# INQUIRY UNDER THE FATAL ACCIDENT AND INQUIRIES ACT INTO THE SUDDEN DEATH OF KENNETH PITT

## SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

***INQUIRY HELD UNDER***
***FATAL ACCIDENTS***
***AND***

***SUDDEN DEATHS***

***INQUIRY (SCOTLAND)***

***ACT 1976***

***SECTION 1(1)(a)***

***SECTION 1(1)(b)***

DETERMINATION by SAMUEL CATHCART, Esquire, Advocate, Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on the 20 March, 19, 20, 21, 22 and 23 June and 10 and 25 July all 2006 into the death of KENNETH PITT

GLASGOW, 27 July 2006.

The Sheriff, having considered all the evidence adduced, DETERMINES:

in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Section 6(1):

(a) that Kenneth Pitt, born 7.6.76, who resided at 67 Clober Road, Milngavie, Glasgow died at the Western Infirmary, Glasgow at 1745 hours on 28 May 2003;

(b) that the cause of death was Pulmonary thromboembolism;

(c) that there were no reasonable precautions whereby his death might have been avoided;

(d) that there were no defects in any system of working which contributed to his death;

(e) that:-

*Psychiatric condition*

(1) Kenneth suffered from psychotic symptoms which required treatment by anti-psychotic drugs. In addition to this he may have been experiencing Asperger's Syndrome. Before any Asperger's Syndrome could be attended to, it was appropriate that Kenneth's psychotic symptoms be dealt with.

(2) Between 1995 and 1997, Kenneth was treated as an out-patient by Dr David Brown, Consultant Psychiatrist, Gartnavel Royal Hospital, Glasgow.

(3) During this period Dr Brown treated Kenneth by prescribing a variety of different drugs.

(4) It was Kenneth's view and that of his parents that anti-psychotic, as opposed to anti-depressant, medication was not appropriate for his condition.

(5) Kenneth did not take the medication as prescribed for him by Dr Brown.

(6) Kenneth's parents were strongly against Kenneth being forced to take medication.

(7) Between 1995 and 1997, Kenneth did not respond to the medication prescribed by Dr Brown.

(8) Dr Brown did not see Kenneth between September 1997 and June 01.

(9) Between 1999 and 2003, Kenneth was employed by the Royal Mail. He was off work from October 2002 until May 2003.

(10) When Kenneth was next seen by Dr Brown in June 2001 his condition was as it had been in September 1997. He was prescribed medication with which he did not comply.

(11) Between June 2001 and January 2003, Dr Brown prescribed a number of alternative drugs, arranged for Kenneth to have two CT scans and a consultation with a consultant psychologist.

(12) In January 2003, Kenneth was referred to the Intensive Community Treatment Team and remained in contact with them for the following three months.

(13) When Kenneth was reviewed by Dr Connolly, Consultant Psychiatrist, in February 2003, she could make no definitive diagnosis.

(14) On 29 April 2003, Kenneth was discharged from the Intensive Community Treatment Team, there being no significant change in his condition.

(15) On 5 May 2003, at the request of his family, Kenneth was seen at home by Community Psychiatric Nurses and admitted as an emergency to the McNiven (now McNair) ward of Gartnavel Royal Hospital under the care of Dr Brown.

(16) Kenneth was admitted as an informal patient and on admission was very distressed. He displayed poor insight and blamed anti-psychotic medication for his problems.

(17) In the McNiven ward, he was placed under constant observation.

(18) On 6 May 2003, Kenneth was seen by Dr Brown who was of the view that Kenneth may need to be given depots, ie. intra muscular injections against his will, at some time in the future, if he continued to refuse oral medication.

(19) On 7 May 2003, Kenneth was detained under Section 25 of the Mental Health (Scotland) Act 1984.

(20) At a multi-disciplinary team meeting on 7 May 2003, it was decided to prescribe risperidone and sertraline in the hope that Kenneth would take this medication voluntarily.

(21) At a multi-disciplinary team meeting on 9 May 2003, Kenneth appeared less thought disordered and less distressed.

(22) As his condition was known to fluctuate Kenneth was further detained under Section 26 of the Mental Health (Scotland) Act 1984.

(23) On 10 May 2003, Kenneth's condition appeared to settle and improve.

(24) On 11 May 2003, Kenneth was transferred to Rutherford ward as that was the ward for his locality and a bed had become available.

