Enid Spurgen born Code A **and died 13.04.1999**

Mr Jewell gave evidence that Mrs Spurgen was his aunt and gave a fairly graphic account of her life.

He said that his aunt had fallen outside the post office in Stubbington in March 1999 and was admitted to Haslar on 19th March for an operation on her right hip.

On 26th March she was transferred to Gosport and initially when he saw her she was fine.

He complained that he did not see a doctor and did not know what progress she was making and by 12th April when he visits his aunt at that stage is unconscious and he is unable to rouse her.

It is at that stage that Dr Reid takes the view that her dose of morphine is too high and that he orders a reduction. At 10pm on the evening of 12th April he is told that his aunt is conscious and had been given sips of water. However by 1.30 on 13th April he receives a telephone call to say that she has died. The cause of death given was:
1a Cerebrovascular Accident as certified by Dr Barton.

The statement of **Dr Holman** was read in which she confirmed that she was employed at Gosport from January 1998. There was some friction between her and Sister Hamlyn and they may have disagreed as to medication and the use of a syringe driver.

She was involved in the care of Enid Spurgen although she does not recall the lady. From the notes she says on 12th April 1999 Mrs Spurgen was seen by Dr Barton and she gave instructions to commence the syringe driver. At that stage she was drowsy and unrousable at times. She was refusing food and drink and complained of pain when moved. She believes that the syringe driver may have been discussed with Mrs Spurgen's nephew and that he wanted his aunt to be kept as comfortable as possible.

She confirms that Dr Barton would have authorised the starting dose from 20 to a maximum of 200mgs of diamorphine, medazalam 20 to 80mgs in twenty four hours.

She confirms that Mrs Spurgen was seen by Dr Reid who authorised the reduction of the diamorphine to 40mgs over twenty four hours.

From her statement it is unclear as to the progress of the administration of diamorphine but it seems that 40mgs was administered at 16.40 on 1st April and at 8.45 on 2nd April and she then records that she witnessed the administration of 20mgs of diamorphine by Staff Nurse Shaw on 12th April.

There seems to be some question about whether there is an error on the drugs record but it is of little effect.

She certainly takes the view that Dr Barton but basically her argument was not accepted

In support of that she says that the entry on 12th April 1999 in the nursing notes states, seen by Dr Reid diamorphine to be reduced to 40mgs over twenty four hours if pain reoccurs the dose can gradually be increased as and when necessary. Enid's nephew has been spoken to and is aware of the situation.

Nurse Hamlyn had a statement read and she said that she made no actual entries on the nursing record and she noted that on 12th April 1999 Enid Spurgeon was prescribed diamorphine, hiascine, medazalam lactulose, ciclozine but once these had been prescribed they would not have been administered until needed. This is the principle of proactive prescribing.

Lynne Barrett gave evidence that she was concerned in the case of Enid Spurgen and she detailed the varying nursing plans over her period in the hospital. She confirmed that Enid was experiencing a lot of pain on movement and that she had been vomiting with oramorph. She confirmed that Dr Barton said the oramorph should be stopped but was recommenced on 31st March 1999.

Her oral morphine was increased to 10mgs on 3rd April and 20mgs on 8th April but on 11th April she was still in pain and the wound on her hip was oozing serous fluid.

By 10th April she is on an anti anxiety drug and she is written up for diamorphine by Dr Reid at 40mgs over twenty four hours on 12th April 1999. She then dies on 13th April at 1.15am.

Beverly Turnbull gave evidence to say that she did have concerns in the early 1990's about the analgesic ladder at Great Ormond Street but that those concerns had been resolved by the mid 1990's.

So far as Enid Spurgen was concerned she does not recall her in any way but from her notes she says that she required much assistance with mobility due to pain and discomfort and that she was in receipt of oramorph 10mgs at 23.15 and 5mgs at 6.50 detailed as at 26th March 1999.

She too goes through the various care plans for Mrs Spurgen and the fact that she was restless and anxious.

Anita Tubritt gave evidence and confirmed that she had administered 5mgs of oramorph to Enid Spurgen on 11th April in accordance with Dr Barton's prescription.

Dr Reid gave evidence to say that he considered Dr Barton clerking in of patients rather brief but that it contained the salient features.

In the case of Mrs Spurgen he saw her on 7th April 1999 and increased her morphine at that stage to 20mgs twice a day for the control of pain. When he next sees her on 12th April she was drowsy and had a diamorphine infusion in position. He then reduced the dose from 40mgs but said that if pain should recur or increase that should go to 60mgs.

