Leslie PITTOCK Code A -24.01.1996

Statement of **Lynda Wiles** was read to you and you will recall that Mr Pittock suffered from severe depression all his life. He had had various admissions to hospital and had received ECT Treatment.

He was physically very strong but his depression overtook him and he made several suicide attempts.

Mr Pittock had been cared for at home by his wife but as a result of concerns expressed by his psychiatric nurse and social worker he was sent to Hazeldene Rest Home where they were able to care for him.

His condition deteriorated and he generally withdrew.

He was eventually admitted to Gosport on 5th January 1996 but he continued to deteriorate mentally and physically. Mrs Wiles takes the view that the nursing staff on the ward were excellent and she understood that her father was transferred to Driad Ward for terminal care. It was never explained to her in words of one syllable.

She was aware that her father was in pain and cried out when the nurses turned him and she remembers a discussion about morphine but does not recall if she was told it was to be administered. She was not alarmed by the thought of him having morphine and she considered it appropriate care.

Mrs Pittock had mentioned a drip but since Mr Pittock was not on a drip Mrs Wiles presumes that was reference to a syringe driver.

It is significant that Mrs Wiles is a retired psychiatric nurse having nursed the elderly mentally ill for most of her career.

The statement of **Rosemary Bayly** was then read. She is the General Practitioner at Fleet Medical Centre in Fleet and from September 1995 to February 1996 was employed as a local Registrar in psycho geriatrics at

Gosport. At that point she had very little experience of psychiatry and was supervised very closely.

It was she who wrote the discharge summary to the GP for Mr Pittock Dr Asbridge on 8th November 1995. She refers to an exacerbation of his chronically depressed mood, continuing problems with constipation, deterioration in mood and deterioration in his physical capabilities and condition.

She describes early morning waking, poor appetite exacerbated by the embarrassment he felt at eating in public. He had a lack of energy and motivation and was unable to enjoy anything. She goes on to describe his treatment, medication etc.

She then goes on to describe that Mr Pittock was admitted again on 13th December 1995 with Dr Banks as his consultant. Again the diagnosis is recorded as depression.

His previous discharge had been on 24th October but within two months is re-admitted.

He was a man in failing health not just from the medical records but from the memory of his daughter Mrs Wiles. He felt that everything was horrible.

The picture we have from then on is of deterioration in Mr Pittock's condition. He is asking staff why they won't let him die, his skin is breaking down and he is described as very poorly.

A reference is made to Dr Lord who is the geriatrician to see if there is any physical reason for his condition or if it is all centred on his depression.

By 3rd January the clinicians have run out of options and Mr Pittock is moved onto the elderly care ward.

The statement of **Victoria Banks** was then read. She was the consultant in old age psychiatry for the Gosport catchment area. As such she covered Mulberry a ward at Gosport and she has a memory of Mr Pittock who she describes as very chronically depressed. He was mentally frail in terms of his ability to cope with life. She confirms Mr Pittock's admission to Mulberry ward and she describes the discussion of ECT

treatment and confirms that Mr Pittock was not sure that he wanted that course of therapy and whether it would be any good.

She too describes the deteriorating condition and records that on the 4th January 1996 she describes Dr Lord's examination with the difficulties detailed are chronic resistant depression, complete dependency, catheter bypass, ulceration of left buttock and hip and hypoproteinaemic.

It is confirmed at that stage that the family had been made aware of Mr Pittock's deteriorating condition and it is confirmed that he is transferred to Driad Ward on 5th January 1996.

It is significant that she refers to 'sick noteing' used where a patient was expected to die. That would give a brief outline of the patients very poor physical state or poor prognosis and a copy would be given to the relatives.

The statement of **Althea Lord** was read. She is the community geriatrician and was consultant geriatrician for the Department of medicine for older people in Portsmouth from 1992 to 2004.

She sees Mr Pittock and confirms that the prognosis is poor because of his extreme functional dependency, his poor nutritional state, his pressure sores together with a background of long standing depression.

