*Version 4 of complete report – June 05 2008 – Enid Spurgin*

**SUMMARY OF CONCLUSIONS**

**Enid SPURGIN**
**DOB: Code A**
**DOD: 13/04/1999**

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

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

However there were failings in the medical care provide to Enid Spurgin also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital

**1. INSTRUCTIONS**

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

**2. ISSUES**

2.1 Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.

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

3.1 At the time of her death in 1999 Edith Spurgin was a 92-year-old lady. She had been previously noted to have a stress fracture of her right hip, not needing operative intervention in 1981. (M38). She was also noted to have Paget's disease in her pelvis in 1988 (M39). She had a probably myocardial infarction in 1989 (M6). In 1997 she had been seen by a Dr Mears, a Consultant Psycho-Geriatrician, for depression (144). He also noted poor eyesight (145). At that time she was on an anti-depressant and was noted

to have a normal mini-mental test score of 27/30 (148). She was followed up by a Community psychiatric nurse over the following year who believed that she was now showing evidence of memory impairment (152) (158).

3.2 Enid Spurgin was admitted to the Haslar Hospital on the 19th March1999 following a fall, was diagnosed as having a proximal femoral fracture, treated by an operation "a dynamic hip screw", on 20th March 1999 (20). The notes for Haslar are not currently available to me, the only information is the hand written one page summary that says post operatively she can be mobilised from bed to chair with two nurses and can walk short distances with a Zimmer frame. It noted she has been incontinent at night and has a small sore on the back of her right leg, which is swollen. This letter states that the only medication she is on is Paracetamol prn. The only nursing information from Haslar is an admission assessment and pressure sore assessment on 19th March (64 & 66).

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

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

3.5 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.

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

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

on 1st and 3rd April (85).

3.8 On 4th April (86) it is noted that the wound is now oozing serous fluid and blood. On 7th April, it is documented that she was seen by Dr Reid who thought the wound site was infected and started Mrs Spurgin on Metronidazole and Ciprofloxacin (both antibiotics) (107). On the 8th April, her MST is increased to 20 mgs bd, on 9th it is documented that she should remain on bed rest until Dr Reid had reviewed the x-ray of the hip.

3.9 Mrs Spurgin clinically deteriorates significantly on the 11th April. She is now very drowsy and unrousable at times and refusing food and drink (107). The wound looks red and inflamed and feels hot (107). As recorded in the nursing notes Mrs Spurgin is seen by Dr Barton (107), and a decision is made to commence a syringe driver. There is no record in the medical notes.

3.10 The patient is seen by Dr Reid on the afternoon of the 12th (108) the Diamorphine dosage is reduced. Early morning of 13th April, death is confirmed (108).

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

3.12 Drug management in Gosport concentrating on the use of analgesia:

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

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

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

3.16 Ciprofloxacin 500 mgs bd is written up on 7th April and continued until 11th April and Metronidazole 400 mgs bd is also written up on 7th April and given

to 11th April. (134)

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

| Drug | Date prescribed | Prescribed as | Prescriber | Given |
|---|---|---|---|---|
| Oramorphine | 26/03 | 10 mgs in 5 mls<br>2.5 – 5 mls oral<br>PRN | Dr Barton | 31/03 1320 5 mgs<br>11/04 0715 5 mgs |
| Oramorphine | 26/03 | 10 mgs in 5 mls<br>2.5 oral<br>4 hourly<br>Regular | Dr Barton | 27/03 1515 5 mgs<br>27/03 1800 5 mgs<br>Then crossed off |
| Oramorphine | 26/03 | 10 mgs in 5 mls<br>5 mgs oral nocte<br>Regular | Dr Barton | 27/03 2200 10 mgs<br>Then crossed off |
| Oramorphine | 27/03 | 10 mgs in 5 mls<br>5 mgs oral<br>4 hourly<br>Regular | Dr Barton | 27/03 0600 10 mgs<br>27/03 1000 10 mgs<br>27/03 1400 10 mgs<br>28/03 0600 10 mgs<br>28/03 1000 10 mgs<br>3 doses missed with no explanation. Crossed off. |
| Oramorphine | 27/03 | 10 mgs in 5 mls<br>10 mls oral nocte<br>Regular | Dr Barton | 27/03 2200 20 mgs<br>Crossed off |
| Co-dydromol | 27/03 or 28/03 (?) | TT 6 hourly oral<br>Regular | Dr Barton | Regular doses 4 x a day until 1200, 31/08 when no further doses given. Crossed off |
| | | NEW CHART | | |
| Morphine<br>MST | 31/03 | 10 mgs bd<br>Oral<br>Regular | Barton | Started 31/03, 0930 and given regularly until last dose 06/04, 0800 crossed off |
| Morphine<br>MST | 06/04 | 20 mgs bd<br>Oral<br>Regular | Barton | Started 06/04, 0800 given regularly until last dose 11/04, 2000. Never crossed off |
| | | NEW CHART | | |
| Diamorphine | 12/04 | 20 – 200 mgs<br>SC in 24 hours<br>Regular | Barton | 12/04 0800 80 mgs<br>12/04 1640 changed to 40 mgs |
| Midazolam | 12/04 | 20 – 80 mgs<br>SC in 24 hours<br>Regular | Barton | 12/04 0800 20 mgs<br>12/04 1640 changed to 40 mgs |

## 4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

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

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

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

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

4.5 The medical assessment undertaken in Gosport was inadequate. There is no record of a significant history or general examination being performed, or if it was it was not recorded. No assessment or explanation at all is sought for why this lady is in pain, particularly if she had not been in pain in Haslar. The major gaps in the written notes particularly on admission represent poor clinical practice.

