FFW/98/06

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER

GOSPORT WAR MEMORIAL HOSPITAL

FURTHER EVIDENCE

ENID SPURGIN

14

GMC AND BARTON INDEX OF FILES RECEIVED FROM HAMPSHIRE POLICE ON 18 JANUARY 2007.

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Operation ROCHESTER.

Additional Evidence Summary.

Relating to the death of:-

Enid SPURGIN.

David SINCLAIR (General Practitioner) Describes Mrs SPURGIN as sprightly, active and an independent woman in good general health. Last saw her on 4th January 1999 when she complained of itching veins in her legs. Previously prescribed gaviscon for heartburn/indigestion, she was an anxious person. Prone op falls in the past not surprising given her failing eyesight and loss of balance due to furring of the neck of arteries.

Malcolm SCOTT (Consultant Orthopaedic Surgeon) first saw Mrs SPURGIN on 22nd March 1999 during ward round following her surgery and again on 24th March. Details care afforded to Mrs SPURGIN by his staff at Haslar Hospital. Finally summarises that Mrs SPURGIN came to Haslar via accident and emergency on 19th March 1999 following a fall at home, she was admitted to ward E.6.Diagnosed with a broken neck of the femur. She was worked up for surgery ands operated on the following day by Mr ARVIND dynamic hip screw surgery. The surgery was successful and she made an unremarkable recovery. Her skin condition caused some concern but not uncommon in patients of her age. Given 2mg morphine pre-op and 3 five mg doses post op. Following recovery from surgery she was assessed by Dr REID from elderly medicine and was fit to transfer to Gosport War Memorial Hospital on 26th March 1999.

Jeanette FLORIO (Staff Nurse GWMH) Explains various entries in nursing notes between 26th March 1999 and 13th April 1999 registering that patient was in a lot of pain on 26th March 1999.

Shirley HALLMAN 2 Statements. (Staff Nurse GWMH) Details concerns around use of diamorphine at GWMH . Recorded that Dr BARTON had made decision to commence syringe driver on 12th March 1999, patient was refusing food and drink, complained of pain when moved. Variously witnessed the administration of diamorphine and midazolam to patient SPURGIN.

Lynne BARRETT. (Staff Nurse GWMH) Further statement re administration off diamorphine.

Kathryn HENNING. (Student Nurse GWMH) Nursing note entries 30th March 1999 and 6th April 1999.

Richard Ian REID (Consultant Geriatrician)

Series of tape recorded interviews with Dr REID in presence of legal representative Will CHILDS under caution 0912hrs – 1410hrs 11.7.06 in respect of Enid SPURGIN.

Keypoints:-
Interview 1.

- Wrote to consultant at Haslar agreeing to take over care of Mrs SPURGIN but expressing concern over her hip to check out that all was well before her transfer on 26th March 1999.
- Dr REID first saw patient SPURGIN on 7th April 1999.She was still in a lot of pain and apprehensive. He increased morphine to 20 milligrams twice daily. Written for x-ray of her right hip as movement painful and there was about a 2 "shortening of her right leg.
- She was 92 and very apprehensive so he prescribed a small dose of tranquilliser (Fluipenthicsal) because fear and anxiety can add to pain.
- Next saw patient on 12th April. She was very drowsy and diamorphine infusion had commenced the day before. Dr REID wrote up a reduced dose to 40mgs for 24hrs and should pain re-occur increase to 60 mgs. Wrote that able to move hip without pain but not rousable suggesting that she had been over sedated with diamorphine.
- Dr REID felt that Dr BARTONS clerking in of the patient was brief but contained the salient features.
- Dr REID commented that a fit 50 year old one would expect to normally rehabilitate. It was a very different matter at 92 particularly someone with a lot of pain in the hip when the chances were remote.
- The term gentle rehabilitation would imply that doctors had considerable doubts about potential to rehabilitate.
- In the case of Mrs SPURGIN her chances of mobilisation were very small.
- When challenged that Dr BARTON had not properly clerked in the patient Dr REID commented that she was under pressure at the time and as he had said whilst her entries were brief they were salient.
- Finally discussion over whether Mrs SPURGIN was capable of carrying her weight on transfer, Haslar said yes, Dr BARTON said no.. Dr REID commented that Mrs SPURGIN could have deteriorated in the ambulance during transfer, also it was not uncommon for patients condition to be 'over egged' to ensure transfer.

