STATEMENT OF DR JANE BARTON

RE: ENID SPURGIN

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, Mrs Enid Spurgin. Unfortunately, at this remove of time I have no recollection at all of Mrs Spurgin. 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 Mrs Spurgin.

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 Barthel 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. The statement largely represented the position at the GWMH in 1998.

I confirm that these comments are indeed a fair and accurate summary of the position then, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mrs Spurgin.

4. Mrs Enid Spurgin was 92 years of age and lived alone in a bungalow, together with her greyhound. I am unable to relate anything of significance in relation to her medical history, being unable to recall Mrs Spurgin at this remove of time, and only very limited previous medical records have been made available to me. From the documentation which has been produced, it appears that in November 1997 she was referred to a Consultant in Elderly Mental Health, seemingly suffering with depression. The Consultant, Dr Mears, carried out a domiciliary visit and reported that Mrs Spurgin had lost interest in the things she previously enjoyed. She had fleeting suicidal ideas, and she described Mrs Spurgin's mood as depressed and hopeless. Dr Mears diagnosed that Mrs Spurgin was suffering from a depressive illness relating to failing physical health and her loss of independence. Mrs Spurgin had been taking Domperidone, and prior to that Prothiaden, but Dr Mears decided that she should try a very small dose of Citalopram. She planned to arrange for the Community Psychiatric Nurse to call to offer support and counselling.

5. Consequent on that assessment Dr Mears then wrote to the Community Psychiatric Nurse on 12th November 1997 asking her to call in to see Mrs Spurgin saying that she had become depressed over the last couple of months, that her physical health was failing and she was losing her independence. The Community Psychiatric Nurse (CPN) duly saw Mrs Spurgin and reported to Dr Mears the following January that poor short-term memory appeared to be her primary problem, and her main concern was poor eyesight and her consequent loss of independence.

6. It appears that she reported a number of falls in the course of 1998 due to her dog pulling her over.

7. Mrs Spurgin was also referred in turn by the CPN to Occupational Therapy for help aids to daily living. A number of suggestions were made to her including a bubble bath which Mrs Spurgin compared to "having a bath with a cobra". Other modifications were, apparently more helpful, including grab rails and a Bath Knight. She was discharged from CPN follow-up, apparently in good spirits, in January 1999.

8. On 19th March 1999 Mrs Spurgin fell and fractured her right leg femur. She was admitted to the Royal Hospital at Haslar, and the following day had a dynamic hip screw inserted. By 26th March it appears that she was considered well enough to be transferred to Dryad Ward at the GWM Hospital for rehabilitation, although I do not know anything of the circumstances in which she came to be admitted, in the absence of medical records in that regard.

9. The nursing note accompanying Mrs Spurgin on her transfer to the GWMH suggested that she was mobile from bed to chair with the assistance of 2 people and could walk short distances with a Zimmer frame. She was said to have no urinary symptoms, but despite being continent during the day she was sometimes incontinent at night. Her skin was described as "paper thin" and so no TED stockings had been given to her following the operation. Her right lower leg was very swollen and had a small break on the posterior aspect. She apparently needed encouragement with eating and drinking but could manage independently. Her only medication at that time was Paracetamol as required.

10. I admitted Mrs Spurgin to Dryad Ward, and my note in this regard in her record reads as follows :-

"26-3-99 Transfer to Dryad Ward

HPC # no femur ®19-3-99

PMH - nil of significance

Barthel xxxxx

not weight bearing

tissue paper skin

not continent

Plan sort out analgesia"

11. Mrs Spurgin had been discharged from the Royal Hospital Haslar relatively shortly after her fracture and operation and I believe we were concerned to reassess her wound and ensure that she should have adequate analgesia, anticipating that she would be in pain. A Nursing Care Plan for 26th March 1999 records that swabs were to be taken, with MRSA screening, and steps taken by the nursing staff to prevent infection. Resulting reports confirm that swabs were taken that day from the nose, throat, groin and wound, all being negative for MRSA. I also authorised blood tests.

12. A nursing entry for 26th March recorded that Mrs Spurgin was experiencing a lot of pain on movement. Her named nurse, Lyn Barrett, also noted that Mrs Spurgin was experiencing a lot of pain on movement. She advised giving prescribed analgesia and monitoring the effect. Concerned to ensure that she had adequate pain relief, I prescribed Oramorph in a 10 mg/5ml solution, 2.5mls 4 hourly, with a further 5mls at night. I also wrote up a further PRN prescription for Oramorph to

be given as necessary - representing a further 2.5/5 mls 4 hourly as required. As Oramorph might bring about constipation, I prescribed Lactulose, 10mls twice a day.

13. The nursing records for 26th March record that Mrs Spurgin was admitted for rehabilitation and gentle mobilisation, and that in Haslar she was mobile with a Zimmer frame and two nurses for short distances, the transfer apparently being satisfactory. It was noted, however, that transfer had been difficult since admission, and that she was complaining of a lot of pain for which she was receiving Oramorph regularly with effect.