For that reason she supports the move to Driad ward because his physical needs were outweighing his psychiatric needs. She confirms at that stage that his bed at Hazeldene Rest Home be given up. She was quite convinced that he was not going to return to the rest home.

The statement of **Jane Tandy** was then read. She is the Consultant Geriatrician who was Mr Pittock's consultant at the relevant time. She has no direct memory of him but she refreshes her memory from the notes and in particular confirms that on the 10th January 1996 she had overall medical responsibility for Driad Ward.

She confirms that day to day cover would be provided by Dr Barton and possibly others from her practice.

She confirms Mr Pittock's drug regime from the hospital notes and confirms that a syringe driver was commenced containing diamorphine on 15th January 1996. It is particular that she says that diamorphine is used not just as a pain killer but also to alleviate distress by making a

patient more comfortable. He was also receiving midazalam which is a drug used to reduce anxiety and agitation.

She does comment that she would have used a lower dosage of diamorphine and midazalam initially when the syringe driver was set up but says that she did not see patient when the dosage was commenced. She also comments that she is not an expert in palliative care.

She describes discussing the matter with Mrs Pittock and agreeing with her that because of Mr Pittock's very poor quality the care plan was for TLC or Tender Loving Care.

She then describes Mr Pittock's further deterioration and the fact that his symptoms were not being controlled by the current drug regime but by 21st January he is described as much more settled, quiet breathing rate 6 per minute not distressed, treatment to continue.

The statement of **Michael Brigg** was then read. He is one of Dr Barton's partners and it was he who authorised a change in Mr Pittock's medication on 20th January. You may recall that the regime was not controlling his pain and he describes the procedure where by staff would seek all approval for a change in medication and the doctor would then attend to sign up ie: approve the record after the event.

He then got on to describe how the syringe driver was changed in order to comply with the change in medication.

On 20th January 1996 he confirmed that Mr Pittock was much more settled, quiet breathing, respiratory rate of 6 per minute and not distressed.

Lynne Barrett then gave evidence in person to say that she had been a qualified nurse since 1986 and worked with Gillian Hamlyn as her clinical manager.

She confirmed that she worked on Driad ward at Gosport War Memorial Hospital and that the clinical care was generally given by Dr Barton.

Her responsibilities on Driad ward were tending to the day to day running of the ward including supervision of junior staff, caring for patients and administration of prescribed medicines. She said that she had been using syringe drivers since 1987 or 1988.

She was involved in the care of Mr Pittock although she had no personal memory of him.

She described Mr Pittock's condition on 9th January and said he had eaten very little but in the evening was very sweaty but without a temperature and seemed to be in generalised pain. A note was made for him to see Dr Barton the following morning.

On 16th January she tells us that his condition remained very poor and he was seen by Dr Barton when his medication was adjusted. His syringe driver was re-charged with 80mgs of diamorphine 60mgs of medazalam amongst other things.

She went into some detail about procedures for dispensing, collecting and administering drugs.

By 19th January the dose of diamorphine has increased to 120mgs and medazalam 80mgs. There were other changes in medication.

By 22nd January Mr Pittock is said to be poorly but very peaceful. At 15.15pm the syringe driver is re-charged with 120mgs of diamorphine and 80mgs of medazalam in addition to other medication. On 23rd January his condition remains poor although he has remained peaceful.

In response to Mr Jenkins she said that she had 20 years nursing experience lots of it with Dr Barton. After Dr Barton had resigned in 2000 she was replaced by a doctor full time Monday to Friday 9-5 who didn't last long and there were several more doctors after that.

Dr Barton attended the ward in the mornings for a limited period. She did Daedalus and Driad wards and would generally do her ward round between 7.30 and 8.00am. She would sometimes come back to the hospital several times during the day at lunchtime or in the evening and she was always very busy. However she always spoke to patients and had as much contact with relatives as she could.

Dr Barton and Sister Hamlyn had a very good working relationship and Dr Barton was very much liked. Staff respected her and her level of commitment to patients was her number one priority.

Many patients were in a poor condition and some of them in the terminal stages of illness.

There was a physiotherapist that attended the hospital but only for one hour a week.

