RESTRICTED

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: BLACK, DAVID ANDREW

Age if under 18: (if over 18 insert 'over 18') Occupation: CONSULTANT PHYSICIAN

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: D BLACK Date: 27/06/2005

SUMMARY OF CONCLUSIONS

Mrs Enid SPURGIN was a 92-year-old lady admitted to the Haslar Hospital on 19th March 1999 following a fall. She undergoes an operation for a proximal femoral fracture and then transferred to the Gosport War Memorial Hospital on 26th March 1999. She is known to have become increasingly frail with poor eyesight, depression and mild memory impairment.

In the Gosport War Memorial Hospital she is in continual pain for which no definite diagnosis is made. She develops a wound infection and then deteriorates rapidly and receives pain relief and palliation for her terminal decline, including subcutaneous Diamorphine and Midazolam and dies on 13th April 1999.

The expert opinion is:

Mrs Enid SPURGIN presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture. The prognosis after such a fracture, particularly in those with impairments of daily living before their fracture is generally poor, both in terms of mortality or in terms of morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications. A significant problem in Mrs SPURGIN's case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, (GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and

symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include - taking suitable and prompt action when necessary"..... "referring the patient to another practitioner, when indicated"..... "in providing care you must - recognise and work within the limits of your professional competence"..... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

I believe that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport. The failure to address the cause of this lady's pain, consider any other actions from 26th March until 7th April. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

Subsequent management of this lady's pain was within current practice with the exception of the starting dose of Diamorphine. The starting dose of Diamorphine at 80mg in the syringe drive is at best poor clinical judgement. However, I am unable to satisfy myself beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her 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 her 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.

2.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

3. CURRICULUM VITAE

Name
Address
E-mail:
DOB
Place

Code A

Marital status Married with 2 children.

GMC Full registration. No: Code A

Defence Union Medical Defence Union. No:

EDUCATION	Leighton Park School, Reading, Berks.	1969-1973
	St John's College, Cambridge University.	1974-1977
	St Thomas' Hospital, London SE1	1977-1980

DEGREES AND QUALIFICATIONS

BA, Cambridge University	1977
(Upper Second in Medical Sciences)	
MB BChir, Cambridge University	1980
MA, Cambridge University	1981
MRCP (UK)	1983
Accreditation in General (internal) Medicine and Geriatric Medicine	1989
FRCP	1994
MBA (Distinction) University of Hull.	1997

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Certificate in Teaching	2001
NHS/INSEAD Clinical strategists program	2003

SPECIALIST SOCIETIES

British Geriatrics Society

British Society of Gastroenterology

British Association of Medical Managers

PRESENT POST

Dean Director of Postgraduate Medical and Dental Education	
Kent, Surrey and Sussex Deanery.	2004-present
Consultant Physician (Geriatric Medicine)	1987-present
Queen Marys Hospital, Sidcup, Kent.	
Associate member General Medical Council	2002-present

PREVIOUS POSTS

Associate Dean.	
London Deanery.	2004
Medical Director (part time)	1997-2003
Queen Mary's Hospital	
Operations Manager (part time)	1996-1997
Queen Marys Hospital, Sidcup, Kent	
Senior Registrar in General and Geriatric Medicine	
Guy's Hospital London and St Helen's Hospital	
Hastings.	1985-1987
Registrar in General Medicine and Gastroenterology	
St Thomas' Hospital, London.	1984-1985
Registrar in General Medicine	
Medway Hospital, Gillingham, Kent	1983-1984
SHO rotation in General Medicine	
Kent & Canterbury Hospital, Canterbury	1982-1983

SHO in General Medicine	
Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

PUBLICATIONS

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The impact of the NSF on everyday Clinical Care. Conference on Clinical governance in elderly care . RCP May 2001

The Geriatricians view of the NSF. BGS Autumn Meeting 2001

The Organisation of Stroke Care. Physicians and managers working together to develop services.

Professional training and clinical governance in geriatric medicine. All at Argentinean Gerontological Society 50th Anniversary meeting. Nov 2001

The future of Geriatric Medicine in the UK. Workshop: American Geriatrics Society May 2002

Liberating Front Line Leaders. Workshop: BAMM Annual Meeting June 2002

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Medical Aspects of Intermediate Care. London Conference on building intermediate care services for the future. Sept 2002

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ntermediate Care Update: London National Elderly Care Conference. June 2003.