(25) On 12 May 2003, Kenneth's improvement appeared to continue. He was allowed a two day pass out of the hospital.

(26) From 14 May 2003 Dr June Ellison, Specialist Registrar, was responsible for Kenneth's in-patient care under the supervision of Dr Brown.

(27) On 14 May 2003, Kenneth was allowed a pass for a further two days.

(28) On 16 May 2003, Dr Ellison telephoned Kenneth's mother advising that Kenneth should be returned to the ward. Kenneth's parents were reluctant to return him and a compromise was reached that he would be returned on 19 May 2003.

(29) On 19 May 2003, Kenneth returned to hospital and was examined by Dr Ellison.

(30 Prior to 27 May 2003, Dr Ellison spoke by telephone to Dr John Cameron, a psychologist with a particular expertise in Asperger's Syndrome, requesting that he assess Kenneth. She was told that Mr Cameron would not assess Kenneth while he was acutely unwell and that it was important to treat his psychotic symptoms prior to assessment.

(31) Dr Ellison wrote a full letter (Crown Pro.2 p.6) to Mr Cameron on 27 May 2003 requesting that he assess Kenneth. At that time Mr Cameron had a waiting list of three to four months.

(32) Dr Ellison next saw and examined Kenneth on 21 May 2003.

(33) Dr Ellison next saw and examined Kenneth on 23 May 2003 when she felt that his mental state was deteriorating.

(34) Dr Ellison telephoned the ward on 27 May 2003 when she was reassured by the information given to her and did not attend to examine Kenneth.

(35) On 28 May 2003, Dr Ellison attended a ward meeting relative to Kenneth's condition.

*Physical condition*

(36) From the time of Kenneth's admission on 5 May 2003, there was considerable concern about his food and fluid intake.

(37) Kenneth refused the food and fluid offered by hospital staff but took some food and fluid provided by his parents.

(38) On his return to hospital on 19 May 2003, Dr Ellison examined Kenneth and found him to be reasonably well hydrated.

(39) A blood sample taken from Kenneth on 20 May 2003, revealed that he was not dehydrated.

(40) On 21 May 2003, Kenneth was examined by Dr Ellison who noted that he had dry mucous membranes. She ordered that a fluid balance chart be created with co-operation from Kenneth's parents.

(41) From 21 May 2003 until Kenneth's death there were deficiencies in the keeping of these fluid balance charts. The charts were not completed appropriately. In relation to some days, no chart had been completed at all. On other days the charts did not fully record the relevant information.

(42) A blood sample taken from Kenneth on 23 May 2003 revealed that he was not dehydrated.

(43) A blood sample taken on 28 May 2003 revealed that Kenneth was suffering from mild to moderate dehydration. A patient with such a blood result would normally be told to drink two to three litres of water per day, rather than immediately being put on intravenous fluids.

(44) Kenneth did not die of dehydration.

(45) Throughout his stay in hospital Kenneth was relatively immobile in that he spent long periods in bed. He was not, however, clinically immobile.

(46) Kenneth`s father requested physiotherapy for him. This was not provided.

(47) It is highly unlikely that anti-psychotic medication played a part in the development of the pulmonary thromboembolism.

(48) It is extremely unlikely that Kenneth's relative immobility and mild-moderate dehydration on their own caused the pulmonary thromboembolism.

(49) It is extremely likely that some other pathology existed, namely, a thrombophilia, an inherited or acquired clotting disorder.

(50) Kenneth's relative immobility and mild-moderate dehydration would not normally have qualified him for thromboembolic disease prophylaxis.

(51) On 28 May when Kenneth's room was visited to ask him to attend the ward meeting he was found collapsed in the toilet. He could not be resuscitated. He was transferred with active resuscitation to the Western Infirmary, Glasgow. Resuscitation was unsuccessful and he was pronounced dead in the Western Infirmary.

