ENID SPURGIN

Police officer witness statements
Transcript suspect interviews

SUMMARY OF EVIDENCE

CASE OF ENID SPURGIN

Background/Family Observations

Enid Dormer SPURGIN was born on Code A She had one brother who died aged 76 years from a stroke. She married at about the age of 26 but had no children. They ran a market garden in Meon, Hampshire until 1958 when her husband died. Mrs SPURGIN sold the business and moved to Gosport where she lived alone until her death at the Gosport War Memorial Hospital on 13th April 1999 aged 92 years.

Mrs SPURGIN was a fit, healthy and active person who was still driving a car at 90 years of age.

In the late 80's she was admitted to QA Hospital with Ryan's disease where she stayed for three weeks. Shortly after leaving the hospital she was again driving and walking her dogs. She appeared not to suffer from the ill effects of leaving hospital.

Mrs SPURGIN was very independent who was always able to hold a conversation with you and was fully aware of her surroundings. She did have help around the home but was adamant that she wished to remain there and would not have a live in companion.

On 19th March 1999 Mrs SPURGIN fell outside the Post Office in Stubbington and was admitted to Haslar Hospital where she had an operation on her right hip. Although in pain the physiotherapists got her sitting up and moving. She was okay in her self and still lucid when she spoke.

On 26th March 1999 Mrs SPURGIN was transferred to the Gosport War Memorial Hospital, Dryad Ward from where she was expected to return home. Whilst at Gosport War Memorial Hospital Mrs SPURGIN seemed fine but stated she rarely saw any doctors or physiotherapists. When the staff were spoken to about this they stated that she was too uncomfortable to be moved and had told the staff to go away on several occasions. In a letter from Mrs SPURGIN's financial advisor on the 9th April he stated that Mrs SPURGIN was terribly depressed and had not seen a doctor.

On 12th April 1999 Mrs SPURGIN when visited by relatives was found to be unconscious and unable to be roused when spoken to by a doctor. The doctor stated that there was nothing wrong with Mrs SPURGIN but she was on a too higher dose of morphine. At 1800 hrs she was still heavily sedated. At 2200 hrs a relative received a call from staff at Gosport War Memorial Hospital who said Mrs SPURGIN was conscious and had taken sips of water.

On 13th April 1999 at 0130 hrs staff again called this time to say that Mrs SPURGIN had died.

Her death certificate was signed by Dr BARTON and the cause was given as cerebralvascular accident.

Mrs SPURGIN was cremated at Portchester Crematorium.

Mrs SPURGIN received a lack of treatment and care whilst at Gosport War Memorial Hospital and was somewhat abandoned, there are also concerns regarding the level of morphine she was prescribed.

Medical history of Enid SPURGIN.

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. She was also noted to have Paget's disease in her pelvis in 1988. She had a probably myocardial infarction in 1989. In 1997 she had been seen by a Dr Mears, a Consultant Psycho-Geriatrician, for depression. He also noted poor eyesight. At that time she was on an anti-depressant and was noted to have a normal minim-mental test score of 27/30 . She was followed up by a Community psychiatric nurse over the following year who believed that she was now showing evidence of memory impairment.

Enid SPURGIN was admitted to the Haslar Hospital on the 19th March 1999 following a fall, was diagnosed as having a proximal femoral fracture, treated by an operation "a dynamic hip screw", on 20th March 1999. 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 Code A Code A 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 next medical notes we have until her death, are written on a single page from Gosport Hospital. 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 paper like. The medical plan was "sort out analgesia".

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."

The next medical note is 12th April, "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.

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. The admission care plan mentions she was experiencing a lot of pain on movement. 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". 28th March "has been vomiting with Oramorph, advised by Dr BARTON to stop Oramorph is now having Metoclopramide three times a day and Co-dydramol".

On 29th 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.

On 4th April 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). 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.

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

The patient is seen by Dr Reed Diamorphine is reduced. On the early morning of 13th April, death is confirmed.

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

Drug management in Gosport and the use of analgesia:

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.

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. 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).

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.