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Mentoring as part of consultant induction. Surviving to Thriving. New Consultant Conference, London June 2004

360 Degree Appraisal. Chairman National Conference. Nottingham June 2004

Maintaining Professional Performance. BAMM Annual Summer School. June 2004

Chronic Disease management. BGS Council Study Day. Basingstoke. July 2004

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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Enid SPURGIN

[2] Full set of medical records of Enid SPURGIN on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

[4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[5] Commission for Health Improvement Investigation Report on
Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital
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[6] Palliative Care Handbook Guidelines on Clinical
Management, Third Edition, Salisbury Palliative Care Services (1995);
Also referred to as the 'Wessex Protocols.'

5. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence; 'M' in front are the microfilm notes).

5.1 At the time of her death in 1999 Edith SPURGIN was a 92-year-old lady. She had been previously noted to have a stress fracture of her right hip, not needing operative intervention in 1981. (M38). She was also noted to have Paget's disease in her pelvis in 1988 (M39). She had a probably myocardial infarction in 1989 (M6). In 1997 she had been seen by a Dr MEARS , a Consultant Psycho-Geriatrician, for depression(144). He also noted poor eyesight (145). At that time she was on an anti-depressant and was noted to have a normal minim-mental test score of 27/30 (148). She was followed up by a Community psychiatric nurse over the following year who believed that she was now showing evidence of memory impairment (152) (158).

5.2 Enid SPURGIN was admitted to the Haslar Hospital on the 19th March1999 following a fall, was diagnosed as having a proximal femoral fracture, treated by an operation "a dynamic hip screw", on 20th March 1999 (20). The notes for Haslar are not currently available to me, the only information is the hand written one page summary that says post operatively she can be mobilised from bed to chair with two nurses and can walk short distances with a Zimmer frame. It noted she has been incontinent at night and has a small sore on the back of her right leg, which is swollen. This letter states that the only medication she is on is Paracetamol prn. The only nursing information from Haslar is an admission assessment and pressure sore assessment

on 19th March (64 & 66).

5.3 The next medical notes we have until her death, are written on a single page from Gosport Hospital (24). This states that the patient was transferred to Dryad Ward on 26th March, with a history of a fractured neck of femur and no significant past medical history. The medical notes state she was not weight bearing, she was not continent, her skin was tissue ? (illegible). The medical plan was " sort out analgesia".

5.4 The next medical note is on the 7th April, "still in a lot of pain and very apprehensive. MST increased to 20 mgs bd yesterday, try adding Flupenthixol. For x-ray of right hip as movement still quite painful - also about 2" shortening right leg."

5.5 The next medical note is 12th March, "now very drowsy (since Diamorphine infusion established) reduced to 40 mgs per 24 hours, if pain recurs increase to 60mgs". Able to move hips ? (illegible) pain, patient not rousable. Final note is dated 1.15 am 13th April. Died peacefully.

5.6 Nursing notes from Mrs SPURGIN's admission on 26th March continually refer to pain. The first night she has difficulty in moving, Oramorphine is given (80). The admission care plan mentions she was experiencing a lot of pain and movements (84). The desired outcome is "to eliminate pain if possible and keep Enid comfortable, which should facilitate easier movement and mobilisation". 27th March, "is having regular Oramorphine but still in pain" (84). 28th March (84) "has been vomiting with Oramorph, advised by Dr BARTON to stop Oramorph is now having Metoclopramide three times a day and Co-dydramol".

5.7 On 29th (85) pain needed to be reviewed and on 31st March 10 mgs bd of MST (Morphine slow release tablets) is documented. "Mrs SPURGIN walked with the Physiotherapist but was in a lot of pain". She was still having pain on 1st and 3rd April (85).

5.8 On 4th April (86) it is noted that the wound is now oozing serous fluid and blood. On 7th April, it is documented that she was seen by Dr BARTON who thought the wound site was

infected and started Mrs SPURGIN on Metronidazole and Ciprofloxacin (both antibiotics) (107). On the 8th April, her MST is increased to 20 mgs bd, on 9th it is documented that she should remain on bed rest until Dr REED had reviewed the x-ray of the hip.

5.9 Mrs SPURGIN clinically deteriorates significantly on the 11th April. She is now very drowsy and unrousable at times and refusing food and drink (107). The wound looks red and inflamed and feels hot (107). A discussion with Dr BARTON (107), a decision is made to commence a syringe driver .