**NOTE:**

At this Inquiry the Crown was represented by Mr. McGeehan, Principal Procurator Fiscal Depute; Mr Hugh Pitt, the father of Kenneth represented the relatives of the deceased; Mrs Robertson, Solicitor, represented Doctors Brown and Ellison; Mr Wightman, Solicitor and later Mr McKenzie, Advocate, represented Greater Glasgow Health Board and Gartnavel Royal Hospital. Although Mr Pitt had applied for legal aid this had been refused. Having heard his evidence on the first day of the Inquiry it was clear that he blamed Drs Brown and Ellison for the death of his son and that he did not regard the medical records as being accurate. It seemed to me that Mr Pitt's position was sufficiently different from that of the Crown to justify separate legal representation and accordingly, through my clerk, I wrote to Mr Pitt's solicitor suggesting that the Legal Aid Board be invited to reconsider its decision to refuse legal aid. I was informed by Mr Pitt's solicitor by letter, that he had advised Mr Pitt that there would be no point in lodging a fresh legal aid application and accordingly Mr Pitt was unrepresented when the Inquiry recommenced on 19 June 2003.

During the course of the Inquiry the procurator fiscal depute called the following witnesses:-

1 Hugh Pitt, 67 Clober Road, Milngavie, Glasgow.

2 Dr David Brown, c/o Arundale Resource Centre, 80/90 Kinfauns Drive, Glasgow.

3 Dr Julie Ellison, c/o Intensive Community Treatment Team, 2 Whittinghame Gardens, 1091 Great Western Road, Glasgow.

4 Dr John Callender, c/o Adult Mental Health Directorate, Royal Cornhill Hospital, Aberdeen.

5 Michael Gribben, c/o McNair Ward, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow.

6 Archibald Murray Ferguson, c/o Rutherford Ward, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow.

7 Robert Scott McNair, c/o Lomond Drug Problem Services, Dumbarton Joint Hospital, Dumbarton.

8 Julie Macleod, c/o Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow.

Mr McKenzie called Dr John Dick, Consultant Physician, Vascular Team, Ninewells Hospital, Dundee as a witness.

***Evidence***

In addition to the evidence of Mr Pitt, the court had the benefit of a report prepared by Mr Pitt and his wife in which they listed a number of concerns about Kenneth's treatment. Their main concerns were that:-

1 Kenneth was not suffering from psychotic illness but was experiencing Asperger's Syndrome, and as such, should not have been prescribed anti-psychotic medication.

2 Kenneth became dehydrated in Gartnavel Royal Hospital due, in part, to the high temperature in his room.

3 Kenneth should have received physiotherapy because of the stiffness/pain in his legs due to the extent of his immobility in hospital.

4 The hygiene standards in Kenneth's room were unacceptable.

5 The medical records were inaccurate.

6 Kenneth had been forced to take a tablet against his will.

Drs Brown and Ellison gave evidence, with the assistance of the medical records, of Kenneth's mental and physical condition and of the treatment provided by them. Their evidence, which I accepted as credible and reliable is reflected in the above findings under Sections 6(1)(e). They were clear that it had not been established that Kenneth had Asperger's Syndrome, but that even if he did have Asperger's Syndrome, he had, in addition, psychotic symptoms. It was their view that the psychotic symptoms had to be treated before addressing Asperger's Syndrome. In considering the reliability of their evidence I also had regard to the evidence of Dr Callender. He had no involvement in Kenneth's treatment, but had been asked to provide an independent assessment. It is clear from his report (Crown production no. 3) and indeed his evidence, that he was not in any way reluctant to criticise those involved in Kenneth's care at Gartnavel Royal Hospital. I will deal with these criticisms in due course but it was Dr Callender's evidence, as I understood it, that he was also of the view that Kenneth was suffering psychotic symptoms which merited treatment by anti-psychotic medication. From the evidence I heard and in particular that of Drs Brown, Ellison and Callender, I came to the view that Kenneth was suffering from psychotic symptoms which merited treatment by anti-psychotic medication. I did not come to the view, on the evidence before me, that Kenneth was experiencing solely Asperger's Syndrome. Before addressing Mr Pitt's other concerns, I will deal with the evidence given by Dr Callender. I accepted that his area of expertise was psychiatry. Although Dr Callender had been sent papers by the Crown, including a copy of the post-mortem report, his report, in its initial form stated the cause of death to be "dehydration". The cause of death in the post-mortem report was Pulmonary thromboembolism. It was clear from the evidence at the Inquiry that