Interview 2.

- Dr REID first saw Mrs SPURGIN 2 days before she was transferred on 24th March 1999.

- Dr REID considered that Dr BARTON was more experienced than he in dealing with palliative cases and patients who were dying.
- Dr REID assessed that Mrs SPURGIN was suffering hip pain post operatively not uncommon in elderly patients so he thought it important to x-ray the hip.
- Dr REID when asked commented that it was unacceptable that baseline checks such as temperature blood pressure heart and lungs were not recorded at all between the 26th March and 7th April 1999.
- It was put that Mrs SPURGIN had been on paracetomal until her transfer to GWMH when she was then administered morphine. Dr REID agreed that this was quite a jump up the analgesic ladder.
- Dr REID's expectation was that the pain issue would be explored.. following surgery he would get a doctor to examine the hip to see if there were any problems there/ infection.
- He added that deep infection from the hip joint could be difficult to diagnose.
- Dr REID agreed that in the case of increasing pain following the successful hip operation something was quite obviously wrong.
- In this case it was difficult to know where the long term plan was, Dr REID does not think he was optimistic about her chances of getting back on her feet.
- When asked whether Dr BARTON would have access to notes upon transfer of the patient Dr REID commented that it was possible that she had either everything or nothing.
- Dr REID could not answer why paracetomal was not continued as pain relief upon transfer.
- When put that Dr BARTON had prescribed ORAMORPH without an explanatory note on the records on 26th and 27th March Dr REID commented that the reasons should have been noted.
- Dr REID concluded that he did not think it unreasonable to wait and see what happened with analgesia, eg to see how the patient fared over 2 or 3 days with increased amounts and to monitor improvement or not then at some point progress or lack of it or increasing pain would be an indication to proceed with further investigation such as x-ray.

Interview 3.

- At the start of this interview Dr REID handed DC QUADE a document prepared in late 2001 outlining his responsibilities as a medical director of Portsmouth Healthcare Trust. He had ticked his responsibilities in 1999 and had placed 3 crosses against things he was not responsible for in 1999.
- Dr BARTON had been a regular attendee at consultancy training sessions.
- Dr REID would have expected Dr BARTON to record in notes the patients changing condition.
- Dr REID highlighted that recent research in the palliative care field had shown that there was widespread ignorance around analgesic prescription.

- Dr REID when asked if it was usual for somebody to jump from the bottom to the top of the analgesic ladder commented that it could happen in the event of a patient in a lot of pain.
- When questioned regarding Dr BARTON's initial prescription of Oramorph Dr REID commented that there was probably no alternative.
- Dr REID conducted his ward rounds on Monday afternoons either with Dr BARTON or accompanied by a nurse.
- It was pointed out that Dr BARTON would visit the ward three times a day and had been admitted to GWMH for a total of 18days, therefore at least 30 visits yet only one entry by Dr BARTON in the medical notes also that 12 days had passed between Dr REID's visit of 7th April and patient admission. No notes had been made by Dr BARTON. Dr REID commented that he had access to nursing notes and that he was able to speak to nurses who would record what medical treatment was going on.
- Dr REID when questioned commented that he was directing and in overall charge of the patient. Dr REID went on to say later in interview that he was appalled there had been no basic record of pulse, temperature and blood temperature (on admission to GWMH) and that was unacceptable.
- The issues of Dr REID decreasing the diamorphine infusion from 80 mg to 40 mg per 24hrs was discussed. Had she been on the ward round with him Dr REID would have told her that it was far too much.
- The issue of the x-ray instigated by Dr REID was discussed the results would have been available within a couple of days. The nursing note recorded that the results were to be reviewed by Dr REID on his round the following Monday (12th March 1999). Dr REID admitted that he had not reviewed the x ray on the 12th adding that by then it was clear that she was experiencing increasing pain and her skin was breaking down and that these were ominous signs and suggested that he thought that she was pretty close to death. He may not have thought about the x - ray because he felt that there were more immediate issues.