5.10 The patient is seen by Dr REED (108) Diamorphine is reduced. On the early morning of 13th April, death is confirmed (108).

5.11 Dependency is also confirmed by a Waterlow score of 32 on the 26th March (i.e. very high risk for pressure sores) (92) and a Barthel of 6/20 on 29th March (94) and 5/20 on 10th April (94).

5.12 Drug management in Gosport concentrate on the use of analgesia:

5.13 At the point of admission Oramorphine 10 mgs in 5 mls (2.5 - 5 mgs 4 hourly prn) is written up on the "as required" part of the drug chart. A few doses are documented to have been given on 31st March - 11th April.

5.14 On the regular prescription Oramorphine 2.5 mgs 4 hourly and 5 mgs at night is written up, first dose given by 10 am on 26th March (125). This is then changed to 5 mgs four hourly with 10 mgs at night up until 28th March, then the Oramorphine is then discontinued and Co-dydramol 2 tablets 6 hourly written and prescribed from 28th March - 1st April (125).

5.15 Metoclopramide 10 mgs three times a day is written up continuously from 28th March to 11th April, but is only actually given to the patient intermittently. Morphine slow release tablets 10 mgs bd (MST) are written up on 31st March and given to 6th April. MST 20 mgs bd is written up on 6th April and given to 11th April.

5.16 Ciprofloxacin 500 mgs bd is written up on 7th April and continued until 11th April and Metronidazole 400 mgs bd is also written up on 7th April and given to 11th April. (134)

5.17 Finally, Diamorphine 20 - 100 mgs is written up on 12th April. 80 mgs in a syringe driver started at 8 am and according to the drug chart "dose is discarded at 16.40 hours and reduced the dosage to 40 mgs in 24 hours". The pump is discontinued at 1.30 am on the patients death on 13th March. Midazolam 20 - 80 mgs is written and is prescribed. 20 mgs put in the syringe driver at 8 am. It appears this was increased to 40 mgs at 16.40 hours and discontinued at 1.30 am on 13th April.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

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

6.2 It is difficult to provide a comprehensive opinion in the absence of the Haslar notes and the very sparse nature of the Gosport notes.

6.3 Mrs SPURGIN a very elderly lady of 92 years, had a number of chronic conditions including poor eyesight, depression, mild memory impairment, ischaemic heart disease, previous fracture of her right hip and known Paget's disease of her pelvis. She had a fall at home resulting in a further proximal femoral fracture and required a dynamic hip screw. This would have been a more complex procedure because of the previous fracture and the possibility that there was Paget's disease in her femur. However, from the one page summary from Haslar, it would appear that she was making reasonable progress at the point of transfer to Gosport. The prognosis in a 92 year old lady with her previous problems, that she would be likely to

return to independent existence at home would already be extremely low.

6.4 The problem documented in Gosport on the point of admission is continued pain, this is difficult to reconcile with the one page summary from Haslar, which says that Mrs SPURGIN is purely on intermittent Paracetamol. There are various possibilities. She may have been undertreated for pain in Haslar, she may have had a dislocation in the ambulance transferring her (this does occur), she may have been starting to develop infection in the wound or she may have had some other orthopaedic problem that was not picked upbetween leaving Haslar and arriving in Gosport. I was also unable to find any report of the x-ray that was taken at Gosport on 7th April.

6.5 The medical assessment undertaken in Gosport was inadequate. There is no record of a significant history or general examination being performed, or if it was it was not recorded. No explanation at all is sought for why this lady is in pain, particularly if she had not been in pain in Haslar.

Good medical practice (GMC, 2001) states "good medical care must include an adequate assessment of the patients condition based on the history and symptoms and if necessary an appropriate investigation"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any other drug or treatments prescribed". The major gaps in the written notes particularly on admission presents poor clinical practice, to the standards set by the General Medical Council.

6.6 However, it was appropriate to provide pain relief. Normally this would be done in a stepwise fashion, starting with the milder pain killers, such as the Paracetamol, she was already on in Haslar. Then to stronger oral medication (such as moderate opioids) and then to stronger opioid analgesia. However, she is started on a regular dosage of stronger opioid analgesia immediately from the point of her admission into Gosport. The reason for this is not documented and represents poor clinical practice.

