



DENNIS BRICKWOOD



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Dennis Brickwood

Date of Birth: Code A Age: 80
 Date of Admission to GWMH: 3rd February 1998
 Date and time of Death: 21.15 hrs on 12th June 1998
 Cause of Death:
 Post Mortem: Cremation
 Length of Stay: 19 weeks

Mr Brickwood's past medical history:-

Masangio-proliferative glomerulonephritis due to chronic renal failure
 Fracture neck of femur
 CA prostate
 Myeloma diagnosed on bone marrow
 Spinal osteoporosis
 Artrial fibrillation

Prior to his admission to hospital in February 1998, Mr Brickwood lived at home with his wife. He fell and sustained a fractured neck of femur. Mr Brickwood had been his wife's main carer as she had also had hip replacements and was not mobile. It was hoped that he would be discharged home with a complete care package or go into residential care. He had deteriorating vision and had cataracts in both eyes. Mr and Mrs Brickwood had a son.

It was noted in Mr Brickwood's notes that he was allergic to morphine and was on warfarin.

Prior to his admission Mr Brickwood had a history of falls. He was a very alert man but slow at times.

He was admitted to Gosport War Memorial Hospital from Queen Alexander for rehabilitation following an operation where a dynamic hip screw was inserted.

A Waterlow score of 25 was recorded on 22nd April 1998 going down to 17. A Barthel ADL index was completed noting 11 on 18th April 1998 going up to 17 later. The aim was to rehabilitate Mr Brickwood with a view to him going home with a complete care package.

A nutritional assessment of 3 was recorded on admission.

15th January 1998

Admitted to Hospital after fall where he sustained a fracture to the neck of femur on the right side.

20th January 1998

Operation dynamic hip screw.

3rd February 1998

Transfer to Gosport War Memorial Hospital for rehabilitation. He was nursed in a side room because he tested positive for MRSA. He was nursed on a Pegasus biwave mattress and needed the help of two nurses for transfers.

March 1998

OT assessment.

5th March 1998

Clinical notes state GP contact by nursing staff. Gets **drowsy with small amount of morphine**. Need to be cautious previously been on MST.

6th April 1998

Unsuccessful home visit.

14th May 1998

Sore heels noted. Skin intact.

24th May 1998

Complained of excessive chest pain. Impression musculoskeletal pain.

4th June 1998

No improvement. Chesty very rattly. **For morphine**. Family happy with care and **syringe driver discussed**.

5th June 1998

Higher dose of oramorph given.

9th June 1998

Changed oramorph to MST. Complaining of chest pain.

10th June 1998

Taking MST/oramorph. For syringe driver is pain not adequately controlled.

11th June 1998

Painful back- swallow and appetite poor. Seen by Dr Knapman syringe driver commenced. Family informed.

12th June 1998

Deteriorating pronounced dead by S/N Giffin at 21.15 hours. Relatives present.

15th June 1998

Death certified. For cremation

OPERATION ROCHESTER
CLINICAL TEAM'S SCREENING FORM

Patient Identification**DenBri****Exhibit number****BJC-06B**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		In pain, but high doses, especially given sensitivity to morphine		
Unexplained By Illness C				

General Comments

80-year-old man, #NOF, myeloma, c/a prostate, osteoporosis, MP-GN
Rising alk p'ase, 1998-06

Sensitive to morphine
initially – tramadol co-dydramol,
note buprenorphine, low dose 'Oramorph', diamorphine

A'iotics – cipro 1998-06-02

1998-06-04 pain in chest, worse over next few days
oramorph > MST > syringe driver

Doses: Diamorph 40-200 mg, Hyoscine 200-800 microg, Midazolam 20-80 mg & oramorph

Wt 65 kg.

Given midazolam 20 mg/ 24 h, \equiv 13 microg/kg/h; diamorph 60 mg/ 24h \equiv 38 microg/kg/h

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/06B
DENNIS BRICKWOOD
80

Hip fracture, carcinoma of prostate, osteoporosis with vertebral fractures, myeloma. Aiming for home but had an unsuccessful home visit. Developed musculoskeletal chest pain and chest infection. Chest xray suggested anterior rib fracture. Codydramol ineffective. Converted to oramorph then dose increase to MST then large dose increase to syringe driver. Died 24 hours after starting driver. No other analgesics tried ?would have responded to NSAID or heat packs.