Many patients could not handle the transfer to the hospital and would go downhill. That was particularly the case with post operative patients. She said that all staff felt that they were being transferred too soon as a result of pressure from the transferring hospital.

She was quite clear that analgesia could be prescribed as a range with or without a syringe driver and staff always started at the lower dose. If there was any change in condition Dr Barton would always be advised. She said that she would always have to be satisfied that any medication would be for the patients benefit and if in doubt she would not administer it. She completely dismissed the idea that patients were over treated with medication.

Mr Wilson asked if patients were ever transferred without notes and Mrs Barratt said yes it had happened but it was rare.

In response to Mr Farthing she said that poorly patients would have been transferred into single rooms and denied that any of it was known as the death ward.

Proffessor Black gave oral evidence to confirm that he had undertaken his assessments from the medical records and documents and that he had not seen any of the patients in person.

He confirmed that Mr Puttock had suffered with various severe depressions since 1959 and had needed care since early in 1993.

He would have been concerned about his behaviour with weight loss increasing frailty, aggression and what he considered to be drug induced parkinsonism.

He had suffered a chest infection, a pseudo obstruction of the bowel probably caused by his treatment. Latterly he was very unwell, very drowsy and it was increasingly clear that his was not a psychiatric problem anymore but it was a physical illness. At that point it was decided he was for long term care and that he would not be leaving hospital.

Because of his agitation and anxiety oramporph would be an appropriate drug to use and on 15th January a syringe driver was fitted although he

had some difficulty in reconciling the fact, reconciling the dose of diamorphine with what he would have expected. The dose of oramorph given on 15th January was 26mgs but when the syringe driver was started it contained 80mgs of diamorphine and 60mgs of medazalam. His view was that 26mgs of oramorph might have been replaced by 13mgs of diamorphine and that any increase would normally be limited to 50per cent each day although there might be circumstances in which you would increase by 100 per cent. That would suggest that the diamorphine to replace the stopped oramorph would be up to a maximum of 30mgs in twenty four hours. He was concerned that starting at 80mgs of diamorphine was three times the dose that might conventionally be dealt with.

Medication would depend very much on which symptoms are being treated. He was very much of the view that diamorphine would be used for pain, agitation, distress and anxiety. As matters progressed the conditions were fairly well controlled and his main area of concern was that he couldn't tell from the notes why there had been the significant increase.

In response to Mr Jenkins he said that his presentation may have been caused by the side effects of the drugs. However the picture was very much that of a dying man. His family were involved and he died without distress. There was no atypical pattern in it.

Mr Farthing asked him about the increase in the dosage of diamorphine and whist he remained concerned at the increase when the syringe driver was installed his review was very much that one had to trust the patient that you were treating and nurses need very much to be involved in the care of the patient. He would expect a daily revue depending on the hospital. In a District Hospital that would much easier but in a Community Hospital staffed by GP's it may be rather difficult.

Good practice was to start dosages low and increase in accordance with the range and the object of the exercise was to achieve relief of symptoms.

He was then asked by Mr Leeper about the principals of rehabilitation and palliative care but took the view that treatment may involve both. The principle is the cure or relief of symptoms. Further the principal may change from rehabilitation to palliative care. The prevention and relief of suffering was palliative care and it was in no way concerned to hasten

death. However it was acknowledged that that may be a side effect of the treatment.

If the sole object of the exercise is to hasten death then that would be unlawful and unethical.

It was important to decide if the condition was susceptible to treatment. It was an art form and the plan needed to be reviewed and changed as necessary. It was a multidisciplinary decision with nurses and family participating.

In order to move on to palliative care you would need to be satisfied that the patient will not respond to further treatment.

He was referred to the GMC Guidance that required an assessment of the condition and what was defined as good clinical care. He accepted that without an assessment there can be no informed diagnosis.

Rehabilitation can be a programme of slowing down any progress in a condition or stabilising the condition.

