam should have been documented. The dose range of midazolam of 40–80mg would generally be seen as excessive for someone of Mr Pittock's age. However, taking into account he was a long term user of benzodiazepines, a higher than usual starting dose would likely be necessary.

vii) The dose of diazepam was increased on the 11th January 1996 with no mention of this in the medical notes.

viii) The sertraline and lithium carbonate were discontinued on the 12th January 1996 with no mention of this in the medical notes. It was unclear if this was on the advice of the psycho geriatricians or not; my understanding is that sertraline should not be discontinued abruptly as this is associated with a withdrawal syndrome that can include anxiety, agitation and delirium. A gradual withdrawal of lithium is also advised (BNF).

ix) A syringe driver was ultimately commenced on the 15th January 1996. It is not documented why it had become necessary to give these medications via a syringe driver. Mr Pittock appeared to have been taking his oral medications and the medical entry noted that he 'will eat and drink'. There was no mention in the medical or nursing notes of pain, retained secretions, agitation or anxiety that day. If he was more drowsy and unable to take his medication it would have been reasonable, particularly if he required morphine for pain relief. However, taking into account Mr Pittock's dose of morphine, the starting dose of diamorphine (80mg) was likely to be excessive for his needs as detailed above. The reasons for including the

hyoscine hydrobromide (400microgram) and midazolam (60mg) over 24hours was not documented. The dose of midazolam of 60mg over 24hours is an above average starting dose for somebody of Mr Pittock's age (see technical issues). He had however, been on long term benzodiazepines and in these patients a larger than usual starting dose may be necessary.

x) On the 16th January 1996 the nursing notes reported some agitation when Mr Pittock was being attended to. Haloperidol 5mg SC over 24hours was added to the syringe driver. Haloperidol is a reasonable part of the approach to treating delirium or terminal agitation in someone of Mr Pittock's age. It should be given with caution, given Mr Pittock's parkinsonism, as it can cause extrapyramidal effects (see technical issues). However, it is not clear from the notes that his agitation had been assessed and hence the possible underlying causes of the agitation considered. Drugs (or their withdrawal) are one of the common causes of agitation or terminal restlessness. Of particular relevance to Mr Pittock, these would include the use of opioids, particularly in inappropriate and excessive doses, hyoscine hydrobromide and benzodiazepines (Wessex Protocol, pages 30, 34). It is possible that a reduction in the dose of diamorphine may have helped Mr Pittock's agitation.

xi) On the 17th January 1996 the dose of diamorphine was increased to 120mg and the midazolam to 80mg SC over 24hours with no reason given in the notes. The nursing notes suggest that Mr Pittock remained tense and agitated.

There is no documentation that a medical assessment was undertaken to determine whether his being 'tense' related to muscle and joint stiffness, possible extrapyramidal effects from the haloperidol or that other causes of agitation had been considered. Again, rather than increase the diamorphine, a reduction may have been more appropriate. Similarly, the discontinuation or reduction in the dose of haloperidol, or substitution for an antipsychotic with a lower risk of causing extrapyramidal effects, e.g. levomepromazine, may have been appropriate.

The nursing notes suggest that Mr Pittock was 'bubbly' due to retained secretions and this appears to be the reason for the hyoscine hydrobromide dose being increased twice in one day from 400 to 600 microgram then to 1200microgram SC over 24hours.

xii) The medical notes entry on the 18th January 1996 suggested that Mr Pittock's symptoms were difficult to control but did not document which symptoms. Levomepromazine 50mg SC over 24hours was commenced. This is an appropriate drug to use for terminal agitation when haloperidol is insufficient. The dose is in keeping with that recommended by the BNF and the Wessex Protocol. However, it would have been usual to substitute it for the haloperidol rather than use it concurrently.

Dr David BLACK

Dr BLACK is an expert in Geriatric medicine. His reporting comments on the standard of care afforded to Mr Pittock and his expert opinion reports specifically:-

> Mr Leslie Pittock was an extremely ill, frail and dependent gentleman on his admission to Gosport War Memorial Hospital and was at the end point of a chronic disease process of depression and drug related side effects that had gone back for very many years.
>
> The major problem in assessing Mr Pittock's care is the lack of documentation. Good Medical practice (GMC 2001) states that good clinical care must include an adequate assessment of the patient's condition, based on history and symptoms and if necessary an appropriate examination".... "In providing care you must keep clear accurate legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any other drugs or other treatments prescribed". The major gaps in the written notes, the lack of evidence of appropriate examinations, use of unusual drug regimes without adequate documentation in the medical notes, changes in

prescription without proper documentation, all represent poor clinical practice clinical practice to the standards set by the General Medical Council. However, by itself, these do not prove that the medical or nursing care provided to Mr Pittock was sub-optimal, negligent or criminally culpable.

