CYRIL DICKS

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Cyril Dicks

Date of Birth: Code A Age: **85**
Date of Admission to GWMH: **28th December 1998**
Date and time of Death: **22.00 hrs on 22nd March 1999**
Cause of Death:
Post Mortem:
Length of stay: **85 days**

Mr Dicks' past medical history:

1955 – Cervical polyp
1980 – Loss of vision left eye, sub-retinal haemorrhage
1987 – left colles fracture
1996 – AF – digoxin
1999 - Cognitive impairment confirmed dementia.
1999 – CVA
2001 – Chest Infection
2001 – August – CVA
2001 – CVA with persistent dysphagia – insertion of PEG tube

Mr Dicks was the youngest of six brothers. He was a retired taxi driver. His wife died in 1993 they had been married for 50 years and had a daughter and son. Mr Dicks lived at Pier House Residential Home. He wore a hearing aid in his left ear and glasses. It was noted that he smoked 2/3 cigarettes a day and was reluctant to eat. He was dependent on nursing staff for all hygiene needs and could only walk a few steps at a time. Mr Dicks was admitted to the Haslar Hospital from the home with pneumonia. It was noted that while at Haslar Hospital Mr Dicks was nursed on a bed with a pressure relieving mattress and cot sides and that he had some red marks in places that were dry but unbroken. Mr Dicks was admitted to the Gosport War Memorial Hospital on 28th December 1998 with pneumonia that had been treated with IV and oral antibiotics, confusion, doubly incontinent and urinary tract infection. It was also noted that he had a catheter insitu.

On admission a Barthel ADL index was completed from 29th December 1998 scoring 2 to 14th May 1999 also scoring 2 the scores reached no higher that 4. An abbreviated mental study was completed on 29th December 1998 with a score of 3 recorded.

A Waterlow score of 14 was recorded on 29th December 1998. With a handling profile also completed on that day noting that Mr Dicks skin was intact need a pressure relieving cushion and 2 nurses and a hoist to help transfer.
Care plans for confusion, reduce mobility, retention of urine – catheterised size 12 and help to settle at night were completed starting on 29th December 1998.

Whilst at Gosport War Memorial Hospital Mr Dicks had a number of falls where he only sustained minor cuts and bruising. Treatment was administered and he was helped back to bed.

28th December 1998

Admitted from Haslar with pneumonia that had been treated with IV and oral antibiotics, confusion, he was doubly incontinent and had a urinary tract infection and had been catheterised.

4th January 1999

Remains poorly not eating or drinking well. Please make comfortable.
Happy for nursing staff to confirm death.

11th January 1999

Daedalus ward/NHS continuing care. Barthel 4/20 – reluctant to do much not eating or drinking. Prefers to be in bed. Plan:- to give up Pier House for Nursing Home if stable in early February 1999.

15th January 1999

Contact record – found on floor in lounge PM, examined small grazes on left hand – reassured and put to bed. Son informed.

17th January 1999

Contact record - found on floor in lounge- no apparent injury. Behaviour very irrational PM.

18th January 1999

Did not wake up this morning, stiff unrousable, not in pain – please make comfortable. **Happy for nursing staff to confirm death.**
Contact record – reviewed by Dr Barton. Extremely sleepy. Family wish Dad to be made more comfortable.

19th January 1999

Remains poorly – unresponsive. Family aware – no active treatment required not for any fluid replace. Use S/C analgesia if necessary.

20th January 1999

Catheterisation due to urinary retention.

22nd January 1999

Contact record – Mr Dicks got off commode and sat on floor. Accident form completed.

25th January 1999

Spent a lot of time in bed. Can transfer unaided. Barthel 3/20 – aggression short lived.

Daughter seen – aware very unwell and may not survive. Agreed not for NG feeds, not for antibiotic if pyrexial and NHS continuing care until early March 1999.

Contact record – seen by Dr Lord – daughter seen and is aware of prognosis in event of change of condition or chest infection to be kept comfortable.

8th February 1999

Small black spot on left heel.

15th February 1999

A bit better – eating more. Barthel 1-2/20.

1st March 1999

Not drinking much. Barthel 1/20 – no new medical problems. Heels vulnerable.

2nd March 1999

Contact record – found on floor by chair, cut to upper lip, contusion to left eye.

3rd March 1999

Podiatry – left 1st lat side toe red and inflammed.

5th March 1999

Podiatry – sat in chair. Right 2nd toe red medical side. Left 1st still red.

8th March 1999

Fall – left perior? Bruising + upper limb. Barthel 2/20. Review end of month.

9th March 1999

Contact record – seen by Dr Lord – no change.

