SUMMARY OF CONCLUSIONS

Leslie PITTOCK
DOB: Code A
DOD: 24/01/1997

Mr Leslie Pittock was an 83 year old gentleman with a long recurrent history of severe depression resistant to treatment. This was complicated by drug induced parkinsonism and subsequent mental and physical frailty and dependency. His admission to the Gosport War Memorial Hospital Mental health beds on the 29th November and subsequent transfer to a medical bed on the 5th January 1997 was the end point of these chronic disease process. He continues to deteriorate and dies on the 24th January 1997.

However there were significant failings in the medical care provided to Mr Pittock and also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day.

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, M = microfilm notes)

3.1 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.

3.2 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).

3.3 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 looks similar to Parkinson's disease but is actually as a result of long-term anti-psychotic medication).

3.4 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).

3.5 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).

3.6 On 22nd December, diarrhoea started and 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). The nursing cardex documents that he started becoming faecally incontinent on 20th December and then had further episodes of diarrhoea (140). It is also noted that by 1st January (147) he was drowsy with very poor fluid intake.

3.7 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.

3.8 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".

3.9 Medical notes after transfer (13M and 15M). On 5th January a basic summary of the transfer is recorded, no clinical examination is either undertaken or recorded.

On the 9th January increasing anxiety and agitation is noted and the possibility of needing opioids 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).

3.10 On 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).

3.11 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). The medical notes on 21st January state "much more settled", respiratory rate of 6 per minute, not distressed and on 24th January the date of death is verified by Staff Nurse Martin in the medical notes (15M).

Note: Nozinan is a major tranquilliser similar to Chlorpromazine but more sedating. It is usually used for patients with schizophrenia and because of its sedation is not usually used in the elderly, though it is not completely contraindicated. Used subcutaneously in palliative care for nausea and vomiting at a dose of 25 - 200 mgs for 24 hours although British National Formulary states that 5 - 25 mgs for 24 hours can be effective for nausea and vomiting with less sedation.

3.12 Drug Chart Analysis:

On 5th January at transfer (16M), Mr Pittock is written up for the standard drugs that he was on in the mental health ward including his Sertraline and Lithium (for his depression) Diazepam (for his agitation) Thyroxine for his hypothyroidism. The drug chart also had Diamorphine 40 - 80 mgs subcut in 24 hours, Hyoscine 200 - 400 micrograms subcut in 24 hours and Midazolam 20 - 40 mgs subcut in 24 hours. Midazolam 80 mg subcut in 24 hours written up but not dated and never prescribed. (18M)

3.13 On 10th January, Oramorph 10 mgs per 5 mls is written up for 2.5 mls four hourly and prescribed on the evening of 10th and the morning of the 11th. On the 11th Oramorph 10 mgs per 5 mls is written up to be given 2.5 mls 4 hourly 4 times a day with 5 mls to be given last thing at night. This is then given regularly between 11th and up to early morning on 15th January. This is a total daily dose of 30 mgs of Morphine (19M). The Lithium and Sertraline are crossed off after the 10th January.

3.14 Diamorphine 80 - 120 mgs subcut in 24 hours is written up on 11th January "as required" as is Hyoscine 200 - 400 micrograms in 24 hours, Midazolam 40 - 60 mgs in 24 hours. 80 mgs of Diamorphine together with 60 mgs of Midazolam are then started by syringe driver on the morning of the 15th January and re-started on both the mornings of the 16th and 17th January. (18M). On 16th January Haloperidol 5 mgs - 10 mgs subcutaneous for 24 hours is written up, prescribed over 24 hours on both 16th and 17th, 1 am not clear if this was mixed in the other syringe driver or was the "second pump" referred to in the nursing cardex. (20M and 27M)

Diamorphine 120 mgs subcut in 24 hours is then prescribed on 18th January, together with Hyoscine 600 mgs subcut in 24 hours. The drug charts (20M) show this starting on the morning of 17th January and at 08.30 hours. If this correct there may have been up to three syringe drivers running, one with Diamorphine 80 mgs, one with Diamorphine 120 mgs in and one with the Haloperidol. The reason for this confusion needs clarification, but is possibly a nursing error with the drug chart.