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)

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 April. 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.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Enid SPURGIN was a Clinical Assistant Dr Jane BARTON. The medical care provided by Dr BARTON to Mrs SPURGIN following his transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (Good Medical Practice, General Medical Council, October 1995, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination.
- in providing care you must keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

The medical records were examined by two independent experts. Dr Robert BLACK in his review of Dr BARTON's care reported specifically:-

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.

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).

Dr Andrew WILCOCK reports:-

i) The notes relating to Mrs SPURGIN's transfer to Dryad Ward are inadequate. On admission, a patient is usually clerked highlighting in particular the relevant history, examination findings, planned investigations and care plan.

ii) There was insufficient assessment and documentation of Mrs SPURGIN's pain and its treatment.

iii) An orthopaedic opinion was not sought even when the pain did not improve with time or increasing doses of morphine that were associated with undesirable effects.

iv)An appropriate medical assessment was not undertaken when Mrs SPURGIN deteriorated, becoming more drowsy and her wound more painful and inflamed.

v) Doses of diamorphine and midazolam that were excessive to her needs were administered.

He further states;-

Mrs SPURGIN was a relatively fit and independent 92 year old widow who lived alone. Whilst walking her dog, she fell and fractured her right hip which was surgically repaired using a dynamic hip screw on the 20th March 1999. Within hours of the surgery there was leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Mrs SPURGIN's hip/thigh on movement continued to be a problem noted by Dr REID when he reviewed Mrs SPURGIN on the 24th March 1999. Surgeon Commander SCOTT reviewed Mrs SPURGIN but no specific comment was recorded in the medical notes regarding Mrs SPURGIN's pain, no changes were made to her analgesia and on the 26th March 1999 she was transferred to Dryad Ward, Gosport War Memorial Hospital. With regards to the standard of care proffered to Mrs SPURGIN in Haslar Hospital, the report of Mr REDFERN raises several concerns.

During her admission to Dryad Ward, the medical care provided by Dr BARTON and Dr REID was suboptimal: there was a lack of clear, accurate, and contemporaneous patient records; inadequate assessment of Mrs SPURGIN's condition; a lack of consultation with colleagues to seek appropriate advice and support; the use of diamorphine and midazolam in doses excessive to Mrs SPURGIN's needs.

When Mrs SPURGIN became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare there was no medical assessment or even simple observations documented. Mrs SPURGIN was not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites due to dehydration. Potentially beneficial treatments (e.g. intravenous hydration, reduction in the dose of morphine, different antibiotics) were not proffered nor advice obtained from the orthopaedic team or a microbiologist. Instead a syringe driver containing diamorphine (equivalent to a 4–6 fold increase in her morphine dose) and midazolam was commenced. On a subsequent review by Dr REID, as a result of finding Mrs SPURGIN unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Dr BARTON in particular, but also Dr REID, could be seen as doctors who breached the duty of care they owed to Mrs SPURGIN by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs SPURGIN by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr BARTON and Dr REID exposed Mrs SPURGIN to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr BARTON and Dr REID leave themselves open to the accusation of gross negligence.

Interview of Dr Jane BARTON.

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified as a registered medical practitioner in 1972. In addition to her GP duties she took

up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 15th September 2005 Dr BARTON in company with her solicitor Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Enid SPURGIN at the Gosport War Memorial Hospital. The interviewing officers were DC Code A and DC Code A.

The interview commenced at 0916hrs and lasted for 28 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/9. This statement dealt with the specific issues surrounding the care and treatment of Enid SPURGIN.

The expert response to the statement of Dr BARTON from Dr WILCOCK is:-

Dr BARTON admits to poor note keeping. However, even with episodes considered potentially serious and significant by Dr BARTON, no entry was made in the medical notes, even on a weekend when Dr BARTON was not presumably time pressured to the same extent. Having read Dr BARTON's statement regarding Enid SPURGIN, I believe the following issues raised remain valid and have not yet been satisfactorily addressed, for example:

- there was insufficient assessment of Mrs SPURGIN's pain on admission to Dryad Ward
- contrary to the usual expectation that pain would reduce post-operatively, the pain continued, even when the dose of morphine was increased to a dose associated with undesirable effects; despite this there was insufficient assessment of the possible causes of Mrs SPURGIN's pain and no orthopaedic review was obtained
- there was a lack of a thorough medical assessment when Mrs SPURGIN's condition deteriorated
- an inappropriate dose of diamorphine was used in a syringe driver
- although the dose of diamorphine was subsequently reduced, the dose of midazolam was increased.