Interview 4.

- By the 12th March 1999 Mrs SPURGIN was dying, she was terminally ill.
- On admission Mrs SPURGIN was prescribed oramorph for pain relief, lactulose for constipation co-dyromol an analgesic and then later diamorphine and hyoscine to dry up chest secretions administered on an as required basis.
- When questioned about the issue of variable dose prescribing Dr REID commented that he had discussed this with Dr BARTON and she had commented that she was not always immediately available..she did this to ensure that patients received adequate analgesia when they required it.
- Dr REID trusted the nurses particularly as with controlled drugs there were always 2 nurses involved in the administration as a safeguard.

- In the case of a wide variable dosage 20-200mg Dr REID would expect the nurses to start with the smallest dose.
- Following further discussion Dr REID commented that he could not imagine in this case why the dose of diamorphine was started at 80mg and that he had reduced to 40mg.

Interview 5.

- Dr REID commented that from the nursing records around the time that the syringe driver started there was a clear indication that Mrs SPURGIN was becoming increasingly distressed and uncomfortable, drowsy at times in but then agitated and distressed at other times..this seemed to Dr REID to be an appropriate indication to commence a syringe driver.
- Dr REID viewed the use of a syringe driver for people regularly receiving small doses as a step up, not a hugely significant event.
- Dr REID added that it would have been good practice to have recorded why the syringe driver was started.
- Following debate over the reduction of oramorph and introduction of co-dyromol earlier in the treatment of Mrs SPURGIN (28.3.99) Dr REID stated that the oramorph and Morphine had caused vomiting so it was not unreasonable to reduce the strength of the analgesic that was being prescribed to see if the lesser dose would control the pain and at the same time stop the vomiting.

Interview 6.
(14th July 2006)

- Dr REID clarified that Mrs SPURGIN received 2 x 20mg doses of morphine tablets on 11th April 1999 before being started on her syringe driver.
- Dr REID confirmed that he had prescribed Flupenthixol a sedative to Mrs SPURGIN on 7th April but from the prescription sheets he could establish that she had not been administered the drug.
- Dr REID formed the opinion that Mrs SPURGIN was terminally ill on 12th April 2006 because she was drowsy and irritable this often being a sign that their death is very close, he had not formed that opinion on the 7th April.
- In this case Midazolam was prescribed within BNF recommended ranges.
- In respect of increasing dosage of Diamorphine and Midazolam Dr REID commented that it would have been helpful had Dr BARTON left written instructions for nurses.
- When asked whether he was happy with the variable dose prescribing of 20 – 200mgs OF Diamorphine by Dr BARTON, Dr REID stated that he thought the answer was no, he had had a conversation with Dr BARTON, and with hindsight he should have crossed out the

prescription and re-written it. The higher level of 200mgs allowed far too much discretion to nursing staff.

- Concerns were raised by interviewing officers about the starting range of 80mgs of Diamorphine in Mrs SPURGINS case. Dr REID agreed that it should have been started at a lower level.

Interview 7.

- In general terms Dr REID would recommend a lower starting dose.. for instance 20mgs and then increase by 50% if the dose insufficient ie to 30mgs.
- Dr REID commented that a starting dose of between 25mgs and 45mgs would have been appropriate.
- Dr REID added that the level of 40mgs that he had reduced the patient to may have still been on the high side but he felt that the lady had been suffering for three weeks he had to make sure that she was not over sedated but at the same time was not going to suffer.
- Dr REID did not know why the Midazolam had been increased from 40 to 60 mgs.
- Interviewing officers referred to the prescription chart particulary an entry at 1640hrs when the Midazolam was increased. Dr REID commented that he found it just absolutely amazing.
- In terms of determining cause of death Dr REID added that it was difficult to say what cause of death is in a situation where the patients do not have something clearly diagnosable ie heart attack or chest infection.

Interview 8.