Dr Barton then gave you evidence and you may remember that she was warned that she was not obliged to give evidence if it was likely to jeopardise her position in any other proceedings but she chose to do so. She started of with a general statement of her position at Gosport War Memorial Hospital and confirmed that she became the sole clinical assistant at Gosport in 1988. It was a cottage hospital and at that time had forty eight long stay beds. There were two consultants responsible for each of the wards Dr Lord responsible for Daedalus ward and Dr Jane Tandy for Dryad ward. However it was common ground that the Consultants had very little time to devote to Gosport the suggestion was that there was a two hour ward round once a fortnight. There is no doubt that Dr Barton was under considerable pressure at Gosport and she would start her day there at 7.30am would visit both wards and review patients and liaise with staff and she was then away from the hospital and in her GP surgery by 9am. She told us that she returned to the hospital almost every lunch time and she would book in patients of whom there were about five a week during the lunch time session and clerking in may take 20 to 30 minutes. If required she would return to the hospital after her surgery at 7pm and she was available on the telephone if needed.

One of the problems was that initially the level of dependency of patients was relatively low. However as time went on that increased and that seems to have been confirmed by Mrs Joines and Mrs Barrett.

Dr Barton took the view that very often the level of expectation was unrealistic but as she said if she didn't do it nobody else was there to do it. That eventually overtook her and she resigned in 2000.

Because of the pressure of the position something had to give and Dr Barton readily accepts in her case it was note taking. The matter was referred to by Professor Black and in particular he was unable to confirm from the notes why certain starting doses of drugs were given and why certain increases were made. She says quite candidly that if this were a District Hospital it would be fully staffed with all grades of doctor who would be available to write up notes to be on call and to share the workload.

Of particular importance is the fact that she was not the sole person dealing with these patients and the very basic minimum was that a consultant was overseeing the care of the patients and at no stage was any prescribing practice criticised.

She then gave evidence specifically about Mr Pittock.

She detailed his medical history and that latterly he had been admitted to Mulberry ward where his depression had been treated with Lithium, Sertraline and he had also received diazepam and thioridazine. He became a management problem at the residential home and was re-admitted to Mulberry ward on 13th December 1995. His physical condition was described as poor and he developed a chest infection and areas of pressure ulceration. By the beginning of 1996 he was bed bound and was expressing the wish to die. He was transferred to Dryad ward on 5th January where Dr Barton took over his care. Dr Lord was the admitting consultant and felt that Mr Pittock was unlikely to get better Dr Barton undertook the assessment. Her admission notes say 5th January 1996 transferred to Dryad ward from Mulberry present problem immobility, depression, broken sacrum, small superficial areas, ankle dry lesion left ankle, both heels suspect, catherterised, transfers with hoist, may help to feed himself, long standing depression on lithium and certraline.

She then said that she would have seen him each week day although nothing is written up until 9th January when she records painful right hand

held in flexion triarthrotec also increasing anxiety and agitation, query sufficient diazepam query needs opiates. Dr Tandy was to take a ward round the following day and she does indeed see him on 10th January. She is the one who notes that Mr Pittock is for TLC Tender Loving Care effectively agreeing with Dr Lord's assessment and that it was not appropriate to try to re-habilitate him. His wife was aware of that.

While she has no recollection of it she presumes that her prescription of oramorph for Mr Pittock that day was as a result of the consultation with Dr Tandy. She refers to the active writing up of a prescription for diamorphine with a dose range of 40 to 80mgs subcutaneously over twenty four hours together with 200 to 400mgs of hyoscine and 20 to 40 mgs of midazolam the same way.

Because she was not based at Gosport and had other duties the principal of pro-active prescription was adopted so that if and when required the medication could be given. All the nursing staff confirm that practice. It is significant that there is continual reference to syringe driver being used for analgesia but from the evidence of Professor Black and from the practice of Dr Barton diamorphine was used not just for pain but to relieve anxiety and distress because of its calming effects.

The following day she increases the dimorphine from 80 to 100mgs and the medazalam 40 to 80mgs. She says quite clearly that while it may not have been necessary to administer those doses at that time the drugs would be available to him to provide relief if necessary as she says given Mr Pittock's poor condition.