In short, Dr BARTON in particular, but also Dr REID, could be seen as doctors who breached the duty of care they owed to Mrs SPURGIN by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs SPURGIN by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain and when her physical state deteriorated in what was possibly a temporary and reversible way. Instead the actions of Dr BARTON and Dr REID exposed Mrs SPURGIN to the inappropriate use of doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr BARTON and Dr REID leave themselves open to the accusation of gross negligence.

Furthermore a Consultant Orthopaedic and Tramua Surgeon Dr Daniel REDFEARN reports:-

Mrs SPURGIN suffered a relatively complex hip fracture as a result of her fall on March 19 1999. The decision to operate and the implants and operative technique employed were

appropriate. I am unable to comment on the quality of the fixation of the fracture in the absence of radiographic record or post mortem findings

She had a significant bleed into her thigh in the early stages post-operatively, and the possibility of compartment syndrome was raised. It is of grave concern that no further action can be identified in relation to this potentially serious and reversible diagnosis. Consequently, it is not possible to confirm that she had a compartment syndrome from the medical record.

Due consideration of the significance of her symptoms of pain and her inability to mobilise was not given consistently at either Haslar or at. Gosport War Memorial Hospital Specifically she did not undergo a further x-ray examination at either hospital, and she was not referred back to Haslar from Gosport War Memorial Hospital. The differential diagnosis should have included implant failure and uncontrolled infection. These complications would have been reversible.

Operation ROCHESTER.

Key points June 2006.

Enid Dormer SPURGIN Born **Code A**

Enid SPURGIN married at the age of 26years and ran a market garden in the Meon Valley Hampshire with her husband Ronald until he died in 1958. The couple were childless.

Her nephew describes her as a fit and healthy and active woman all of her life, she was tall of slim build and driving a car until she was 90.

At the time of her death in 1999 she was 92 years of age.

She had previously suffered a stress fracture of the right hip in 1981. In 1988 she was noted to have Pagets disease in her pelvis and suffered a probable Myocardial Infarction in 1989.

In 1997 she was seen by Dr MEARS a Consultant Psycho-Geriatrician for depression, he also noted poor eyesight. She was showing signs of memory impairment.

Otherwise Mrs SPURGIN was a relatively fir and independent widow living alone.

On the 19th March 1999 she suffered a fall whilst walking her dog fracturing her right hip.

She was admitted to Haslar Hospital where her hip was surgically repaired using a dynamic hip screw.

Within hours of the surgery there followed the complication of leakage from the wound causing her right thigh to swell to twice its normal size.

It was considered that she had probably developed a haematoma due to a bleeding vessel in the wound.

Post operatively Mrs SPURGIN was mobilised from a bed to a chair and walked by nurses small distances with a zimmer frame.

She Code A had a small sore on the back of her right leg.

She was given pain relief, paracetamol as required.

On 26th March 1999 Mrs SPURGIN was transferred to Dryad ward at Gosport War Memorial Hospital. A single page medical note records that she had a history of fractured neck of the femur and no significant past history. She was not 'weight bearing' Code A. The medical plan was to 'sort out analgesia'.

Nursing notes refer to pain, the first night she had difficulty in moving and was given Oramorphine.

On the 27th March she was receiving regular Oramorphine but was still in pain.

On the 28th March the nursing notes comment that Mrs SPURGIN had been vomiting with Oramorph and that Dr BARTON had advised to stop the Oramorph and try Metoclopramide three times a day and co-dydramol.

On 29th March pain needed to be reviewed.

On 31st March 10mgs of morphine slow release tablets were administered. He is noted to have walked with a physiotherapist but remained in a lot of pain which remained between the 1st and 3rd of April.

Code A

On 7th April Mrs SPURGIN was seen by Dr BARTON, who thought the wound site was infected and prescribed antibiotics.

On the 7th April 1999 a medical note comments that Mrs SPURGIN was 'still in a lot of pain and very apprehensive'. The note suggested X ray of the right hip as movement was still quite painful.