- The starting dose of 80mgs of Diamorphine prescribed by Dr BARTON was according to Dr REID completely inexplicable. He should have spoken to her about it but could not remember if he had.
- Dr REID in interview reviewed the death certificate completed by Dr BARTON which had recorded cause of death as cerebral vascular accident. Dr REID explained that this was a stroke in laymans terms. There was a reference to Mrs SPURGIN 'leaning to the left and having difficulty swallowing' in her nursing notes on 10th April 1999. These could be features of stroke.
- There was no written evidence (within the medical notes) to suggest whether Mrs SRURGIN had or had not suffered a stroke.
- There was conversation about whether the death should have been reported to the coroner Dr REID thought it should upon the basis that death had followed within a year of the operation.
- In terms of his consultant supervisory duties Dr REID commented that it consisted of conducting a weekly ward round.
- At the time of dealing with Mrs SPURGIN Dr REID was working very long hours but this did not affect his ward rounds just the ability to speak with relatives. Latterly he had realised that Dr BARTON was

very busy, and that GP cover was insufficient with increasing turnover of patients. A Doctor was required Monday to Friday 9-5.

- Dr REID was not aware of Dr BARTON cutting back on anything other than note keeping.
- Dr REID had approached Dr BARTON towards the end of 1999 and discussed the issue of increasing workload and whether it was possible for her to continue doing her job and shortly after that she tendered her resignation.

Interview 9.

- Dr REID confirmed that in laymans terms septicaemia and toxaemia was blood poisoning.
- When questioned Dr REID generally could not see why analgesics should have been reduced in Mrs SAPURGINS case, but agreed that it was appropriate to look at the causes of infection and to be treating them. It was possible that something should have been done in terms of the infection before it was although it was difficult to say in the absence of medical records.
- The purpose for getting the x-rays done on 7th April was to see whether there was evidence of infection.
- Dr BARTON should have considered speaking to a micro-biologist.
- Dr REID conceded that whilst pain was being treated nobody addressed what was causing the pain and subsequent increases in pain.
- Dr Reid did not believe that Mrs SPURGIN had been overdosed with morphine.
- Dr REID when asked highlighted that his medical note of the 7th April 1999 was the only note to show that medical assessment had been conducted to exclude potentially reversible causes of the patients deterioration.
- Dr REID had not recollection of a conversation with Mrs SPURGINS nephew on the 12th April 1999 when Dr REID was alleged to have said that there was nothing wrong with Mrs SPURGIN she was just on a too high dose of diamorphine. He could not imagine saying it.
- When asked to explain his comment to Dc GREENALL that Dr BARTON and Nurse HAMBLIN were a formidable pair, he recalled a meeting when he formed the impression that ' this is what we do here, almost this is our patch, you're the new kid on the block and don't interfere... Dr BARTON and Nurse HAMBLIN would make decisions and stick to them without compromise.. they were brusque and this attracted complaints.

Code C

D.M.WILLIAMS
Detective Superintendent.
6th September 2006.

MG20

HAMPSHIRE CONSTABULARY

RESTRICTED
FOR POLICE AND PROSECUTION ONLY (WHEN COMPLETE)

FURTHER EVIDENCE/INFORMATION REPORT

URN				

To:- Crown Prosecution Service

Office

R v Gosport War Memorial Hospital (SPURGIN)

Next Court date at

Offences

Submitted as indicated:

Compensation form(s)	☐	Proceedings outstanding further information (as below)	☐
Case File Information form	☐	Receipts/estimates re compensation claim	☐
Conviction memorandum (certified copy)	☐	Record(s) of interview	☐
Custody Record (copy)	☐	Statement (copy) - witness	☒
Custody Record - updated (copy)	☐	Statement (original) - witness	☐
Drink drive forms roadside/hospital/station procedure	☐	Recorded evidence of interview of defendant(s)	☒
DVLA printout	☐	TICs schedule(s)	☐
Exhibit List	☐	Witness availability list updated	☐
Exhibits (copy documents)	☐	Witness - list of convictions/cautions	☐
Medical Report/Surgeon's statement (copy)	☐	Witness list	☐
Previous convictions/cautions (defendants)	☐	Other – specify:	☐
Prisoner production copy Home Office order attached	☐		

Further information/remarks (continue on separate sheet if necessary):

Attached are a further 16 statements regarding Enid SPURGIN Dr SINCLAIR Mrs SPURGIN's GP, Dr SCOTT Consultant at Haslar Hospital, Night nurse FLORIO at GWMH, Staff nurse HALLMANN at GWMH x 2, Nurse BARRETT at GWMH and Health Care Support worker HENNING at GWMH along six rviews of Dr BARTON and five interviews of Consultant Dr Reid at GWMH (not proof read).