In my view the drug management as Gosport was sub-optimal. There was no written justification at any stage for the high doses of Diamorphine and Midazolam written up in the drug charts and subsequently prescribed to Mr Pittock. The notes and the drug charts leave confusion as to whether at one stage there may have been three syringe drivers being used. The dose of Nozinan may have been prescribed by verbal prescription and not written up in the drug chart. Combinations of the higher than standard doses of Diamorphine and Midazolam, together with the Nozinan were very likely to have caused excessive sedation and may have shortened his life by a short period of time, that in my view would have been no more than hours to days. However, this was a dying man, the family appeared to have been appropriately involved and the patient did eventually die without distress on 24th January. While his care is sub-optimal I cannot prove it beyond reasonable doubt to be negligent or criminally culpable.

Interview of Dr Jane BARTON

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified a registered medical practitioner in 1972. In addition to her GP duties she took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 3rd March 2005 Dr BARTON, in company with her solicitor, Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Lesile PITTOCK at the Gosport War Memorial hospital. The interviewing officers were DC Code A and DC Code A

The interview commenced at 0915 and lasted for 25 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/3. This statement dealt with the specific issues surrounding the care and treatment of Elsie DEVINE.

Expert response to statement of Dr BARTON

The statement of Dr Barton regarding her care and treatment of Mr Pittock was provided to Dr David BLACK on completion of his initial report on the case. He is currently reviewing the statements of Dr BARTON against his report. Although not fully completed and therefore subject to change his first draft highlights the following points.

i) Mr Pittock was admitted to Mulberry ward on 14th September 1995 and not 29th November 1995 as stated in his report (para 5.4). Dr Black also assumed incorrectly that Dr Lord was a male referring to him as 'him' (para 6.9).

ii) Paragraph 13 does imply that an external examination of Mr Pittock's pressure area's may have been undertaken. However as in Dr Black's report (para 6.10) no general physical examination is otherwise recorded to have taken place.

The statement of Dr Barton regarding her care and treatment of Mr Lesile Pittock was also provided to Dr Andrew Wilcock on completion of his initial report on the case. Although not completed and therefore subject to change his draft highlights the following points.

Dr Barton admits to poor note keeping and proactive prescribing due to time pressures in 1996. Even with significant episodes in Mr Pittock's care however, no entry was made. Having read Dr Barton's statement regarding Mr Pittock, I believe that the main issues raised in my report (BJC 71), dated 24th April 2005, remain valid and have not yet been satisfactorily addressed due to a lack of clarity regarding:

- the nature of Mr Pittock's pain and its possible cause(s)
- the justification for the proactive prescribing of a syringe driver containing diamorphine, hyoscine and midazolam 'just in case he needed it'
- the lack of use of 'as required' doses of the above drugs instead of, or subsequently, alongside the syringe driver
- the basis for Dr Barton's use of diamorphine specifically for the relief of agitation
- the lack of assessment of the possible cause(s) of Mr Pittock's agitation
- how the dose of diamorphine Mr Pittock ultimately received (80mg) was calculated in a way that can be clearly related to his existing dose of opioid
- given the difficulty of controlling the symptoms, whether Dr Barton sought advice.

As some of the above points relate directly to Dr Barton's knowledge of the management of pain and other symptoms in a palliative care setting it would

be helpful if she could state what specific training she had received in relation to this. In particular, where she obtained her understanding from with regards to the indications for the use of morphine/diamorphine, the phenomenon of tolerance to opioids, the methods of determining an appropriate dose of diamorphine given a patients oral morphine dose and what prescribing guidelines she was aware of and/or followed.

Operation ROCHESTER.

Leslie PITTOCK.

KEYPOINTS May 2005.

Leslie Charles PITTOCK Born Hemel Hempstead 11.12.1913.

Suffered depression/ attempted suicide between 60's and 90's.

During the 2 months prior to death suffered, depression, suicidal, poor mobility shuffling gait, diarrhoea, chest infection, poor fluid/food intake, hypoproteinaemia. He may have been developing cerebrovascular disease and Parkinsons.

1993-1996 Knowle hospital for depression, discharged to Hazledene rest home, then to Gosport War memorial Hospital where he died 24.01 1996. Cause of death Bronchopnemonia.