On the 8th April the morphine slow release tablets are increased to 20mgs as required. It is documented that Mrs SPURGIN should remain bed rested until Dr REID had reviewed the X ray of her hip.

Mrs SPURGIN deteriorates on 11th April, nursing notes record that she is very drowsy and refusing food and drink. The wound looks red and inflamed and feels hot.

Following discussion with Dr BARTON a decision is made to commence a syringe driver.

The patient is seen by Dr REID who reduces the level of diamorphine.

On the 12th April diamorphine is written up 20-100mgs. 80mgs was started in a syringe driver at 0800hrs and was discarded at 1640hrs when the dosage was reduced by Dr REID to 40mgs in 24hrs. 20mgs of Midazolam was also placed in the syringe driver at 0800hrs.

On the 12th April the notes record that she was now very drowsy and not rousable. Diamorphine was reduced from 60mg's to 40mg's with a note to increase to 60mgs if pain recurs.

At 1.15am on 13th April it is noted that Mrs SPURGIN died peacefully.

Clinical team assessment.

5. Enid SPURGIN.92. Died 12th April 1999 eighteen days after admission to Gosport War memorial hospital. She had suffered a fractured hip which had been repaired with a dynamic hip screw. She could get from a bed to a chair with the help of 2 nurses before the transfer, and had paracetomal as required for pain relief.

Pain became an issue as soon as she arrived at Dryad. Analgesia was started with Oramorph regularly and then regular co-dydramol and then MST at low dose. The dose was increased after continued pain was noted. She had deteriorated on the day a syringe driver was started, but she is reported as denying pain.

Diamorphine was started at 80mg per 24hrs via a syringe driver. This is a very high dose 5-6 fold increase. It is not clear who chose this dose but the way the drug was prescribed the nurses could have used a dose anywhere between 20 to 200 mg a day. It had to be reduced, because she was too drowsy and it probably contributed to her death.

No evidence of consultation with appropriate specialist over the management of her operation wound infection. Rapid escalation of opiate dose. Poor drug prescription when diamorphine infusion was commenced, nurse could have set up anything from a dose of 20-200 mg per day and still been in compliance.

Dr Jane BARTON from Caution interview with police 15th September 2005.

Within a prepared statement Dr BARTON commented that upon Mrs SPURGINS transfer to Dryad Ward on 26th March 1999 her right lower leg was very swollen and had a small break on the posterior aspect. She needed encouragement with eating and drinking but could manage independently.

Her only medication at that time was paracetamol as required.

Dr BARTON admitted Mrs SPURGIN to the ward making a brief admission note.

She believes that she was concerned to reassess her wound and ensure that she should have adequate analgesia. Swabs were taken all being negative for MRSA.

It was noted that Mrs SPURGIN was experiencing pain, she prescribed Oramorph and Lactulose.

On 27th March Dr BARTON increased the Oramorph dose concerned that the previous dose had not been adequate in relieving pain.

Dr BARTON was subsequently contacted by nursing staff, she believes she was informed that Mrs SPURGIN had been vomiting with the Oramorph. Accordingly it was discontinued and Co - Dydramol commenced.

Further negative tests were made for infection.

Dr BARTON believes she again reviewed Mrs SPURGIN on 31st March when she prescribed Morphine Sulphate as a consequence of inadequate pain relief of Co-Dyrdramol. Oramorph was given simulataneously.

By 6th April Dr BARTON had increased the Morphine Suphate dosage to 20mgs twice a day, concerned that she was developing an infection from an oozing wound, she subsequently prescribed antibiotics.

Dr REID saw the patient on 7th April confirming the fact that Morphine Sulphate had been increased and prescribing a minor anti-depressant. He requested an X ray of the hip. Dr BARTON is unable to say what the x ray demonstrated as there is no report available.

It appeared that Mrs SPURGINS condition deteriorated over the weekend 10th/11th April and it appears a discussion took place between the nephew and nursing staff with the nephew recorded as having been anxious that Mrs SPURGIN should be kept as comfortable as possible.