He felt that Mrs Spurgens chances of mobilisation were very small.

He first saw her two days before she was transferred and considered her fit for transfer. However she was still suffering from hip pain after the operation.

He considered generally that Mrs Spurgen was on too much diamorphine and it is he that orders the decrease.

He has no doubt that by 12th March Mrs Spurgen is dieing and her condition is not reversible.

He accepted that she was increasingly distressed and agitated and that would be a reason to prescribe diamorphine. However he would expect to see the reasoning recorded in the notes.

He accepted that whatever the situation there was insufficient doctor time to afford the correct level of attention particularly to patient families and if there was a choice he will prefer that time was given to the patient rather than note taking or discussions with family.

Dr Barton gave evidence and noted that on transfer to Gosport Mrs Spurgen was admitted because of her previous fractured neck of femur with a repair on 19th March 1999. She had no previous relevant history, she was not weight bearing, had very thin paper tissue skin, was not continent and she needed to have her analgesia resolved.

Dr Barton prescribed oramorph in a 10mg dose as 2.5mls four hourly with 5mls at night. It is recorded that she had been admitted for rehabilitation and gentle mobilisation however she was complaining of a lot of pain and that was the reason for the oromorph.

Because of her fragile skin she was at very high risk of bed sores. By 27th March she was having regular oromorph but was still in pain. Dr Barton considered that the oromorph was not dealing adequately with the pain relief and she increased the prescriptions. That continued until the 28th March when it was recorded that she was vomiting on oramorph and codridamol four times a day was prescribed with metoclopramide to be given as required.

Dr Barton did say that in the normal course of events Dr Reid would have seen Mrs Spurgen but in the absence of any note she is unable to give any explanation as to whether she was seen or not.

The codridamol was inadequate and accordingly Dr Barton prescribes 10mgs of morphine sulphate on 31st March.

On 31st March Dr Barton prescribes morphine sulphate and that continues but does not resolve the pain problem and it is recorded that she continues with pain. The dose is increased but does not seem to be resolving the problem and by 7th April Dr Reid records she is taking 40mgs of morphine sulphate a day and that is not solving the problem.

She becomes incontinent and is not drinking. By 10/11th April she has become restless, she is leaning to the left, does not appear to be at all well

and is experiencing difficulty swallowing. The consideration is that she may have had a CVA and against that background she is started on morphine in the syringe driver. That is written up as a dosage of 20 to 200mgs of diamorphine and 20 to 80mgs of medazalam. Other medication is given.

Dr Reid conducts a ward round and feels the level of diamorphine is inappropriate and reduces it to 40mgs. However he does say that if pain should recur it should be increased to 60mgs. However when the diamorphine is reduced the pain recurs and the dose was gradually increased.

Professor Black gave evidence and confirmed that Enid Spurgeon had undergone an operation for a femoral fracture and that she presented a common problem in geriatric medicine.

She was an elderly lady with a number of chronic conditions and was becoming increasingly frail.

He said that the prognosis after such a fracture is generally poor both in terms of mortality and in terms of mobility and up to twenty five per cent of patients in such category will die shortly after the fracture.

He did point out that the problem at Gosport was the apparent lack of medical assessment and lack of documentation.

He does criticise the starting dose of diamorphine at 80mgs as 'poor clinical judgement'. However he cannot satisfy himself that such a high dose of diamorphine hastened the death other than by a very short period of time being hours. However it may be noted that Dr Reid then reduced the dose to 40mgs.

He did give on the balance of probability the cause of death as:
1a Infected Wound
1b Fractured Right Hip (Operated on 20.03.99)

Dr Wilcock gave evidence and gave a brief history and in particular said that on her admission to Driad Ward she was cared for by Dr Barton and Dr Reid but again confirms that the note taking was inadequate and was therefore impossible to work out the reasoning behind the dosage of diamorphine and medazalam.

He felt that there was a failure to assess a condition or to react appropriately when her wound became tender and inflamed despite antibiotics. She complained of pain which appeared to be excessive which was treated by Dr Barton and Dr Reid by increased use he indicated that she had been unresponsive since the syringe drive had been started he was quite clear that the 80mgs of diamorphine was excessive and he would have expected a starting dose of 10mgs. He believes that was what made her unresponsive.

In response to Mr Leper he indicated that the medication would have contributed more than minimally to her death and he was concerned that the cause of the pain had not been addressed. Her condition was not improving and he was concerned that nobody had asked why.