6.7 The nursing notes document that her pain does not settle and is considerably interfering with her attempts at rehabilitation. She is then troubled with vomiting and the opioid analgesia is in fact stopped and replaced with oral co-dydramol. Her vomiting does apparently settle but her pain continues, so she is restarted on a strong opioid analgesia on 31st March. I believe this was appropriate pain management at this stage.

6.8 She is seen by a consultant on 7th April, who is clearly concerned that there is continuing pain and arranges for an x-ray. There is no record of the result of this x-ray in the notes. However, there appears to be a working assumption that she may have a wound infection and is appropriately started on antibiotics. On 11th April there is a rapid deterioration in her condition. This is documented in the nursing notes but there is no medical note made on the 11th April. The nursing notes suggest that she was seen by Dr BARTON on 11th April, and a decision was made to start a syringe driver. However, I do wonder if this is incorrect and that she was seen early in the morning of 12th April as a syringe driver starts at 8am and not on the 11th April. No medical note is made by Dr BARTON.

6.9 In view of the clinical deterioration on 11th April, despite the patient receiving appropriate antibiotics, I believe it was appropriate to start a syringe driver, as there is no doubt in my view that Mrs SPURGIN was now dying. The likeliest cause is an unresolved infection in the wound and in her hip but the original cause of the pain remains undiagnosed. The opportunity for any possible remediation is well past at this stage. Diamorphine is then written up, prescribed at 80 mgs per 24 hours. The prescription in the notes was 20 - 200 mgs of Diamorphine in 24 hours and it is not clear whether Dr BARTON or the nurse in charge suggested the dose of 80 mgs. At that time Mrs SPURGIN was on 20 mgs twice a day (i.e. 40 mgs) of Morphine Sulphate, slow release. Diamorphine subcutaneously is usually given at a maximum ratio of 1 - 2 (i.e. up to 20 mgs Diamorphine in 24 hours for 40 mgs of Morphine) (Wessex Guidelines). However, her pain was not controlled and it would have been appropriate to give a higher dose of Diamorphine. Conventionally this would be 50% greater than the previous days, (Wessex Guidelines). Some people might give up to 100%. Thus a starting dose of Diamorphine of 40 mgs in 24 hours would seem appropriate. Mrs SPURGIN was prescribed 80 mgs which in my view was excessive, though this was reduced to 40 mgs after the intervention of the consultant

Dr REED, some 8 hours later.

6.10 Midazolam was also added to the infusion pump on 12th April. Midazolam is widely used subcutaneously in doses from 5 - 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was originally 20 mgs for 24 hours which is within current guidelines. This was increased to 40 mgs later in the day, which although remains within current guidelines, many believe that elderly patients may need a lower dose of a maximum 20 mgs in 24 hours (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine, 6th edition, 2003). Morphine is compatible with Midazolam and can be used in the same syringe driver.

6.11 Mrs SPURGIN is thought to have been excessively sedated, the dose of Diamorphine is reduced on 12th April. She subsequently dies.

The prediction of how long a terminally ill patient will live is virtually impossible and even palliative care experts show enormous variation (Higginson I J and Costantini M. Accuracy of Prognosis Estimates by 4 Palliative Care teams: A prospective cohort study. BMC Palliative Care 2002 1:1.)

6.12 In my view the dose of Diamorphine used in the last hours was inappropriately high, however, I cannot satisfy myself to the standard of "beyond reasonable doubt" that this had the finite effect of shortening her life in more than a minor fashion of a few hours.

7. OPINION

7.1 Mrs Enid SPURGIN presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture. The prognosis after such a fracture, particularlyin those patients with impairments of daily living before their fracture is generally poor, both in terms of mortality or in terms of morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and

complications. A significant problem in Mrs SPURGIN's case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, (GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include - taking suitable and prompt action when necessary"..... "referring the patient to another practitioner, when indicated"..... "in providing care you must - recognise and work within the limits of your professional competence"..... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

I believe that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport. The failure to address the cause of this lady's pain, or consider any other action from 26th March until 7th April. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

7.2 Subsequent management of this lady's pain was within current practice with the exception of the starting dose of Diamorphine. The starting dose of Diamorphine at 80mg in the syringe drive is at best poor clinical judgement. However, I am unable to satisfy myself beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002

2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.

3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.

4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG.

Palliative Medicine 1987; 1:149-153.

5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129

6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. 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 I 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, I 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. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9. I 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.

10. 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.