There follows an entry on the nursing record suggesting that Mrs SPURGIN was seen by Doctor BARTON probably the morning of 12th April 1999. In view of her condition and deterioration Dr BARTON prescribed Diamorphine and Midazolam to provide relief from pain and distress to be administered by syringe driver.

The doses were commenced at 80mg Diamorphine and 20mgs Midazolam at 0900hrs on 12th April 1999.

Dr BARTON anticipates that the doses were discussed with her.

Dr REID carried a ward round later that afternoon and reduced the dose of diamorphine to 40mgs noting that it should be increased to 60mg if pain recurred, by then approximately 25mgs of diamorphine would have administered from Dr BARTONS prescription.

At no time was the medication provided with the intention of hastening Mrs SPURGIN's demise.

Expert Witness Dr Andrew WILCOCK (Palliative medicine and medical oncology comments:-

Mrs Spurgin was a relatively fit and independent 92 year old widow who lived alone. Whilst walking her dog, she fell and fractured her right hip which was surgically repaired using a dynamic hip screw on the 20th March 1999.

Within hours of the surgery there was Code A swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Mrs Spurgin's hip/thigh on movement continued to be a problem noted by Dr Reid when he reviewed Mrs Spurgin on the 24th March 1999.

Surgeon Commander Scott reviewed Mrs Spurgin but no specific comment was recorded in the medical notes regarding Mrs Spurgin's pain, no changes were made to her analgesia and on the 26th March 1999 she was transferred to Dryad Ward, Gosport War Memorial Hospital. With regards to the standard of care proffered to Mrs Spurgin in Haslar Hospital, the report of expert orthopaedic surgeon raises several concerns.

During her admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal: there was a lack of clear, accurate, and contemporaneous patient records; inadequate assessment of Mrs Spurgin's condition; a lack of consultation with colleagues to seek appropriate advice and support; the use of diamorphine and midazolam was in doses excessive to Mrs Spurgin's needs.

When Mrs Spurgin became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare there was no medical assessment or even simple observations documented.

Mrs Spurgin was not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/ toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites due to dehydration. Potentially beneficial treatments (e.g. intravenous hydration, reduction in the dose of morphine, different antibiotics) were not proffered nor advice obtained from the orthopaedic team or a microbiologist.

Instead a syringe driver containing diamorphine (equivalent to a 4–6 fold increase in her morphine dose) and midazolam was commenced. On a subsequent review by Dr Reid, as a result of finding Mrs Spurgin

unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Expert Witness Dr David BLACK (Geriatrics) comments:-

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 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 Spurgins 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.

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

Expert Consultant Orthopaedic Surgeon Dr Daniel REDFERN comments:-

Mrs Spurgin suffered a relatively complex hip fracture as a result of her fall on March 19th 1999. The decision to operate and the implants and operative technique employed were appropriate.

The expert was unable to comment on the quality of the fixation of the fracture in the absence of radiographic record or post mortem findings.

The patient had a significant bleed into her thigh in the early stages post-operatively, and the possibility of compartment syndrome was raised. It is of grave concern that no further action can be identified in relation to this potentially serious and reversible diagnosis. Consequently, it is not possible to confirm that she had a compartment syndrome from the medical record.

Due consideration of the significance of her symptoms of pain and her inability to mobilise was not given consistently at either Haslar or at Gosport War Memorial Hospital. Specifically she did not undergo a further x-ray examination at either hospital, and she was not referred back to Haslar from Gosport War Memorial Hospital. The differential diagnosis should have included implant failure and uncontrolled infection. These complications would have been reversible.

Evidence of other key witnesses.

Carl JEWELL Nephew, background in respect of deceased. Visited Aunt at Haslar hospital impressed by level of care, Mrs SPURGIN seemed OK in herself and was lucid.

Visited aunt four or five times after transfer to Gosport War memorial hospital. She seemed fine.

Visited Aunt on 12th April 1999 she was unconscious and unrousable. Dr REID told him that she was on too high a dose of morphine. Doctor told nurse to reduce aunts diamorphine, he said she would be alright.

Received call at 0130hrs 13th April and informed that she had died.