The subsequent drug charts all appear to be missing for the final 6 days, however the nursing notes (27M, 28M and 29) suggest that there was a fairly constant prescription of 120 mgs of Diamorphine 24 hours, Midazolam 80 mgs 24 hours, Hyoscine 1200 mgs, Haloperidoi 20 mgs and Nozinan 50 mgs. On the 20th there was no Haloperidol and the Nozinan was increased 100 mgs a day. This is still the prescription on 23rd January (27M).

Drug	Date prescribed	Prescribed as	Prescriber	Given
Oramorphine	10/01	10 mgs in 5 mls 2.5 mls, 4hrly oral Regular	Barton	10/01 2200 11/01 0800 (never crossed out)
Diamorphine	?	40 mgs S/C in 24 hours Regular	Barton	Never given or crossed off
NEW DRUG CHART				
Midazolam	?	20 - 40 mgs S/C in 24 hours Regular	Barton	Never given or crossed off
Diamorphine	11/01	80 – 120 mgs S/C in 24 hours PRN	Barton	15/01 ? 80 mgs 16/01 0815 80 mgs 17/01 ? 80 mgs
Midazolam	11/01	40 – 60 mgs S/C in 24 hours PRN	Barton	15/01 ? 60 mgs 16/01 ? 60 mgs 17/01 ? 60 mgs
Midazolam	? 16/01	80 mgs S/C in 24 hours PRN	Barton	Never given
Oramorphine	11/01	10 mgs in 5 mls Oral 2.5 mls 4 hourly Regular	Barton	Regular doses 4 times a day until 0600 on 15/01 No further doses Not crossed off
Oramorphine	11/01	10 mgs in 5 mls Oral 5 mls nocte	Barton	11/01 – 15/01 2200 No further doses Not crossed off
Diamorphine	18/01	120 mgs S/C in 24 hours	Barton	"17/01" 0830 120 mgs (probably 18/01)

4. TECHNICAL BACKGROUND AND EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider if there are any actions so serious they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Mr Leslie Pittock. Also if the actions or omissions by the medical team, nursing staff or attendant GP's contributed to the demise of Mr Pittock, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 In particular I will discuss a) whether Mr Pittock had become terminally ill and if so whether symptomatic treatment was appropriate and b) whether the treatment provided was then appropriate.

4.3 Mr Pittock has an unfortunate long history of depression, which had become more difficult and complex to manage and increasingly distressing in terms of his agitation related to his depressive symptomatology.

4.4 He had many treatments including high levels of drug treatment over many years and many episodes of electro convulsive treatment (ECT).

4.5 The complex and unresolved psychiatric problem led to a requirement to move to a residential accommodation in 1993. However he had further relapses and problems in 1995. A change occurred by September 1995 where the residential home was now noticing weight loss, increasing frailty and falls. Although a subsequent admission only came to the conclusion that he was depressed I have no doubt that his terminal decline was starting from that time.

4.6 By October 1995 he had extremely poor mobility and a shuffling gate. When re-admitted in December is aggressive, essentially immobile and extremely mentally distressed alongside his increasing physical frailty.

4.7 It is impossible in retrospect to be absolutely certain what was causing his physical as well as his mental decline. It may be that he was now developing cerebrovascular disease on top of his long standing drug induced Parkinsonism together with his persistent and profound depression agitation. It is not an uncommon situation for people with long standing mental and attendant physical problems, to enter a period of rapid decline without a single new diagnosis becoming apparent.

4.8 His deterioration is complicated by a probable chest infection (64, 81), which does not respond particularly well to appropriate antibiotic and physiotherapy treatment. He also has bowel complications attendant on all his other medical and drug treatment (116).

4.9 Dr Banks, psychiatric service asked Dr Lord, Consultant Geriatrician, to see the patient on 2nd January and he is actually seen on 4th January 1996. Dr Lord describes a very seriously ill gentleman. His comments that a long-stay bed will be found at the Gosport War Memorial and that he is unlike to return to his residential bed, reflect the fact that it was probably in his mind that this gentleman was probably terminally ill.

4.10 Mr Pittock is then transferred to Dryad Ward and is apparently seen by Dr Barton. A short summary of his problems is written in the notes but no physical examination, if undertaken, is documented. The lack of an examination, or record of an examination, if undertaken, would be poor clinical practice.

4.11 It remains clear from the nursing record that he remains extremely frail with very little oral intake on 7th January (25M). When seen again by Dr Barton on 9th, there is the first note suggesting that Opiates may be an appropriate response to his physical and mental condition.