Medical records examined by Key Clinical team who assessed the care delivered prior to death as negligent and cause of death unclear.

4th January 1996 (20 days before death) Consultant Geriatrician Dr Althea LORD notes severe depression, total dependency, catheterisation, lateral hip pressure sores, and hypoproteinaemia, recommending move to long stay bed at Gosport War Memorial Hospital.(BLACK comments reflects that PITTOCK probably terminally ill).

5th January 1996 transferred for long term care TO Gosport War Memorial Hospital.

9th January Dr BARTON suggests Opiates may be appropriate response to physical and mental condition.

10th January medical notes Dr TANDY record that 'TLC' is to be administered and Oramorph prescribed.

15th January syringe driver Diamorphine commenced.

16th January Haloperidol (antipsychotic) added to the syringe driver.

18th January Nozinan administered, the dosage doubled on 20th January.

20th January Dr BRIGG increased Nozinam and discontinued Haloperidol

21st January patient reported as 'settled'.

24th January 1996 - death.

Case assessed by multidisciplinary key clinical team. 2004.

Leslie PITTOCK. 82. 5th January 1996 – 24th January 1996. Gosport War Memorial Hospital. He was physically and mentally frail, deteriorating on a mental health ward. Medical notes state pain in flexed right hand. Nursing notes state generalised pain. Arthrotec tried plus oramorph. Syringe driver started five days later with a large dose increase when converting from oramorph to diamorphine. Notes on the 21st January 1996 record a respiratory rate of 6 per minute, likely as a reflection of the dose of opiates ie he was probably opiate toxic but the dose was not reduced. Cause of death unclear, although he was very frail, but opiates could have contributed.

Dr Jane BARTON. From caution interview with police 3.3.2005.

Workplace demands were substantial. A choice to be made between detailed note making or spending more time with patients.

Due to demands of work adopted a policy of pro-active prescribing.

Dr BARTON noted Dr LORDS poor prognosis of Mr PITTOCK on 5th January 1996 and believed that Dr LORD felt that Mr PITTOCK was unlikely to get better and that he was not likely to live for a significant period.

Following admission to GWMH on 5th Jan 1996 Mr PITTOCK placed under the care of Dr Jane TANDY. Assessed by Dr BARTON.

Would have seen Mr PITTOCK every week day Monday to Friday.

Dr BARTON made the note of 9th January 1996, prescribed arthrotec for pain in the hand.

Mr PITTOCK seen by Dr BARTON and Dr TANDY on 10th January.. Dr TANDY noted dementia etc, and wrote that he was for TLC. This indicated to Dr BARTON that Dr TANDY agreed with Dr LORD'S assessment and felt Mr PITTOCK was not appropriate for attempts at rehabilitation but for appropriate nursing care and treatment only. Discussed with Mrs PITTOCK who agreed.

Dr BARTON prescribed Oramorph no doubt as a consequence of liaison with Dr TANDY. This was for relief from pain anxiety and distress. Also proactively wrote prescription for diamorphine upon the basis that Oramorph may be insufficient, and that further medication should be available should he need it.

On Monday 15th January 1996 Dr BARTON would have reviewed all of the patients in the usual way including Mr PITTOCK. Believes she may have been told that his condition had deteriorated over the weekend experienced marked agitation and restlessness and significant pain and distress. Believe assessment was that Mr PITTOCK in terminal decline.

Tried to judge medication as necessary to provide appropriate relief whilst not excessive.

Dosages effectively increased appropriate to increased pain/ distress of patient.

Dr BRIGG examined patient on 20th January, few modifications to drug regime so therefore presumably not inappropriate.

Dr BRIGG examined on 21st January Mr PITTOCK settled. With quiet breathing not distressed.. drug treatment continued therefore not inappropriate.

Expert Dr Andrew WILCOCK (Palliative medicine and Medical Oncology) comments..

- Notes inadequate.
- Pain not appropriately assessed.
- Opioids not appropriate as administered to alleviate anxiety and agitation.
- Not necessary to use syringe driver (unless patient unwilling or unable to take medicines orally)
- Doses of diamorphine 40-120mgs excessive to needs of the patient (far exceeding appropriate starting dose)
- Appropriate dose would be 10-15mgs.
- Little doubt that Mr PITTOCK was naturally coming to the end of his life.
- At best DR BARTON had attempted to allow a peaceful death, albeit with excessive use of diamorphine.
- Opinion that Dr BARTON breached her duty of care, by failing to provide treatment with skill and care, difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs may have contributed more than minimally negligibly or trivially to his death. Dr BARTON leaves herself open to the accusation of gross negligence.
- Given the nature of Mr PITTOCKS decline, Bronchopneumonia appears to be the most likely cause of death.