On 15th January she is told that Mr Pittock had experienced marked agitation and restlessness and appeared to be in significant pain and distress. Accordingly 80mgs of diamorphine 60mgs of madazalam and 400mgs of hyacine were commenced at 8.25 on the morning of 15th January. From her evidence that seems to be in the face of the marked agitation and restlessness and the appearance that Mr Pittock was in pain and distress. She is quite clear that the drug regime was at all times necessary to give relief of the condition and to insure that was established rapidly and maintained through the syringe driver.

The increase in medication seems to have solved the problem to a large extent although there was some agitation when he was being attended to. For that reason she adds 5 to 10mgs of haloperidiol to the syringe driver and 5mgs was given as the starting dose.

When she sees Mr Pittock the following day 17th January it appears that he was tense and agitated and Dr Barton says that for that reason increased the prescription to 120mgs of diamorphine as she says with the specific aim of relieving the agitation and that he was becoming tolerant of the medication and was likely to experience further agitation and the pain and distress might return.

On 18th January she notes that there is further deterioration subcutaneous analgesia continues difficulty controlling symptoms trinizinan. Nozinan is an anti-psychotic but used for palliative care for pain and severe restlessness.

Her interpretation of the nursing notes is that Mr Pittock appeared comfortable that would seem to indicate that he had relief from his symptoms but that he would experience pain distress and agitation when receiving care such as being turned.

During the weekend Dr Barton is not on duty but her partner Dr Brigg is and he is consulted about Mr Pittock and increases the nozinan to 100gs. He notes that the haloperidol should be discontinued with the increased dose of nozinan. Dr Brigg then sees Mr Pittock on 21st January and writes up the notes of his consultation the previous day. He says that Mr Pittock was not distressed and was much more settled and did he did not disagree with the overall patient management. She confirms that she would have seen him as part of her rounds on 22nd January and 23rd January and at 1.45 on 24th January Mr Pittock died.

The cause of his death is given as:
1a Bronchopneumonia

In response to questions from you she confirmed that it would take 20 to 30 minutes to clerk in a patient and that in all she had three and a half sessions a week and that the lunch and evening attendance at the hospital was extra and in essence voluntary. A session was three hours.

In response to Mr Jenkins she said that at the relevant time there was no ECG equipment at Gosport and no defibrillator. Even if they had an ECG there was no one there who could interpret it.

She was clear that no consultant had ever queried the drug chart nor had the pro-active prescribing ever been queried. Everyone knew that's how it was dealt with including the consultants.

She was quite clear that the nursing staff were key to patient care and that in common with Professor Black the clinical team would rely absolutely on the nursing records because the doctor was just seeing a snap shot of the patient at that particular moment.

Finally **Dr Andrew Wilcock** gave evidence.

Dr Wilcock dealt briefly with the history and in particular the poor record keeping.

He was quite clear that Mr Pittock was naturally coming to the end of his life, but he is quite convinced that there was excessive use of diamorphine he considered that it was the range that was the problem and he was concerned that didn't seem to be any recorded assessment of pain. He said that the effects of an overdose would be drowsiness, confusion, sedation, respiratory depression and that would probably lead to death. In reply to Mr Jenkins he said that the record keeping was not as required.

As tight as time might be decisions should be documented without those it was impossible to unravel the situation afterwards. It also meant that decisions could not be justified. He said that he was far more use to giving medication as required and assessing the patient in the light of reactions to that. If needs be that could be done two or three times a day and that was the kind of thing that happened in patients homes. There was no doctor in attendance there and medication was managed.

In response to Mr Townsend he said that the commencement of diamorphine was a decision for the doctor and should not be open to any misinterpretation.

In response to Mr Leper he said that he would prefer small doses to be available intermittently and on the basis of as required the patient can get drugs in the absence of the doctor on the basis of pre-emptive prescription. He could not approve of going straight to a syringe driver and particularly at a dose that he did not think was appropriate. He had not doubt that morphine was a very safe drug but it is the use of the drug that may present problems.

He confirmed that pre-emptive prescription of small amounts as required was perfectly in order and was good clinical practice. However he had never seen procedure as it was being operated in Gosport.