+ 2 further statements from Dr BLACK

All documents indicated above are attached.

Officer in case	STEPHENSON	Rank	DS	Div. No./Wt No.	Code C	Date	18/07/2006
Supervisor's name	WILLIAMS	Rank	D/SUPT	Div. No./Wt No.		Date	

RESTRICTED

Comments on Haslar Hospital Notes – Enid Spurgin 22nd August 2006

1. INSTRUCTIONS

To examine and comment upon the medical notes from Haslar Hospital in the case of Enid Spurgin. In particular if they raise issues that would impact upon the expert statement on Enid Spurgin already prepared.

2. DOCUMENTATION

The report is based on the following documents.

2.1. Haslar Hospital notes JR/14 provided to me by the Hampshire Constabulary (August 2006).

2.2. Report regarding Enid Spurgin (BJC/45). Dr D Black 27th June 2005.

3. CHRONOLOGICAL/CASE ABSTRACT (The number in brackets refer to the page of evidence)

3.1. Mrs Spurgin had an admission to the Haslar Hospital in 1997 having had a fall and developed a fracture of the right patella and a non displaced fracture of sternum. (45, 46). She made a good recovery. Mrs Spurgin is then admitted on the 19th March 1999 having been pulled over by her dog and suffered a right sub-trochanteric fratured femur (66). The notes recorded that she lived alone but was self caring and independent and was alert and orientated on admission. Her Haemoglobin on admission was 12.2 (67).

3.2. She goes to theatre on 20th March for a straightforward operation (73). However from the evening of the 20th March (69,79,80) she is complaining of discomfort in her leg and her leg is held in external rotation with a lot of ooze from the wound. The clinical impression is a potential bleeding into the wound and that the patient was now was hypovolaemic. A full blood count is undertaken (93) which shows that her haemoglobin has fallen to 8.2 gms per litre. She is then transfused 3 units of blood starting on 21st March (80). There is concern late on 21st that she is in early pre-renal failure (81) but by the 22nd things seemed to have improved, her renal function is reasonable with a urea of 10.9 and a creatinine of 115 (82) and her haemoglobin post transfusion is now 11.1. However, her right hip is still extremely painful (82) and the thigh is noted to be considerably enlarged.

3.3. On the 24th March, Dr Lord is asked to see her to consider rehabilitation at the Gosport War Memorial Hospital. The medical notes note that she had been transfused 3 units of blood but "otherwise made an unremarkable

post operative recovery". (83)

3.4. Dr Reed, Consultant Physician in Geriatrics, sees her on 24th and he states in his letter and in the notes "the main problem was the pain in her right hip and swelling of the right thigh. Even a limited range of passive movement to the right hip was still very painful. I was concerned about this and would like to be reassured that all is well from an orthopaedic viewpoint. If you are happy that all is well I should be happy for Mrs Spurgin to be transferred to the War Memorial Hospital for further assessment and hopefully remobilisation." (11,84)

3.5. On 25th it is noted the right leg is still swollen and the skin is tissue thin and that a haematoma has developed and broken down (85).

The nursing notes (27-28) add little. They note that she was given blood on 21st March and required morphine because of a lot of pain or movement on 21st. Beyond this there is no mention of pain, swelling or analgesia required. However on 24th she is noted to be incontinent of urine overnight, cot sides are required and that she was unsettled. As she was documented to be alert and orientated on admission, this suggests that on 24th she was developing evidence of an acute confusional state.

3.6. The drug charts for her 1999 admission are on pages 36-39. They document her on the once only and pre-medication drugs, the pre-medication antibiotics and morphine. On the as required, shows that she was given 5 mgs of morphine on three occasions, two on the 20th the day of the operation and one on the 21st the day after the operation. She also received Paracetamol every day of her admission apart from 23rd March.