In his assessment of Dr BARTONS prepared statement Dr WILCOCK comments that:-

- According to Dr BARTONS job description she should take part in weekly consultant ward rounds.
- Consultants were responsible for patient care and should have been available to discuss complex patient issues.

- Given patient numbers 44, and admission numbers Dr BARTON should have been able to satisfactory manage in a half post as clinical assistant with regular consultant supervision.
- It is completely unacceptable for the trust to have left Dr BARTON with continuing medical responsibilities without consultant supervision and regular ward rounds, to fail to do so would be a serious failure of responsibility by the trust in its governance of patients.

Expert Dr David BLACK (Geriatrics) reports that Mr PITTOCK was extremely frail and dependent, and at the end of a chronic disease process of depression and drug related side effects spanning 20 or more years.

- Problem in assessing care due to lack of documentation.
- Lack of notes represents poor clinical practice, no written justification for high doses of Diamorphine and Midazolam.
- Drug management afforded to patient is sub-optimal.
- Starting dose of 80mgs of diamorphine is approximately 3 times the dose that conventionally applied.
- Combination of higher than standard doses of drugs, Diamorphine, and Midazolam combined with Nozinan likely to have caused excessive sedation and may have shortened life by a short period of time, hours to days.
- Whilst care is sub-optimal cannot prove to be negligent or criminally culpable.
- Predictions of how long terminally ill patients live are impossible, even palliative care experts show enormous variation.
- Medication likely to have shortened life but not beyond all reasonable doubt.

Other key witnesses.

Daughter Linda WILES (also a retired registered metal nurse) understood that Mr PITTOCK was transferred to GWMH for terminal care. She watched her father die through self neglect. He had become extremely frail and had lost the will to live. She was not alarmed that her father was given morphine, she considered it appropriate care.

Mr PITTOCKS GP Dr Martin ASHBRIDGE, comments that he suffered chronic intractable depression for which he received continual treatment. It was apparent that in the 5 months prior to his death his physical condition has begun to deteriorate.

Dr Althea LORD employed as Consultant Geriatrician at GWMH, Queen Alexandra Hospital and St Mary's Hospital Portsmouth between March 1992 and June 2004. Consultant for all patients over 65yrs requiring specialist care for their physical health. Assessed Mr PITTOCKS prognosis as poor (ie patients chances of survival were slim and unlikely to survive for long) on 4th January 1996, transfer to GWMH

Dryad ward in order to address patients physical and psychiatric needs. Not intended to be a comprehensive care plan.

Dr Jane TANDY employed by East Hants Primary Care trust as Consultant Geriatrician in elderly medicine since 1994, covered Dryad ward until late 1996. On 10th January 1996 DR TANDY had overall medical responsibility of the ward. Dryad was a long term care ward containing frail and elderly patients difficult to manage due to medical or nursing requirements. There was no resident doctor on the ward which was covered by local GP Dr BARTON. Dr TANDY's responsibilities included a ward round once fortnightly. No requirement for a GP to notify Dr TANDY of every change to drugs prescribed to patients, unless her advice was sought by the GP, this occurred infrequently.
On 10th January 1996, Dr TANDY conducted a ward round with Dr BARTON and Sister HAMBLIN and prescribed 5mg Oramorph to alleviate pain and distress. Thereafter Dr TANDY recites the drugs prescribed by Dr BARTON, and comments that she would have used lower dosage of Diamorphine and Midazalam (than prescribed by Dr BARTON) her practice was to use the lowest dose to achieve the desired outcome diminishing adverse effects. There was no resident doctor to review the medication.

Dr Michael BRIGG a Gosport general practitioner. On 20th January 1996 responding to nursing concerns as to the patients clinical response to Haloperidol, Dr BRIGG stopped the dose and increased dose of Nozinan. He did not see the patient at the time but visited later.

Nurse Gillian HAMBLIN. Consultants attended once fortnightly on Mondays unless on leave when it would be monthly. Her practice was to challenge Dr BARTON if she did not feel levels of drugs prescribed were appropriate. Syringe drivers used once a patient becomes incapable of swallowing. The term TLC means that a patient was very likely to die. Nurse HAMBLIN commenced the syringe driver diamorphine on 15.1.1996., and an increased dosage on 18.01.1996. There no policy or protocol regarding the use of syringe drivers prior to 2000.

Nurse Lynne BARRATT administered Diamorphine to Mr PITTOCK on the 16th and 23rd January 1996.