Helen McCORMACK(formerly Helen MEARS) Psychiatric Consultant saw Mrs SPURGIN on 11th November 1997 depressed and becoming increasingly frail, intellectual and with it but did not want to socialise. Failing eyesight and

hearing she would rather be dead than carry on like this. She has a one eyed rescue greyhound that she walks 3 times a day. Provides detailed background.
As a result wrote to Mrs SPURGINS GP Dr TAYLOR on 12th November 1997.

Fraser HARBAN Senior house officer anaesthetics Royal Hospital Haslar. Explains his detailed handwritten note re anaesthetic post op 20th March 1999.

Ian GURNEY Pre registration house officer Royal Hospital Haslar. ON 24TH March wrote that patient would benefit from Dr LORD for rehabilitation commenting ' she was previously well with no significant past medical history, living alone and independently with no social service input. She was transfused with three pints of blood but has otherwise made an unremarkable post op recovery. She has proved quite difficult to get mobilised and her post op rehabilitation may prove somewhat difficult...

Gill RANKIN Army nursing officer in charge Orthopaedic ward, Royal Hospital Haslar. On 26th March 1999 wrote Mrs SPURGINS transfer letter to Dryad ward.

Gillian HAMBLIN Clinical manager (Senior sister) Dryad Ward. Describes ward routines. Was the nursing manager for Mrs SPURGIN in charge of all aspects of patient care with the exception of drug prescription. Lynne BARRATT was the named nurse but junior to Mrs HAMBLIN. Mrs HAMBLIN never administered drugs to this patient, but as senior sister it was her duty to ensure that drugs were given appropriately.

Lynne BARRETT Staff nurse Dryad Ward. Reviews and explains medical notes and nursing care afforded to Mrs SPURGIN. Morphine sulphate tablets given to Mrs SPURGIN twice daily between 31st March and 11th April 1999. On 12th March at 0900hrs 60mgs of diamorphine reduced to 40mg at 1640hrs the same day. Does not know why Dr BARTON started the dose at 60mg.

Freda SHAW Staff nurse Dryad Ward. Explains her entries on nursing notes. Administered Morphine sulphate on four occasions between 31st March and 8th April 1999. Administered 80mgs of Diamorphine and 20mgs of Midazolam at 0900rs on 12th April 1999.

Code A Staff nurse covering Dryad Ward on nights. Noted that Mrs SPURGIN had a poor night on 10th April 1999 and administered Oramorph on 11th April.

Code A Night clinical manager (sister) Gosport War Memorial Hospital. Comments upon hospital routine. At 0115am 13th April 1999 she verified death. She wrote 'Died peacefully death confirmed by night sister Fiona WALKER in the presence of Staff Nurse Siobhan COLLINS'

Code A Staff nurse. As above+ comments upon training administration drugs and explains nursing note entries 11th -13th April 1999.

Code A Staff nurse. Witnessed various drug administration to Mrs SPURGIN.

Code A Staff nurse. Details concerns around use of syringe drivers. Witnessed Oramorph administered to Mrs SPURGIN 26th and 27th March1999.

Anita TUBRITT Senior Staff nurse. Administered Oramorph to Mrs SPURGIN on three occasions.

Code A Staff nurse. Details drugs administered to Mrs SPURGIN.

Code A Senior Physiotherapist Gosport War Memorial Hospital. Explains physio note of 1st April 1999.

Detective Constables Code A
Conducted tape recorded interviews with Dr BARTON on 15th September 2005 she produced a prepared statement.

D.M.WILLIAMS
Detective Superintendent 7227.
8th June 2006.

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.

Code A (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.

Code A 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.

Code A (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 Code A 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 Code A 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 A

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

HAMPSHIRE CONSTABULARY

C.51 1/99

Identification Ref. No. DB/2011

Court Exhibit No.

R - v -

Description

A certified copy of a Death Certificate (Sturgis)

Time/Date Seized/Produced

19th May 2005

Where Seized/Produced

Office for National Statistics

Seized/Produced by

D. Burgess

Signed

Incident/Crime No. Operation Rochester

Major Incident Item No. x 618

Laboratory Ref:

PLEASE ATTACH WITH TAPE

GLOUCESTERSHIRE CONSTABULARY

Station.

J1 No. Item No.

O.I.C.

Identification Ref No.