Cause of death unclear and use of analgesia was not ideal

PL grading B2

08-DEC-2003 14:57

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/08B	Brickwood, Dennis	<p>condition was deteriorating prior to starting opioids.</p> <p>Patient was being actively prepared for discharge against his and his family's will (because they did not wish to pay for residential care) when he developed a chest infection which did not respond to antibiotics, despite a change of antibiotic. Opioids not started until he was failing on the second antibiotic. Clear complaints of pain from the patient. Excellent reasons for pain (vertebral fractures and cracked rib).</p> <p>My quibble is with the speed at which the dose of morphine/diamorphine was escalated and the large amount of hyoscine and midazolam added to the syringe driver. But I suspect death was accelerated little if at all - the doses were just a little unnecessary.</p>	A2

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Officer's Report

Number: R13D

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: FCU FLEETREF:
TEL/EXT:

SUBJECT:

DATE: 14/02/2003

On Wednesday 29th January 2003 (29/01/2003) I went to the home of Code A concerning the death of his father Dennis John BRICKWOOD , born Code A

Prior to his death, his father lived with his wife in Gosport. Sometime before his death his father was diagnosed with Prostate Cancer. It was caught fairly early and was not deemed to be terminal. He went into Haslar Hospital for chemotherapy treatment in tablet form. This treatment was successful and he was transferred to the Gosport War Memorial Hospital for rehabilitation.

A few weeks before his fathers death Mr Anthony BRICKWOOD was approached by staff. They requested that he look for a nursing home for his father as he could not stay there indefinitely. Mr BRICKWOOD states that his father was very alert and vocal. He had made a friend called Terry . Mr BRICKWOOD recalls that the two of them used to complain about the nurses who did not appear to be looking after the older and more frail patients properly.

Dennis BRICKWOOD would often tell his son that the nurses would just place food in front of patients who were clearly unable to feed themselves then an hour or so later would just take it away again without attempting to help them eat.

Mr Anthony BRICKWOOD recalls a senior nurse named Phillip who appeared to be running the ward. He seemed to have a lot of authority and was making decisions that would normally be associated with a doctor.

The evening before his fathers death Anthony had gone to visit his father after work. He found his father in good spirits, talking about the football results. Anthony's brother was also there with his son Thomas. Dennis BRICKWOOD was asking about Thomas' homework and asked him to come back tomorrow to tell him about it. At about 7.00pm (1900) the family left. About an hour later Anthony received a call from the hospital saying his father had taken a turn for the worse. He immediately went to the hospital to find his father unconscious, he noticed that he had been fitted with a syringe driver and was receiving Diamorphine. His father never regained consciousness and died the next day. As far as Mr Anthony BRICKWOOD was concerned there was no doctor on duty over that period.

The two main questions that the family are seeking answers to are:

DOCUMENT RECORD PRINT

What sort of emergency occurred shortly after they left that evening?

Who attended his father and who authorised that he should be put on such large doses of Diamorphine?

Dennis BRICKWOOD was cremated. The family is represented by Ann ALEXANDER .

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BA

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD EREF:
TEL/EXT:

SUBJECT:

DATE: 06/12/2003

I visited Mr Antony BRICKWOOD at 2000 hrs on Tuesday 25th November 2003 (25/11/2003) at his home address, Mr Dennis BRICKWOOD was also present (brother).

The meeting was in relation to their father Dennis BRICKWOOD B: Code A and as per the policy log.

I outlined the concerns as noted in officers report 13D and noted the further comments of Code A BRICKWOOD as;

At the time of his fathers deterioration the family had been searching for a suitable rest home for him to move to.

His father was in the hospital for rehabilitation after a hip replacement. He had come through six weeks of isolation for a super bug.

Mr BRICKWOOD wishes to know:

1. Why the family were not consulted prior to the treatment being commenced?
2. Who took the decision and why?
3. Who administered the drug?
4. In what quantity?
5. And what was actually given to their father?

The BRICKWOOD family is happy to be informed by way of a letter, they have been given a copy of the medical records.

Antony BRICKWOOD was agitated during the meeting but he suffered the loss of his wife three weeks ago from cancer.

Expert Review

Dennis Brickwood

No. BJC/06B

Date of Birth:

Code A

Date of Death: 12 June 1998

Mr Brickwood was admitted to hospital on 15 January 1998 after a fall where he sustained a fracture to his neck of femur.

On 3 February 1998 he was transferred to Gosport War Memorial Hospital for rehabilitation. His medical history included carcinoma of the prostate, osteoporosis and myoma.

He was assessed in March 1998 with a view to being discharged home but, following a trial visit on 6 April 1998, this was not considered a possibility.

In May 1998 he developed musculoskeletal chest pain together with a chest infection.

The infection did not respond to antibiotics despite a change in treatment.^{DB1}

Opioids were started when Mr Brickwood's condition was failing on the second antibiotic tried.

The experts note that the Morphine/Diamorphine was escalated and a large amount of Hyoscine and Midazolam added to the syringe driver although it was not felt death was accelerated as a result of this treatment.