Nurse Freda SHAW administered Diamorphine to Mr PITTOCK 17.1.1996.

Nurse Bridget AYLING in accordance with policy witnessed the accurate recording of Diamorphine prescribed, and recorded on drug charts.

Nurse Code A re - charged the syringe driver with Diamorphine on 21.1.1996, and witnesses and recorded the withdrawal of Diamorphine for the patient on 4 other occasions.

Nurse Code A witnesses withdrawal of drugs for Mr PITTOCK on 3 occasions.

Nurse Code A variously administered ORAMORPH and verified the death of Mr PITTOCK 24.10.1996.

HAMPSHIRE CONSTABULARY

C.51 1/99

Identification Ref. No. DB/2001

Court Exhibit No.

R - v -

Description

CERTIFIED COPY OF A DEATH CERTIFICATE (PITTOCK)

Time/Date Seized/Produced

19TH MAY 2005

Where Seized/Produced

OFFICE FOR NATIONAL STATISTICS

Seized/Produced by DAVID BURGESS

Signed

Incident/Crime No. OPERATION ROCHESTER

Major Incident Item No. X 608

Laboratory Ref:

PLEASE ATTACH WITH TAPE

GLOUCESTERSHIRE CONSTABULARY

Station.

J1 No. Item No.

O.I.C.

Identification Ref No.

Court Exhibit No. DB 2001

R-v-

Description

A CERTIFIED COPY OF A DEATH CERTIFICATE

Time / Date Seized / Produced

19TH MAY 2005

Where seized / Produced

OFFICE FOR NATIONAL STATISTICS

~~Seized~~ Produced By

DAVID BURGESS

Signed

Incident Crime No. OPERATION ROCHESTER

Major incident item No.

Laboratory Ref

P27B (Rev 2/02)

Code A

Note (1) Births and Deaths.

This certificate is issued in pursuance of the Births and Deaths Registration Act 1953. Section 34 provides that any certified copy of an entry purporting to be sealed or stamped with the seal of the General Register Office shall be received as evidence of the birth or death to which it relates without any further or other proof of the entry, and no certified copy purporting to have been given in the said Office shall be of any force or effect unless it is sealed or stamped as aforesaid.

Note (2) Births.

A name given to a child (whether in baptism or otherwise) before the expiration of twelve months from the date of registration of its birth, may be inserted in Space 17 of the entry in the birth register under the procedure provided by Section13 of the Births and Deaths Registration Act 1953. If the parents or guardians wish to avail themselves of this facility at any time, they must deliver a certificate of baptism or of naming to the registrar or superintendent registrar having the custody of the register in which the birth was registered. This certificate must be in the prescribed form and can be obtained on application to any registrar.

STATEMENT OF DR JANE BARTON - RE: LESLIE PITTOCK

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Leslie Pittock. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Pittock.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal bartel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients.

4. Whilst the demands on my time were probably slightly less in 1996 than the position which then pertained in 1998 and beyond, certainly even by 1996 there had been a significant increase in dependency, increase in bed

occupancy, and consequent decrease in the ability to make notes of each and every assessment and review of a patient. These difficulties clearly applied both to me and the nursing staff at the time of our care of Mr Pittock. Similarly I had by this stage felt obliged to adopt the policy of pro-active prescribing to which I have made reference in my previous statement to you, given the constraints and demands on time.

5. In any event, it is apparent from Mr Pittock's medical records that he was 83 years of age and had been suffering from depression since his 50's. Mr Pittock had been living in a residential home, Hazeldene and also had been an in-patient at the Knowle Hospital where he had received Electro Convulsive Therapy as treatment for severe depression. Having returned to Hazeldene, early in 1995 it is recorded that by September that year Mr Pittock had taken to his bed and was no longer eating and drinking properly. In view of his general condition and depression, he then appears to have been admitted to Mulberry Ward at the G W M H having been seen at Hazeldene by a Community Psychiatric Nurse in September 1995.

6. The note of the Community Psychiatric Nurse for the 1st September 1995 records that she had been asked to review Mr Pittock's mood and behaviour. She said that he had lost 1 stone 2 pounds in two months and appeared physically frailer, anxious and had fallen at times. She recorded the drug regime at that time, and her view that the best course of action was to arrange an admission to Mulberry Ward for assessment of the regime and to provide interim intensive support for Mr Pittock.