14. The nursing staff confirmed that Mrs Spurgin's skin was very fragile and a Waterlow pressure sore score produced a figure of 32, a figure of 20 or more indicating very high risk. In consequence, Mrs Spurgin had a Pegasus B-wave mattress in an attempt to prevent the development of pressure sores.

15. Following my prescription, Mrs Spurgin did indeed receive Oramorph on 26th March, 2 doses of 5mgs followed by a further 10mgs that night. The nursing entry for the night of 26th March records that she required much assistance with mobility due to pain/discomfort. A further 5mgs Oramorph was then given early the following morning.

16. The following day, 27th March was a Saturday, but I believe that I was on duty that weekend and would have visited the ward on the Saturday morning, and would therefore have assessed Mrs Spurgin's condition although I did not have an opportunity to make an entry in her records. Her nursing entry record for 27th March noted that Mrs Spurgin was having regular Oramorph but was still in pain. I anticipate that when I

assessed her on the morning of 27th I was concerned that the Oramorph previously administered had not been adequate in relieving pain, and the drug chart shows that I increased the prescription accordingly, prescribing 10mls of Oramorph to be given 4 times a day, with a further 20mls at night. With 5mgs having been given at about 6.00 am, a further 20 mgs were given in the course of the day. It was not considered necessary to administer Oramorph at 6.00 pm, but the 20mg dose was then given at 10.00 pm, representing a total of 45mgs that day.

17. Further Oramorph was then given the following day, 28th March, with 2 lots of 10mgs being administered in the morning as prescribed, but thereafter it was discontinued. The nursing entry records that Mrs Spurgin had been vomiting with the Oramorph and that I advised that it should be stopped. I anticipate that I was contacted by the nursing staff, being on duty that weekend, and I advised that in view of the vomiting the Oramorph should be discontinued. I asked that Mrs Spurgin should be given 2 tablets of Co-Dydramol 4 times a day, together with Metoclopramide 10mgs, to be given as required. Both drugs are written up on the drug chart as having been authorised by me, and I subsequently endorsed the prescriptions with my signature.

18. I would then have reviewed Mrs Spurgin again the following morning, Monday 29th March and I anticipate I hoped that the Co-Dydramol might be successful in relieving the pain at that time. The nursing records show that Mrs Spurgin's wounds were re-dressed, and further swabs were taken from the wound site and from the axilla to test once more for MRSA and other infection. There is an entry in the Nursing Care Plan signed by Lyn Barrett requesting further swabs in this regard. The swabs were subsequently reported as being negative for infection.

19. I also prescribed Senna tablets on 29th March for constipation.

20. Dr Ian Reid, Consultant Geriatrician, under whose care Mrs Spurgin had been admitted, would generally carry out a weekly ward round, but there is no entry recorded for the week commencing 29th March and I am unable now to say if he saw Mrs Spurgin in the course of that week. I would, however, have reviewed Mrs Spurgin again the following day, 30th March. The nursing staff noted that her wounds were re-dressed, Mrs Spurgin having a wound on her calf in addition to the wound on her hip at the site of operation. One wound was said to be oozing slightly.

21. Unfortunately, the Co-Dydramol appears to have been inadequate in relieving Mrs Spurgin's pain. I believe I would have reviewed Mrs Spurgin again on 31st March, and there is an entry on the drug chart recording a prescription by me for 10mgs of Morphine Sulphate to be given twice a day. The first dose was administered at 9.30 am that morning, and I anticipate this would have been in consequence of inadequate pain relief from the Co-Dydramol, although again I did not have an opportunity to make a specific entry in Mrs Spurgin's records. The nursing notes, however, record the fact that she was commenced on 10mgs of Morphine Sulphate twice a day, and that when she walked with the Physiotherapist she was in a lot of pain. It appears that in addition to the Morphine Sulphate given that day, 5mg Oramorph was given at 1.15 pm for pain, that being available through my original PRN prescription, but apparently with not much effect.

22. A further 10mgs of Morphine was given at 8.00 pm in accordance with my prescription.

23. On 31st March her wounds were re-dressed once more, and there is reference in the nursing notes to a wound on her ankle, reflecting the fact that her skin was indeed very fragile.

24. Unfortunately, the Morphine Sulphate appears to have been unsuccessful in alleviating Mrs Spurgin's pain entirely. The nursing record indicates that she was still having pain on movement the following day, 1st April.

25. The following day, 2nd April Mrs Spurgin was now noted as having a small wound on her arm. She continued to have Morphine Sulphate, 10mgs twice a day, but on 3rd April it was again noted that she still continued to have pain on movement even with the Morphine Sulphate.

26. I would not have seen Mrs Spurgin over the course of the weekend 3rd/ 4th April, but anticipate that I would have reviewed her condition again on the following Monday, 5th April.