Kenneth did not die of dehydration. I was, therefore, concerned about the reliability of Dr Callender's evidence. When cross-examined by Mr McKenzie, Dr Callender stated that he may have meant the effects of dehydration. However, upon being questioned further, he agreed that dehydration was outwith his particular area of expertise. It seemed to me that Dr Callender's report took as it starting point the wrong cause of death and, on his own evidence, involved a cause of death which was out with his area of expertise. I came to the view, therefore, that his evidence had to be viewed with some caution. It was only when the procurator fiscal depute drew his attention to the correct cause of death in the post-mortem report that Dr Callender's report was altered, although in the main, the rest of his report remained unchanged. I did not attach weight to the evidence of Dr Callender when it was outwith his own area of expertise. While Dr Callender was in agreement with Drs Brown and Ellison in that Kenneth suffered psychotic symptoms, there was dispute in relation to when anti-psychotic medication should have been given forcibly to Kenneth by way of "depot" injections. In deciding to delay "depot" injections, Drs Brown and Ellison took into account *inter alia* the following factors:- (1) the importance of observing and assessing Kenneth before considering the best course of treatment; (2) the importance of trying to build a relationship of trust with Kenneth and his family in order to encourage Kenneth to take oral medication voluntarily; (3) Kenneth's view and that of his family that he should not take anti-psychotic medication; (4) the importance of choosing the least restrictive treatment option which recognised Kenneth's autonomy;(5) that a depot injection was a treatment of last resort and that if Kenneth had been given an injection forcibly this may have had an adverse effect on him seeking psychiatric help in the future; (6) that there was an improvement in Kenneth's symptoms on or about 9 May 2003; (7) depot medication was likely to have unpleasant side effects; (8) there was no evidence of physical deterioration until the blood results of 28 May 2003 and there was no evidence of immediate physical risk. Dr Callender on the other hand was of the view that depot injections should have been given. In his report Dr Callender states:

"A more vigorous use of anti-psychotic medication might have allowed a degree of improvement in Mr Pitt's mental state and thereby improved his intake of food and fluids. However, it is likely that this would only have been possible by forcibly injecting him. This is a procedure that most clinical technicians are reluctant to undertake for reasons such as respect for autonomy. If family members are also strongly opposed then it becomes doubly difficult to proceed. Nevertheless, Mr Pitt was detained in hospital under the Mental Health Act. If the freedom of patients is to be curtailed in this way then this carries with it an entitlement to effective treatment of the illness that lead to the need for detention".

In my view, while there may well be force in the view taken by Dr Callender, it cannot be said that Drs Brown and Ellison were in error in delaying depot injections, in particular, in view of the anti-psychotic medicine stance taken by Kenneth and his family. Mr Pitt was clear in his evidence that he would have regarded forcibly injection as unacceptable. In fairness to Dr Callender he agreed that the decision of Dr Ellison to give Kenneth one final opportunity to comply with medication on 23 May 2003 before proceeding to depot injections, in view of the imminent holiday weekend and her wish to discuss the matter with Kenneth's parents first was not unreasonable. Dr Callender accepted in cross-examination that there was no guarantee that depot injections would have been effective. Further, Drs Brown,

Ellison and Callender were agreed that it would have taken at least two weeks for depot injections to have a therapeutic effect. Accordingly, even if given at a time after his return on 19 May this would not have prevented Kenneth's death.

In relation to immobility and dehydration I heard evidence in addition to Mr Pitt and the medical staff, from three members of the nursing staff at Gartnavel Royal Hospital. It is clear from the evidence led and from medical records that there was concern about Kenneth's food and fluid intake. I accepted the evidence that Kenneth would not take food or fluid offered by hospital staff but that his parents were able to persuade him to take some food and liquid. Dr Ellison examined Kenneth on two, possibly three, occasions in relation to dehydration. Three blood samples were taken from him and analysed. Two of these were normal and only the third on 28 May showed mild to moderate dehydration. I accepted Mr Pitt's evidence that the temperature in Kenneth's room was excessively high. This evidence was supported, to some extent, by Nurse Robert McNair. A fluid chart should have been commenced on 21 May but this did not take place. No satisfactory record was kept between the time of the decision to keep such charts and the date of Kenneth's death. Medical and nursing staff were aware of the concern about Kenneth's food and fluid intake but the fact remains, nevertheless, that on 28 May Kenneth was suffering from mild to moderate dehydration and the decision to chart his food and fluid intake had not been implemented. While I concluded that the decision to commence charting Kenneth`s food and fluid intake was not implemented appropriately, I accepted evidence that medical and nursing staff were aware that this was an area of concern. In light of this and other evidence, in particular, that of Dr. Dick, I considered, but concluded that it was inappropriate to make any finding under Section 6(1)(c ) or (d ).