7. From Mr Pittock's records it appears then that he was admitted to Mulberry Ward on the 14th September 1995 under the care of Consultant in Old Age Psychiatry, Dr Vicki Banks. Mulberry Ward is the long stay

elderly mental health ward at the Gosport War Memorial Hospital. On admission it was recorded that there had been a deterioration of Mr Pittock's mood and physical capabilities over recent months. Whilst on Mulberry Ward, Mr Pittock's depression was treated with Lithium, Sertraline, and he also received Diazepam and Thioridazine.

8. Mr Pittock was then discharged from GWMH on 24th October 1995. The subsequent discharge letter to Mr Pittock's GP from Dr Rosie Bayly, Registrar to Dr Banks, stated that Mr Pittock had scored 8 out of 10 on a mental health score, and that he had been offered ECT for his depression but had turned it down as it had not been very effective previously. Dr Bayly referred to his frail physical condition, but said that his mood had improved quite a bit during his admission and that he seemed to have more energy. He was apparently to be followed up as a day patient.

9. Mr Pittock was then re admitted to Mulberry ward from Hazeldene on 13th December 1995. The nursing staff at the residential home were said to have found it increasingly difficult to manage him as he had become both physically and verbally aggressive. On 20th December his physical condition was described as poor, and he later developed a chest infection and areas of pressure ulceration.

10. With his condition remaining poor, Dr Bayly wrote a note on 2nd January 1996 requesting Dr Althea Lord, Consultant Geriatrician, to see Mr Pittock. In her note Dr Bayly said that on admission Mr Pittock's mobility had initially deteriorated rapidly and that he had developed a chest infection. She reported that his chest was now clearing, but he remained bed bound, expressing the wish to die. The following day, Mr Pittock was said to be deteriorating.

11. Dr Lord then undertook an assessment on 4th January. In Mr Pittock's records she said that she would be happy to take Mr Pittock to a long stay bed at the hospital. Recording the position at this time when then writing formally to Dr Banks on 8th January, Dr Lord said she noted that he had suffered from a chronic resistant depression and long courses of ECT in the past had not been effective. He had recovered from a recent chest infection but was completely dependent with a Bartel score of zero, Code A Code A He had hypoproteinaemia with an albumin of 27 and was eating very little although he would drink moderate amounts with encouragement. She felt that he would need high protein drinks as well as a bladder wash out but overall felt that his prognosis was poor and would be happy to arrange transfer to Dryad on 5th January. She gathered that Mrs Pittock was also aware of his poor prognosis.

12. In noting that his prognosis was poor I believe that Dr Lord felt that Mr Pittock was unlikely to get better and that sadly he was not likely to live for a significant period.

13. Accordingly, Mr Pittock was admitted to Dryad ward the following day, 5th January, though under the care of Consultant Geriatrician Dr Jane Tandy, and I undertook his assessment. Unfortunately, given the very considerable interval of time I now have no real recollection of Mr Pittock, but my admission note in his records reads as follows:

> "5-1-96 Transfer to Dryad Ward from Mulberry
>
> Present problem
>
> Immobility depression
>
> broken sacrum. Small superficial areas

ankle dry lesion L ankle
both heels suspect

Catheterised
transfers with hoist
may help to feed himself

Long standing depression on Lithium and
Sertraline"

14. I also prescribed medication for Mr Pittock, continuing the Sertraline, Lithium, Diazepam, and Thyroxine which had been given during his stay on Mulberry Ward, together with Daktacort cream for his pressure sores.

15. I believe that I would have seen Mr Pittock each weekday when on duty at the hospital. 5th January 1996 being a Friday, I would have seen him again on 8th January and reviewed his condition. I have not made a note, but anticipate that his condition may have been essentially unchanged.

16. I saw Mr Pittock again on Tuesday 9th January and made the following entry in his notes:

"9-1-96 Painful R hand held in flexion
Try arthrotec
Also increasing anxiety and agitation
? sufficient diazepam
? needs opiates"

17. The nursing note for 9th January documents that Mr Pittock had taken a small amount of diet. He was noted to be very sweaty that morning, but

apyrexial. He stated that he had generalised pain and it was noted that he would be seen by me that morning.

18. The prescription chart shows that I prescribed Arthrotec, which would have been for the pain in Mr Pittock's hand as recorded by me in the notes. The prescription is in fact dated for the previous day. I do not know now if the date is in error or if I had prescribed and seen him the previous day, and made a substantive note the following day, 9th January. In any event on 9th January I noted that Mr Pittock had increased anxiety and agitation, and raised the possibility that it might be necessary to increase the diazepam and prescribe opiates. I would have been conscious that a ward round with Dr Tandy was to take place the following day, and that a change in medication could sensibly be considered then.