27. I saw Mrs Spurgin again the following morning, 6th April, and although I would not have had an opportunity to make a specific note in her records, I believe that as she was experiencing pain which was still not adequately controlled by the Morphine Sulphate, I was concerned to increase the dose of Morphine Sulphate to 20mgs twice a day. 10mgs had been administered at 8.00 am, but 20mgs were then given at 8.00 pm that evening.

28. I believe I was also concerned at the possibility that Mrs Spurgin was now developing an infection from her wounds. On 6th April the nursing staff noted that the wound in her right hip was oozing large amounts of serous fluid and some blood. Swabs were taken from the wound on her

calf, and staphylococcus infections were subsequently reported to us several days later.

29. On 7th April the nursing staff recorded that the fracture site was red and inflamed, and Mrs Spurgin was seen by me, with my indicating that she should be commenced on Metronidazole and Ciprofloxacin, and I anticipate that I was concerned Mrs Spurgin was developing an infection and should commence these antibiotics even in advance of the results of the swabs.

30. Dr Reid saw Mrs Spurgin the same day in the course of what I anticipate was a ward round, and noted specifically that she was still in a lot of pain and was very apprehensive. He also recorded the fact that the Morphine Sulphate had been increased to 20mgs twice a day the previous day. He advised that Flupenthixol, a minor antidepressant should be given and he wrote up a prescription for the Flupenthixol on her drug chart accordingly. He also asked that an x-ray of Mrs Spurgin's hip should be undertaken as movement was still quite painful and there appeared to be a 2 inch shortening of her right leg. I am unable now to say what the x-ray demonstrated as there is no report available in the medical records provided to me.

31. The nursing record confirms that x-ray was arranged for the following day at 3.00 pm.

32. I anticipate that I would have seen Mrs Spurgin again on 8th and 9th April, and noted that her condition remained essentially unchanged - that she was in a lot of pain as recorded by Dr Reid on 7th April in spite of the fact that she was now taking 40mgs of Morphine Sulphate a day. On 8th April it was reported by the nurses that the wound on her hip

was oozing slightly overnight and the redness of the edges of the wound was subsiding. A nursing entry on 9th April records that she was to remain in bed and rest until Dr Reid had seen the x-ray of her hip, suggesting that the x-ray was in fact undertaken.

33. On 9th April Mrs Spurgin was catheterised as she had become incontinent and was in great pain when toileted. Her urine was very concentrated, as she was not drinking. The catheter drained 500mls urine over night.

34. Unfortunately, it appears that Mrs Spurgin's condition deteriorated over the weekend of 10th/11th April. The nursing entry on 10th April records that she had a very poor night. She was said to be leaning to the left, did not appear to be as well, and was experiencing difficulty in swallowing. The reference to her leaning to the left raised the possibility that Mrs Spurgin might have had a cerebro vascular accident. The stitch line from the site of the operation was said to be inflamed and hard, with a complaint of pain from Mrs Spurgin. It appears in consequence of the pain my original PRN prescription for Oramorph was utilised, 5mgs of Oramorph being given at 7.15 am on 11th April by Night Nurse Code A

35. An assessment of the wound the same day, 11th April, by the nursing staff indicated that the wound was not leaking, but the hip felt hot and Mrs Spurgin was complaining of tenderness all around the site. She was said to be very drowsy and irritable.

36. Unfortunately, it appears that Mrs Spurgin deteriorated in the course of the afternoon. A further nursing entry that evening records that her nephew was telephoned at about 7.10 pm as her condition had

deteriorated. She was now said to be very drowsy and unrousable at times, was refusing food and drink, and was asking to be left alone. The site around the wound in the right hip still looked red and inflamed and she felt hot. She apparently did not have pain when left alone but complained when she was moved at all. It appears that a discussion took place between Mrs Spurgin's nephew and the nursing staff, with the nephew recorded as having been anxious that she should be kept as comfortable as possible.

37. The next entry in the nursing records indicates that Mrs Spurgin was seen by me, and that she was to be commenced on a syringe driver. Although there is no date by the side of that entry, suggesting that I would have seen Mrs Spurgin on the night of Sunday 11th April, I think in fact this represents a nursing entry made the following morning, 12th April. That accords with the date of the prescription for Diamorphine and Midazolam to be administered by syringe driver which I have written up on the drugs chart for 12th April.

38. I anticipate that in the usual way I would have reviewed Mrs Spurgin on the morning of Monday 12th April, and in view of her condition and deterioration, I was concerned that Diamorphine and Midazolam should now be available to provide relief from pain and distress. I wrote up a prescription on her drugs chart for Diamorphine to be administered subcutaneously by syringe driver at a dose range of 20-200mgs, Hyoscine to be available PRN - as required - 200-800 mcgs and Midazolam to be administered at a dose range of 20-80mgs. In case of nausea I also prescribed Cyclizine, 50-100mgs to be given as required subcutaneously, together with a further prescription of Lactulose and Senna tablets in case of constipation.