In relation to Kenneth's immobility, I accepted that he spent many hours on or in his bed although he was able to visit the toilet and go to the telephone. As such, I concluded that while Kenneth was relatively immobile, he was not clinically immobile. In relation to physiotherapy, it was Mr Pitt's evidence that he requested this repeatedly for Kenneth. A document, Crown production no. 8, produced by Julie MacLeod who prepared a critical incident review report disclosed that of 12 members of the nursing staff who were asked about this, all stated that no request had been made of them by Kenneth's family for physiotherapy. I accepted as credible and reliable the evidence of Mr Pitt when he said that he did ask for physiotherapy. I did so, in part because he was able to describe the clothing of the person of whom the request was made and exactly where in the hospital the request was made, and in part because of my assessment of Mr Pitt's demeanour at the Inquiry. He struck me as the sort of person who would not hesitate to request physiotherapy for his son if he thought this appropriate. I also accepted his evidence that physiotherapy was not provided for Kenneth.

The Inquiry heard evidence from Dr John Dick, Consultant Physician - Vascular Team, Ninewells Hospital, Dundee. Dr Dick gave evidence with the assistance of his report,( production no. Clo. 1). Dr Dick was not involved in Kenneth's treatment but he had been asked to provide an independent assessment in relation to Kenneth's physical condition and the treatment or lack of treatment provided. Dr Dick gave evidence that immobility can give rise to the risk of pulmonary embolism or DVT. In his use of the word immobility he explained that he meant someone not able to get out of bed, not able to flex calf muscles, not able to move for four or five days or

someone in a catatonic state. From the information provided to Dr Dick he concluded that Kenneth was not someone whom he would describe as immobile but rather as someone who was relatively immobile. It was his view, having considered the blood chemistry results of 28 May 2003 that Kenneth was experiencing a mild to moderate degree of dehydration. It was his opinion that the relative immobility and "modest" dehydration were not in themselves enough to have caused the large pulmonary embolus found at post-mortem examination. In relation to anti-psychotic medication, it was Dr Dick's opinion that it was "highly unlikely that this played a part in the development of the pulmonary embolus". According to Dr Dick there was no evidence that physiotherapy as such prevents deep vein thrombosis. He said that it was extremely likely that the embolus started in the pelvis as no residual clot was found at autopsy and also in light of the size of the clot. He continued that clots in the pelvis are unlikely to give rise to symptoms. It is likely that the clot formed in Kenneth's pelvis 48 hours before death. As relative immobility and modest dehydration are not in themselves enough to cause the large pulmonary embolus found, Dr Dick opined that it was extremely likely that some other pathology existed. Dr Dick strongly suspected that Kenneth had a thrombophilia, an inherited or acquired clotting disorder. It was his opinion, that because of this thrombophilia or underlying condition that the modest dehydration and relative immobility acted to trigger the clot. It was his evidence that it was not practice to screen all patients for thrombophilia. Relative immobility and a modest dehydration would not normally have qualified for Kenneth for thromo-embolic disease prophylaxis given his age and lack of other pathologies. It was Dr Dick's view that Kenneth's death was not foreseeable.

I had no difficulty whatsoever in accepting Dr Dick's evidence as credible and reliable. He showed considerable care in responding to questions and his answers were full and convincing.

I accepted Mr Pitt's evidence that the toilet in Kenneth's room was not functioning properly and that dead flies could be seen on the windowsill. Again some support for Mr Pitt's evidence was found in that of Nurse McNair at least in relation to the toilet. These are not, however, matters which, in my view, have a direct bearing on Kenneth's death.

From the evidence I heard I am unable to conclude that the medical or nursing records had been amended nor that they did not record events accurately.

From the evidence led at this Inquiry, I am unable to conclude that Kenneth was forced to take a tablet by medical or nursing staff.

I have dealt with Mr. Pitt`s concerns above. I do not propose to rehearse the submissions made by the Crown, Mrs. Robertson or Mr. McKenzie as these were to a large extent consistent and were upheld by me .

I would like to express my sympathy and condolences to the Pitt family and, particularly, to Hugh Pitt who gave evidence and represented his family at the Inquiry. I hope this Inquiry has assisted them in coming to terms with their tragic loss.