19. The notes show that Dr Tandy and I then saw Mr Pittock the following day, 10th January. Dr Tandy noted his dementia, that he was catheterised, had superficial ulcers, his Barthel score remained zero, and he would eat and drink. She wrote that Mr Pittock was "for TLC" (tender loving care). This indicated that Dr Tandy effectively agreed with Dr Lord's assessment and felt Mr Pittock was not appropriate for attempts at rehabilitation but was for all appropriate nursing care and treatment only. She noted that she had had discussion with Mr Pittock's wife who had agreed that in view of his very poor condition this was appropriate.

20. The nursing note for the same day confirmed that we had seen Mr Pittock and that his condition remained poor, with Mrs Pittock being aware of this.

21. The prescription chart shows that I prescribed Oramorph for Mr Pittock the same day, no doubt in consequence of liaison with Dr Tandy at the time of the ward round. This would have been for relief of pain, anxiety and distress. The dose is recorded as 2.5 mls in what is a 10mg/5ml ratio, 4 hourly. The regime was written up for doses at 6.00 am, 10.00 am, 2.00 pm and 6.00 pm. It appears that I also proactively wrote up a prescription for diamorphine, in a dose range of 40 - 80 mgs subcutaneously over 24 hours, together with 200 - 400 mcgs of Hyoscine and 20 - 40 mgs of Midazolam via the same route. I anticipate we were concerned that the Oramorph might be insufficient and that further medication should be available just in case he needed it.

22. Sister Hamblin recorded in the nursing notes the same day that Mrs Pittock was seen and was aware of her husband's poor condition. He was to occupy a long-stay bed. It was clear his condition was such that he would not recover and in essence all that could be given was palliative care, with his death expected shortly.

23. I anticipate that I would have seen Mr Pittock again the following day. Although I did not make a clinical entry in Mr Pittock's records, I wrote up a further prescription chart for the various medications Mr Pittock was then receiving. In addition I increased the Oramorph available for Mr Pittock's pain, anxiety and distress, by adding an evening dose of 5mls to the four daily doses, to tide Mr Pittock overnight. I also provided a further prescription for Hyoscine, Diamorphine, and Midazolam, with the latter two drugs being at a slightly greater level than I had written the previous day, at 80 - 120 mgs and 40 - 80 mgs respectively. I would have been concerned that although it was not necessary to administer the medication at that stage, Mr Pittock's pain, anxiety and distress might

develop significantly and that appropriate medication should be available to relieve this if necessary. The Sertraline and Lithium were discontinued from this point, given Mr Pittock's poor condition.

24. I anticipate that I would have seen Mr Pittock on the Friday morning, but would then have been away from the hospital over the weekend. I returned on the morning of Monday 15th January, and would have reviewed all of the patients on both Dryad and Daedalus wards in the usual way, including Mr Pittock. I believe I may have been told that his condition had deteriorated considerably over the weekend and he appeared to be experiencing marked agitation and restlessness and to be in significant pain and distress, through his mental and physical condition. Unfortunately, I did not have an opportunity to make a clinical entry in Mr Pittock's notes, I anticipate due to lack of time, but the nursing note indicates that I saw Mr Pittock and that 80mgs of Diamorphine, 60mgs of Midazolam, and 400mcgs of Hyoscine over 24 hours were commenced subcutaneously via syringe driver at 08.25 that morning.

25. The previous medication, including the Oramorph, was clearly insufficient in relieving Mr Pittock's condition. He had been transferred to the ward in a poorly condition, and had been considered by consultants at about that time to be in terminal decline. Dr Tandy in particular had noted that he should have "TLC" - in other words palliative care in circumstances in which he was clearly dying. Since then Mr Pittock had deteriorated yet further. My concern therefore was to ensure that he did not suffer anxiety, pain and mental agitation as he died. I believe my assessment of Mr Pittock's condition at this time was also that he was in terminal decline.

26. I tried to judge the medication, including the increase in the level of opiates to ensure that there was the appropriate and necessary relief of his condition, whilst not administering an excessive level, and to ensure that this relief was established rapidly and maintained through the syringe driver. This had to take into account the fact that the Lithium and Sertraline with their additional sedative effects had previously been discontinued and that he would have developed some tolerance to the oral regime.

27. Although the nursing notes suggest that Mr Pittock continued to deteriorate, his pulse was noted to be stronger and regular, and he was said to be comfortable during the night.

