LIVE

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 Y25H.

Wrote to a consultant at Haslar agreeing to take over the care of Mrs Spurgin but expressing concern over her hip and to check out that all was well before her transfer on 26th March 1999.

First saw Mrs Spurgin on 7th April 1999. She was in a lot of pain and apprehensive. 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 the 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.

Felt that Dr Barton's clerking in of the patient was brief but contained the salient features.

A fit 50 year old, he 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 of rehabilitation 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. Stated 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 Y25I.

First saw Mrs Spurgin 2 days before she was transferred on 24th March 1999.

Considered that Dr BARTON was more experienced than he in dealing with palliative cases.

Assessed Mrs SPURGIN was suffering hip pain post operatively, not uncommon in elderly patients, thought it important to x-ray the hip.

Stated 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. Agreed that this was quite a jump up the analgesic ladder.

The 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.

Deep infection from the hip joint could be difficult to diagnose.

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, did 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.

Could not answer why paracetomal was not continued for pain relief upon transfer.

When Dr Barton prescribed ORAMORPH on 26th and 27th March stated that the reasons should have been noted.

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. Lack of progress or increasing pain would be an indication to proceed with further investigation such as x-ray.

Interview Y25J.

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.

Would have expected Dr Barton to record in notes the patients changing condition.

Highlighted that recent research in the palliative care field had shown there was widespread ignorance around analgesic prescription.

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.

Regarding Dr Barton's initial prescription of Oramorph, commented that there was probably no alternative.

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 18 days, 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. Stated 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.

Was directing and in overall charge of the patient. 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 April 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 there were more immediate issues.

Interview Y25K.

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 then later diamorphine and hyoscine to dry up chest secretions administered on an as required basis.

Had discussed variable dose prescribing with Dr Barton, she had commented that she was not always immediately available and she did it to ensure that patients received adequate analgesia when they required it.

Trusted the nurses particularly with controlled drugs as there were always two 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.

Could not imagine in this case why the dose of diamorphine was started at 80mg. He had reduced to 40mg.

Interview Y25L.

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 but then agitated and distressed at other times. This seemed to be an appropriate indication to commence a syringe driver.

Viewed the use of a syringe driver for people regularly receiving small doses as a step up, not a hugely significant event.

Stated that it would have been good practice to have recorded why the syringe driver was started.

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.

14th July 2006.

Interview Y25M.

Clarified that Mrs SPURGIN received 2 x 20mg doses of morphine tablets on 11th April 1999 before being started on her syringe driver.

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.

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 death is very close had not formed that opinion on the 7th April.

Midazolam was prescribed within BNF recommended ranges.

In respect of increasing dosage of Diamorphine and Midazolam 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.

The starting dose of 80mgs of diamorphine was too high and it should have been started at a lower level.

Interview Y25N.

Would recommend a lower starting dose. For instance 20mgs and then increase by 50% if the dose insufficient i.e. to 30mgs.

A starting dose of between 25mgs and 45mgs would have been appropriate.

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.

Did not know why the Midazolam had been increased from 40 to 60 mgs and found it just absolutely amazing particularly an entry an entry on the prescription chart at 1640hrs when the Midazolam was increased

It was difficult to say what cause of death is in a situation where the patients do not have something clearly diagnosable i.e. heart attack or chest infection.

Interview Y25O.

The starting dose of 80mgs of Diamorphine prescribed by Dr BARTON was completely inexplicable. Should have spoken to her about it but could not remember if he had.

Cerebral vascular accident is 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 Spurgin had or had not suffered a stroke.

Thought that Mrs Spurgin's death should have been reported to the coroner upon the basis that death had followed within a year of the operation.

In terms of his consultant supervisory duties stated that it consisted of conducting a weekly ward round.

Was working very long hours at the time of dealing with Mrs SPURGIN 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.

Was not aware of Dr Barton cutting back on anything other than note keeping.

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 25P.

Confirmed that in layman's terms septicaemia and toxaemia was blood poisoning.

Could not see why analgesics should have been reduced in Mrs Spurgin's 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.

Whilst the pain was being treated nobody addressed what was causing the pain and subsequent increases in pain.

Did not believe that Mrs Spurgin had been overdosed with morphine.

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.

Did not recollect a conversation with Mrs Spurgin's nephew on the 12th April 1999 when he was alleged to have said that there was nothing wrong with Mrs Spurgin she was just on a too high dose of diamorphine. 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.

Part of a tape recorded interview with Dr. REID in the presence of legal representative Will CHILDS under caution 1556hrs – 1627hrs 08 08 2006 in respect of Enid SPURGIN

Interview 25X.

Mrs Spurgin's prognosis was for mobilising and eventual return to her home. The patient had been in hospital for about 24 days and during that time she seemed to be in pain from her hip.

There was a possibility of infection or further damage to the hip and that other treatment options may include further discomfort and/or prolonged stay in bed which would be unlikely to restore the lady to full mobility.

The treatment options would be for Mrs Spurgin to return to surgery for examination and the possibility of superficial or deep wound infection. The possible result of further examination may well entail treatment which would

render Mrs Spurgin in traction for many weeks or even some months, by which time there would be little chance of her re-mobilising

The x-ray for Mrs Spurgin did not appear to have been done and by the time that Dr. REID saw her 5 days later she was considered to be terminally ill.

It was put to Dr. REID that neither he nor Dr Barton investigated the possible problems of this patient's hip. He stated that he had requested an x ray as previously mentioned, and repeated that when he next saw Mrs Spurgin she was considered to be terminally ill, so pursuance of an x-ray had 'lost it's relevance'.

Confirmed that, according to the medical notes of Mrs Spurgin, she had not been written up as being 'not for 555' (resuscitation). Also that there was no mention that Dr. BARTON was 'happy for nursing staff to confirm death'.

It was put to Dr. REID that in spite of the above, Mrs Spurgin was considered to be terminally ill on 12th April, and Dr. REID agreed that someone should have possibly chased up the x-ray for this patient.