4. EXAMINATION OF THE FACTS AND COMMENTS

4.1. The availability of the Gosport notes do significantly alter the interpretation of my opinion in my report of 27th June 2005 on Enid Spurgin.

4.2. Having examined the Gosport notes, it is apparent this lady did not have a straight forward post-operative course. An event happened on the night of the operation which was almost certainly a significant bleed, such that she required 3 units of blood to bring her haemoglobin up to a near normal range. This was associated with continual pain until the time of her discharge, swelling and very poor mobilisation. It is almost certain that she had a haematoma either into her joint or her muscles. This would have been of considerable size and was causing considerable pain and it is reasonable to assume that this was the cause of the pain when transferred to Gosport War Memorial Hospital.

4.3. Indeed, it is my view that this was not thoroughly investigated in Gosport as no investigations were undertaken that might have confirmed this as the cause of pain. Dr Reed notes this and asks that she is given an orthopaedic clearance before transfer. There is no evidence in the notes that the orthopaedic team undertook any further investigations or gave further thought to the cause of the pain or what its future management should be. I must therefore change my view 6.4. It is clear the lady did have under-treated pain in Haslar and it was reasonable for the doctors treating her at Gosport War Memorial to make an assumption that this was resolving problem and nothing more needed to be done or investigations undertaken.

However, as stated in paragraph 6.5 the medical assessment undertaken was still inadequate and there is no explanation in the notes to say that it was noted that she had been in pain for several days and that this should be treated symptomatically.

4.4. It now seems likely to me that Paracetamol was probably not an adequate response to her pain, but it is still my view that a stronger oral medication would have been more appropriate at this early stage in Gosport War Memorial, rather than going straight to stronger opioid analgesia.

In my view the natural history of most intramuscular or other haematomas related with fractures is that they will gradually improve over time, unless they become secondarily infected.

In this case it is possible that during the admission at Gosport War Memorial, her deterioration around the 11th April was due to deep seated secondary infection, despite the oral antibiotics. I think it is unlikely that there was significant evidence of deep infection before that because she is reviewed by a consultant on 7th April, who is concerned by the pain, examines her, and would have noted if she was significantly pyrexic or toxic.

4.5. I have therefore considered whether the lack of a medical assessment or the apparent failure to address further the cause Mrs Spurgin's pain up until the 7th April were a contributory factor in her death. It is my view that these factors were unlikely to have made any significant difference to her subsequent death.

I understand that the cause of death recorded on the death certificate of Mrs Spurgin was Cerebrovascular Accident. I can find no evidence at all in the notes to support this diagnosis for cause of death.

5. CONCLUSION

Having read the documents from Haslar Hospital I want to make one further change to the opinion of my original report regarding Enid Sturgin. I would like the last paragraph of 7.1 to now read:

"I believe there are a number of areas of poor clinical practice in this case of the standards set by the General Medical Council. The lack of medical assessment, or documentation of that assessment on admission to Gosport. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes. The recording of Cerebrovascular Accident as the cause of death with no evidence, or history, or of any examination to support this conclusion.

1. iNSTRUCTIONS

To examine and comment upon witness statements in the case of Enid Spurgin. In particular if they raise issues that would impact upon any expert witness report provided.

2. DOCUMENTATION

The report is based on the following documents.

2.1. Draft report regarding Enid Spurgin, prepared by Mr D R M Redfern, provided to be by the Hampshire Constabulary (August 2006).