28. The notes continue that the following day, 16th January, Mr Pittock's condition remained very poor and that there had been some agitation when he was being attended to. It would appear therefore that the medication commenced the previous day had been largely successful in relieving Mr Pittock's condition, but not entirely. At the same time, it would seem that Mr Pittock's pain, distress and agitation had been such that he was indeed tolerant to the medication given, including the level of diamorphine I had felt appropriate.

29. In view of the agitation I decided to add between 5 - 10mgs of Haloperidol to the syringe driver, with 5mgs being given at that time. The fact that I saw Mr Pittock and prescribed is recorded in the nursing notes, but again I anticipate my commitments in attending to patients at that time meant that I did not have an opportunity to make an entry in Mr Pittock's notes.

30. Mr Pittock's daughter apparently visited later that day and was said now to be aware of her father's poorly condition.

31. I believe I saw Mr Pittock again the following morning, 17th January. It appears from the nursing notes that Mr Pittock was tense and agitated and so I decided to increase the level of his medication. I wrote a further prescription for 120mgs of diamorphine, noted by me on the drug chart to have been at about 08.30. This was with the specific aim of relieving the agitation, and from concern that as Mr Pittock would be becoming inured to the medication and tolerant of it, so he might experience further agitation, and the pain and distress might return. I also increased the Haloperidol to 10mgs and the Hyoscine to 600mcgs, the latter to dry the secretions on his chest, suction being required that morning.

32. I returned to review Mr Pittock in the early afternoon. The nursing note suggests that the medication was revised at that stage, and it is possible that the changes I had recorded earlier were instituted at about this time.

33. Unfortunately, Mr Pittock appears to have deteriorated further that evening. He was however said by Sister Hamblin now to be settled and aware of when he was being attended to. My inference was that the increase in the medication had not seemingly caused Mr Pittock to be excessively sedated.

34. I believe I saw Mr Pittock again the following morning, Thursday 18th January. The nursing note indicates that his poorly condition continued to deteriorate. I made an entry in his records on this occasion, as follows:

"18-1-96 Further deterioration
sc analgesia continues
difficulty controlling symptoms
try nozinan."

35. I believe from my note that Mr Pittock's agitation had returned and we were having difficulty controlling his symptoms. I therefore increased the Haloperidol to 20mgs and decided to add 50mgs of Nozinan to the syringe driver to run over 24 hours, Nozinan being an antipsychotic, used also in palliative care for pain and severe restlessness.

36. The nursing note states that he appeared comfortable in between attentions, from which I would infer that he had adequate relief from symptoms, but he would experience pain, distress and agitation when receiving care, such as being turned, that being necessary to prevent the further development of bed sores.

37. Later that day a marked deterioration in Mr Pittock's condition was noted by the nurses. Clearly Mr Pittock's condition continued to deteriorate given the fact that he was in the process of dying. His breathing was noted to be intermittent and his colour poor.

38. I would not have been on duty over the weekend, and it appears that one of my GP partners, Dr Michael Briggs, was available. The records show that on Saturday 20th January, he was consulted about Mr Pittock, and he advised that the Nozinam should be increased to 100mgs and the Haloperidol discontinued. My expectation is that Dr Briggs would have been advised of Mr Pittock's condition and the drug regime. The only modification being in the antipsychotic medication, it would seem that Dr

Briggs did not consider the general regime to be inappropriate in view of Mr Pittock's condition.

39. Dr Briggs specifically recorded in the notes that Mr Pittock had been unsettled on Haloperidol, that it should be discontinued and changed to a higher dose of Nozinan.

40. It seems that Dr Briggs then saw Mr Pittock the following day. He has made a record in the notes for 21st January, in addition to the entry for the verbal advice given the previous day. Dr Briggs noted that Mr Pittock was much more settled, with quiet breathing and a respiratory rate of 6 breaths per minute. Dr Briggs said that he was not distressed, and stated "continue". Again, it would seem that Dr Briggs did not disagree with the overall medication which was being administered in view of Mr Pittock's condition.

41. I would have seen Mr Pittock again on the Monday morning, 22nd January. I have not made a note, but the nursing records indicate that Mr Pittock was poorly but peaceful.

42. I would have seen Mr Pittock again on 23rd January, when again it was said by the nurses that his poorly condition remained unchanged and that he remained peaceful. In view of the fact that the medication was apparently relieving his symptoms, it was not necessary to alter either the nature or the amounts being given.

43. Sadly, in the early hours of 24th January, Mr Pittock deteriorated suddenly, and he died at 01.45.

Signed Code A

dated 3-3-05

Handed to D.C. Yates

Code A