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

4.7 The nursing notes document that her pain does not settle and is considerably interfering with her attempts at rehabilitation. She is then troubled with vomiting and the opioid analgesia is in fact stopped and replaced with oral co-dydramol (a moderate oral opioids). Her vomiting does apparently settle but her pain continues, so she is restarted on a strong opioid analgesia on 31st March.

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

4.9 In view of the clinical deterioration on 11th April, despite the patient receiving appropriate antibiotics, I believe it was appropriate to start a syringe driver as she was drowsy and unrousable at times, as there is no doubt in my view that Mrs Spurgin was now dying. The likeliest cause is an unresolved infection in the wound and in her hip but the original cause of the pain remains undiagnosed. The opportunity for any possible remediation is well past at this stage. Diamorphine is then written up, prescribed at 80 mgs per 24 hours. The prescription in the notes was 20 – 200 mgs of Diamorphine in 24 hours and it is not clear whether Dr Barton or the nurse in charge choose the dose of 80 mgs. At that time Mrs Spurgin was on 20 mgs twice a day (i.e. 40 mgs total) of Morphine Sulphate, slow release although received 45 mgs in total on the 11th April. Diamorphine subcutaneously is usually given at a maximum ratio of 1 – 2 (i.e. up to 20 mgs Diamorphine in 24 hours for 40 mgs of Morphine) (Wessex Guidelines). However, her pain was not controlled and it would have been appropriate to give a higher dose of

Diamorphine. Conventionally this would be 50% greater than the previous days, (Wessex Guidelines). Some people might give up to 100%. Thus a maximum starting dose of Diamorphine of 40 mgs in 24 hours would seem arguable. Mrs Spurgin was prescribed 80 mgs which in my view was excessive, thus poor and negligent medical practice. This was reduced to 40 mgs after the intervention of the consultant Dr Reid, some 8 hours later. This was an appropriate intervention.

4.10 Midazolam was also added to the infusion pump on 12th April. Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was originally 20 mgs for 24 hours which is within current guidelines. This was increased to 40 mgs later in the day, which although remains within current guidelines, many believe that elderly patients may need a lower dose of a maximum 20 mgs in 24 hours (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine, 6th edition, 2003). There is no assessment or justification for this decision in the medical notes, nor is it possible to tell if this is a medical or nursing decision. Morphine is compatible with Midazolam and can be used in the same syringe driver.

4.11 As Mrs Spurgin is thought to have been excessively sedated and the dose of Diamorphine is reduced on 12th April, thus the decision to increase the dose of Midazolam at the same time seems inexplicable. Mrs Spurgin dies on the 13th April.

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

4.12 In my view the dose of Diamorphine used on 11th was inappropriately high, however, I cannot satisfy myself to the standard of "beyond reasonable doubt" that this had the definite effect of shortening her life in more than a minor fashion of a few hours. I understand the cause of death on the death certificate was Cerebrovascular Accident. There is nothing in the medical notes to substantiate this diagnosis which is misleading and probably inaccurate.

**5. OPINION**

5.1 Mrs Enid Spurgin presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture. The prognosis after such a fracture, particularly in those patients with impairments of daily living before their fracture is generally poor, both in terms of mortality or in

terms of morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications.

5.2 However there were failings in the medical care provide to Enid Spurgin, in particular:

- The failure to undertake a clinical assessment of Mrs Spurgin on admission to Gosport War Memorial Hospital.
- The failure to make any diagnosis or assessment of the cause of pain on admission and until 7th April.
- The prescription on admission, without explanation, of strong opioid analgesia, when apparently she had only need Paracetamol in Hasler.
- The failure to follow up the xray undertaken on the 7th April.
- The failure to document the reason for starting the syringe driver.
- The failure to explain in the notes the decision to start with 80 mgs of Diamorphine in the syringe driver, in my view a negligent decision.
- The failure to explain the decision to increase the dose of Midazolam at the same time as the Diamorphine is reduced on the 12th April.
- The failure to record a reason to give 2 doses of MST on the morning of the 6th April.
- Reporting the cause of death as 'Cerebrovascular Accident', without any clinical evidence.

5.3 There are also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The failure to give regularly prescribed dose of Oramorphine, without explanation.
- The failure to cross off the MST from the regular drug chart on the 11th April.
- The use of the regular side of the drug chart for variable doses of drugs given in the syringe driver.
- The failure to write dosages of controlled drugs in words and figures as well as the total to be given.

## 6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the

opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

**7. STATEMENT OF TRUTH**

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: ______________________________ Date: ______________