2.2. Record of interview with Dr I Reid, 4th July 2006 provided by Hampshire Constabulary (August 2006)

2.3. Record of interview with Dr I Reid, 11th July 2006 provided by Hampshire Constabulary (August 2006)

2.4. Record of interview with Dr I Reid, 14th July 2006 provided by Hampshire Constabulary (August 2006)

2.5. Report regarding Enid Sturgin (BJC/45) Dr D Black 27th June 2005.

2.6. Report regarding Enid Sturgin (BJC/14) Dr D Black 22nd August 2006

3. COMMENTS

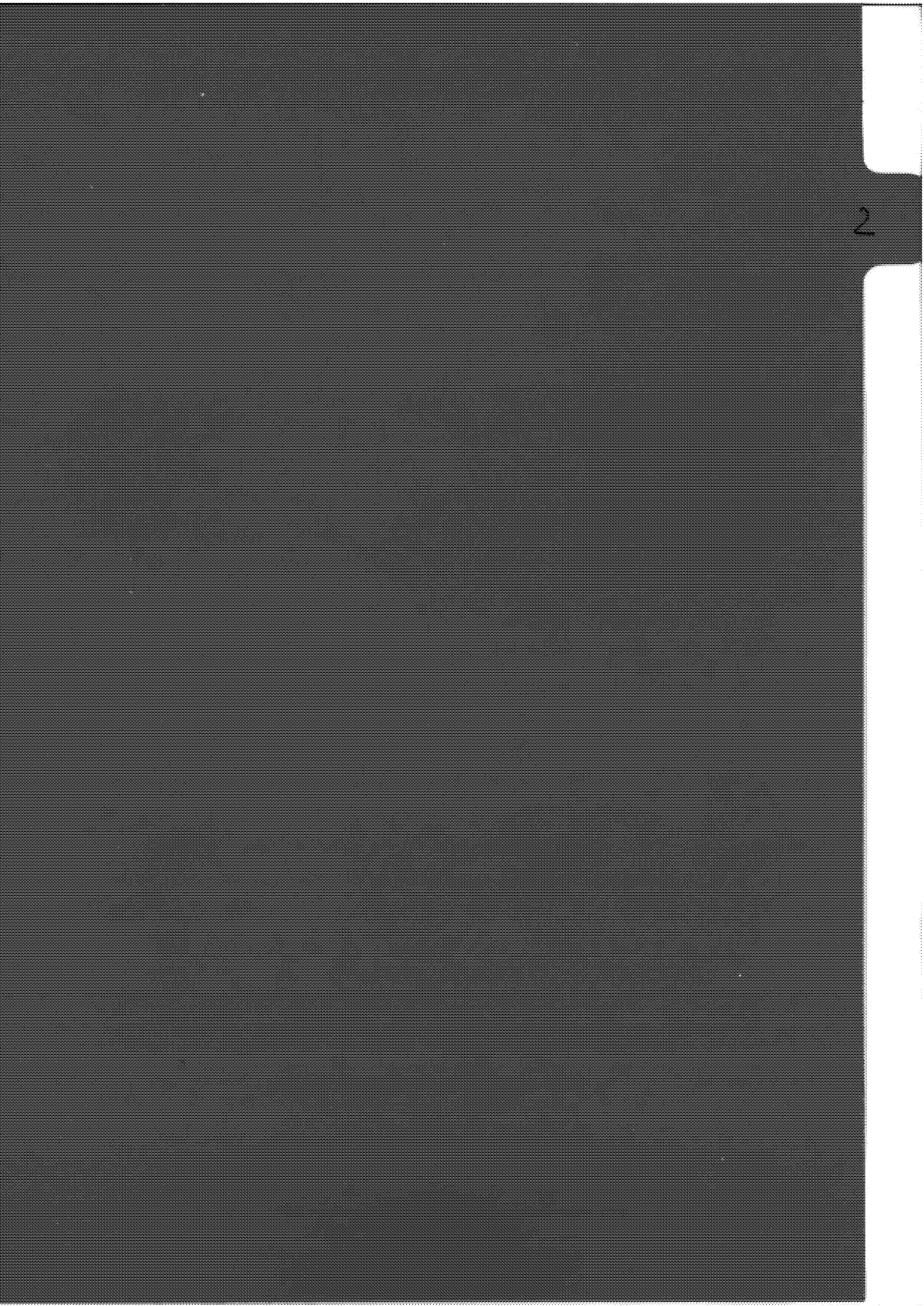
3.1. Comments on witness statements.

3.1.1. I have read the statement report by Mr D R M Redfern and it does not affect my reports of Enid Sturgin of 27th June 2005 modified on 22nd August 2006.

3.2. I have read the reports of the interviews with Dr I Reid I do not wish to change my report of the 27th June 2005 modified on the 22nd August 2006

4. CONCLUSION

4.1. Having read all the documents provided by the Hampshire Constabulary, I do not wish to change my report of the 27th June 2005, modified 22nd August 2006.



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