4.12 It is my view that this gentleman by this stage had come to the end point of a series of mental and physical conditions and that his problems were now irreversible. The decision that he was now terminally ill and for

symptomatic relief seems to have been made appropriately with both the family and the ward staff and there was no disagreement with this decision.

This is indicated in the medical notes by the comment "for TLC" (13M) together with the statement that it was discussed with the wife "for TLC" (note TLC. tender loving care). Beyond the statement in the medical notes that the patient was "for TLC" there is no specific justification given for the Oramorph, in particular, to be started. The notes are at best very sparse making a full assessment of Mr Pittock's mental and physical state extremely difficult. In particular, there is a failure to offer any detailed assessment of the pain, agitation or distress he was in that would allow an objective view on his symptoms and prognosis. The lack of documentation is likely to mean that these detailed assessments did not take place.

4.13 On the 10th Oramorphine was started. Oramorphine and Diamorphine are particularly used for pain in terminal care. The nursing notes document that he had some pain; but most of his problems appeared to be restlessness, agitation and mental distress. However, despite the evidence of serious pain, morphine like drugs are widely used and believed to be useful drugs in supporting patients in the terminal phase of the restlessness and distress that surrounds dying. I would not particularly criticise the use of Oramorphine in conjunction with his other psychiatric medication at this stage. The decision is to stop non-palliative drugs like Sertraline was reasonable.

4.14

In my previous report for the police (31st Jan 2005) I wrote in paragraph 6.14:

"The Drug Chart analysis (para. 5.12) described Diamorphine, Hyoscine and Midazolam all written up to be prescribed with a dosage range. This is quite common clinical practice, the aim of which is to allow the nursing team to have some flexibility in the management of a patient needing symptom control at the end of their life without having to call a doctor to change the drug charts every time a change in dosage is needed to maintain adequate palliation."

As this could be misunderstood I wish to make it clear that this refers to the practice of allowing on the PRN side of the drug chart a small dosage range of a drug to be available for breakthrough pain or distress, as is normal in palliative care practice. It is not to support either (a) writing up large dosage ranges of drugs, or (b) the use of PRN side of the drug chart for prescription for syringe driver, both of which are poor medical practice.

4.15 The dose of Oramorph given from the early morning of 15th January was 30 mgs of morphine a day (see paragraph 3.13) (19M). On the 15th a syringe driver is started containing 80 mgs Diamorphine and 60 mgs of Midazolam. If a straight conversion is being given from Morphine to Diamorphine then you normally as a maximum halve the dose i.e. 30 mgs of Oramorphine might be replaced by 15 mgs of Diamorphine (Wessex protocol). If you are increasing the dose because of breakthrough agitation or pain then it would be normal to increase by 50% each day, some clinicians might increase by 100%. This would suggest that the maximum dose of Diamorphine to replace the stopped Oramorphine would be 30 mgs of Diamorphine in 24 hours. Starting 80 mgs of Diamorphine is approximately three times the usual expected dose. No justification is

provided in the notes for starting at approximately 3 times the dose.

I believe the dose of Oramorph originally prescribed between 11th and 15th January was appropriate if Mr Pittock was terminally ill by that stage. However, no justification is given within the notes for originally writing up the higher than usual doses of Diamorphine and Midazolam on 11th January, the same time as the Oramorph was started, nor indeed is any rationale made in the medical or nursing notes on the decision to commence the syringe driver on the 15th January. This lack of medical documentation is poor clinical practice, and without justification of the dosage used is likely to have been negligent clinical practice. Although the nursing cardex suggests it was Dr Barton's decision to start the syringe driver on the 15th (25M), nothing is recorded in the medical notes.

4.16 Midazolam was also started at a dose of 60 mgs per 24 hours. The main reason for using this is terminal restlessness and it is widely used subcutaneously in doses from 5 - 80 mgs per 24 hours for this purpose. Although 60 mgs is within current guidance, many believe that elderly patients need a lower dose of 5 - 20 mgs per 24 hours. This would again suggest that the patient was being given a higher starting dose of Midazolam then would usually be required for symptom relief. Where clinicians significantly deviate from standard clinical practice, it is poor clinical practice not to document that decision clearly.