Court Exhibit No. DB 2011

R-v-

Description

A CERTIFIED COPY OF A DEATH CERTIFICATE

Time / Date Seized / Produced

19TH May 2005

Where seized / Produced

Office for National Statistics

Seized / Produced By

DAVID BURGESS

Signed Code A

Incident Crime No.

Major incident item No.

Laboratory Ref

P27B (Rev 2/02)

Code A

Note (1) Births and Deaths.

This certificate is issued in pursuance of the Births and Deaths Registration Act 1953. Section 34 provides that any certified copy of an entry purporting to be sealed or stamped with the seal of the General Register Office shall be received as evidence of the birth or death to which it relates without any further or other proof of the entry, and no certified copy purporting to have been given in the said Office shall be of any force or effect unless it is sealed or stamped as aforesaid.

Note (2) Births.

A name given to a child (whether in baptism or otherwise) before the expiration of twelve months from the date of registration of its birth, may be inserted in Space 17 of the entry in the birth register under the procedure provided by Section13 of the Births and Deaths Registration Act 1953. If the parents or guardians wish to avail themselves of this facility at any time, they must deliver a certificate of baptism or of naming to the registrar or superintendent registrar having the custody of the register in which the birth was registered. This certificate must be in the prescribed form and can be obtained on application to any registrar.

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

Code A 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 Code A Code A 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 Sue Nelson.

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.

39. Administration of Diamorphine and Midazolam are then recorded as having commenced by syringe driver at 9.00 am on 12th April, the Diamorphine at a dose of 80mgs, and the Midazolam at 20mgs. I anticipate that the dose of both the Diamorphine and the Midazolam would have been discussed with me. I believe I would have considered 80mgs to be appropriate at that time given the fact that the Oramorph was clearly inadequate in alleviating Mrs Spurgin's pain and distress. She had by that time been receiving 40mgs of Morphine Sulphate per day, with a further 5mgs of Oramorph Code A day previously, and I considered this increase in medication to be a reasonable one in view of her condition at that time.

40. Dr Reid then appears to have carried out a ward round that afternoon, recording that Mrs Spurgin was now very drowsy since the Diamorphine infusion had been established - though of course there were nursing entries for 11th April, preceding the administration of the Diamorphine, which indicated that she had been very drowsy at that time, which I anticipate was in consequence of her infection. In any event, Dr Reid felt it advisable to reduce the Diamorphine infusion to 40mgs, but noted that if the pain recurred, it should be increased to 60mgs. He recorded that it was now possible to move Mrs Spurgin's hip without pain and that she was not rousable at that time.

41. The corresponding entry in the nursing records indicates that the Diamorphine was to be reduced to 40mgs, but if the pain recurred, the dose could be gradually increased as and when necessary. It was noted that Mrs Spurgin's nephew had been spoken to and was aware of the situation. I anticipate that the nursing staff were well aware by this stage that Mrs Spurgin was probably dying and would have been concerned to make her nephew aware of the position.

42. In consequence of Dr Reid's review, the nursing records show that the dose of Diamorphine in the syringe driver was discarded, with 40mgs over 24 hours being commenced at 4.40 pm. Accordingly, from the time when the Diamorphine was instituted at 9.00 am only approximately 25mgs of Diamorphine would have been administered in accordance with my initial prescription by the time of the change in dose at 4.40pm.

43. The nursing night staff recorded that on the night of 12th April Mrs Spurgin's condition "remained ill". Her urine was said to be very concentrated. The syringe driver was apparently satisfactory, though she appeared to be in some discomfort when attended to, so that even the 40mgs of Diamorphine was not seemingly successful in relieving her pain and distress entirely. Her breathing was reported as very shallow.

44. Sadly, Mrs Spurgin is recorded as having died peacefully at 1.15 am on 13th April.

45. The Diamorphine and Midazolam, and indeed the Oramorph and Morphine Sulphate which preceded them were prescribed by me and in my view administered solely with the intention of relieving the pain and distress which Mrs Spurgin was suffering. At no time was the medication provided with the intention of hastening Mrs Spurgin's demise.

Signed and dated Code A
15-9-05 handed to
9.43 am
D.C. Code A

Code A