The nursing notes documented anxiety, agitation and generalised pain for which the Midazolam and the strong opioids (Oramorph and Diamorphine) were started. Midazolam is often used for the restlessness of terminal care and although Oramorphine and Diamorphine are usually used for severe pain, in clinical practice it is often used as well for the severe restlessness of terminal care. One study of patients on a long stay ward (Wilson J.A et.al. Palliative Medicine 1987:149-153) found that 56% of terminally ill patients on a long-stay ward receive opioid analgesia. Hyoscine is also prescribed in terminal care to deal with excess secretions which can be distressing for both patient and carers. I believe this was appropriately prescribed and given.

4.17 Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Based on the evidence suggesting unusually high dosage of these medications being used I have considered whether there was evidence in the notes of any drug complications, in particular whether giving three times the normal starting dose for both Diamorphine and Midazolam together caused excessive sedation or other side effects that might be considered negligent. I was only able to find two pieces of evidence. The first was a statement in the nursing notes (26M) that by the evening that the syringe driver was started, the patient was unresponsive. The aim of palliative care is to provide symptom relief not possible over sedation leading to unconsciousness. However, this did not continue and Mr Pittock was noted to be more alert and agitated again on the 16th.

Secondly on the 21st January (15M) a respiratory rate of 6 per minute is noted suggesting some possible respiratory depression.

4.18 A further drug, Nozinan, a sedating major tranquilliser is added to the drug regime, 50 mgs a day on the 18th January and increased to 100 mgs a day on the 20th January. Though this is within the therapeutic range in

palliative care, 25 - 200 mgs a day when it is used for nausea and vomiting, the BNF advises 5 - 20 mgs a day and that the drug should be used with care in the elderly because of sedation.

The rationale for starting Nozinan appears to be the fact that the patient had become unsettled on Haloperidol (a different sort of major tranquilizer) and Nozinan is more sedating that Haloperidol. A verbal order to increase the dose of Nozinan from 50 to 100 mgs is documented in the medical notes (M15). This suggests that the 100 mgs was not actually written up within the Drug Charts, which if true, would be poor clinical practice. The absence of the drug charts makes this harder to determine.

4.19 The prediction of how long a terminally ill patient would live is virtually impossible and even palliative care experts show enormous variation (Higginson I.J. and Constantini M. Accuracy of Prognosis Estimates by 4 Palliative Care Teams: A prospective cohort study. BMC Palliative Care 2002 1:21). The combination of the high doses of Diamorphine, the high doses of Midazolam and the high doses of Nozinan are in my view likely to have caused excessive sedation beyond the need the symptom control in this dying man. In my view the medication is likely, but not beyond reasonable doubt, to have shortened life. However, I would have expected this to have been by no more than hours to a few days had a lower dose of all, or indeed any, of the drugs been used instead.

5. OPINION

5.1 Mr Leslie Pittock was an 83 year old gentleman with a long recurrent history of severe depression resistant to treatment. This was complicated by drug induced parkinsonism and subsequent mental and physical frailty and dependency. His admission to the Gosport War Memorial Hospital Mental health beds on the 29th November and subsequent transfer to a medical bed on the 5th January 1997 was the end point of these chronic disease process. He continues to deteriorate and dies on the 24th January 1997.

5.2 However there were significant failings in the medical care provided to Mr Pittock, in particular:

- The failure to undertake a physical examination of the patient on admission to the medical ward at the Gosport War Memorial Hospital, or if it was undertaken, the failure to record in the notes.

- The prescription of a high dose of Diamorphine (40 – 80 mgs) on the PRN part of the drug char ton admission, without explanation.

- The failure to document a detailed assessment of his pain and distress in the notes prior to starting regular opioid treatment.

- The use of approximately 3 times the usual expected daily dose of Diamorphine when starting the syringe driver, together with a dose of 60 mgs of Midazolam, without any explanation in the notes, in my view negligent clinical practice.

5.3 There were also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The failure to cross off the regular prescription of Oramorphine and Diamorphine when rewritten on the 11th January and on the 15th January.

- The use of the PRN side of the drug chart to write up regular syringe driver medication for PRN use.

- The failure to date several prescriptions.

- Inaccurate information on the drug chart for the prescription of the Diamorphine on the 18th January.

- The failure to write dosages of controlled drugs in words and figures as well as total dosages given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which 1 have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, 1 have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. 1 will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. 1 understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature:, _____. Date:_____