10th March 1999

Podiatry – left 1st much improved virtually healed. Right 2nd also improved.

13th March 1999

Contact record – found on floor by side of bed. Checked for injuries.

15th March 1999

No great change. Barthel 2/20.

16th March 1999

Contact record – fell to floor in lounge. Abrasion right eye. Accident form completed.

18th March 1999

Contact record – bruising also noted on right side hip.

20th March 1999

Not so well – in pain when being moved in bed. Generalised twitching and distressed.

22nd March 1999

Marked deterioration over weekend. Family happy with treatment. Died at 22.00 hours found by S/N Basher. Death confirmed at 23.10 hours by SSN Farrell.

Contact record – 22.00 hours found in bed dead. Daughter informed does not want to see.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
CD G.068396

Exhibit number
BJC-17

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Very unclear what happened at the end.		
Unexplained By Illness C				

General Comments

85-year-old X-painter, psychiatric care and Residential Home, deafness, prostate trouble,
1998-12-14 (A) Haslar increased confusion, poor mobility, ?chest infection
1998-12-28 > GWMH confusion, double incontinence,
1999-01-04 'Remains poorly... I am happy for nursing staff to confirm death.'[JAB]
1999-01-11 'Probably N/Home if stable in early Feb '99. [Lord]

1999-01-18 '...not in pain...' [JAB]
1999-01-19 'use sc analgesia if necessary' [JAB]
'Keep comfortable' [Lord]
1999-03-15 '...Barthel 2/20. Eating – can feed himself (Variable)... [Lord]
1999-03-20 'commenced sc continuous diamorphine & midazolam' [Nursing notes]

1999-03-22 ' Marked deterioration over weekend. [?] unwell... I am happy for nurng staff to confirm death.' [JAB]

1999-01-29 Oramorph 10mg/5 ml 2.5-5 ml 4 hrly PRN
1999-01-04 ditto
1999-01-04 diamorphine 20-200 mg in 24h sc, hyoscine, midazolam [NONE given]

NO record of DIAMORPH sc INFUSION

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/17
CYRIL DICKS
85

Dementia, incontinent, very dependent.
Deteriorating gradually then rapidly over the weekend of 20-21/3/99. One nursing record states sc analgesia and midazolam started on 20/3/99. There is no record of this on the available medication cards or in the medical notes. Elsewhere in GWMH notes the nurses write diamorphine doses given via syringe driver in the notes in red. This is not done here. I do not know if he was given diamorphine.

Cause of death is not clear anyway but if diamorphine was not given it was natural. Care reasonable but fell on the ward and they were prepared to use diamorphine where it was not clearly indicated.

PL grading A2

BJC/17	Dicks, Cynl	Appears to have been dying slowly, but in an expected manner, from longstanding dementia complicated by an acute ?cerebrovascular complication in January. He appeared to be in pain, and was certainly agitated, in the later stages and was probably treated with subcutaneous diamorphine and midazolam, according to the nursing note. But no doses are stated (unusually – in other cases the nurses have written the doses in their notes) and at present I cannot trace an administration record in the drug charts to show that the drugs were ever given, or in what dose. I am sure he would have died, no matter how well he was cared for. It is possible that his death was marginally accelerated by sedation, but I cannot at present adduce any hard evidence for that.	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BP

TO: REF:
STN/DEPT:

FROM: Code A REF:
STN/DEPT: MCD E TEL/EXT:

SUBJECT: DATE: 21/01/2004

I visited Code A at her home address at 2000 hrs, 21st November 2003 (21/11/2003). Also present was her husband and brother, Leslie DICKS and his wife. I outlined the purpose of my visit as per the policy log and gave the family a set of the medical records relating to their father, Cyril Aubrey DICKS Code A - 22/03/1999.

I went through the family's concerns as recorded in officers report 11E.

They further wished to add that whilst their father was in Haslar Hospital he had been 'picky' with is food, this was normal. He hadn't complained of being in any pain but then he probably would not have mentioned it and that whilst he was moody, he was lucid and talking and was able to walk with the aid of a stick. He had never suffered from ill health apart from having a small hernia.

The family state that Mr DICKS was admitted to the GWMH for recuperation in order to get his strength back.

Upon admission he is described as being in good spirits with no complaints of pain. The family members between them visited him daily.

Approximately two weeks after being admitted the family were told that Mr DICKS had suffered a massive stroke, the following day they were informed that he was 'getting better', then they were told that he was 'failing'.

When the family turned up to visit Mr DICKS on his birthday he was sat up in bed awaiting his presents. They describe him as being 'perky and happy'. They describe his condition as being variable. When he was in bed with his eyes closed he appeared to be asleep on other occasions he would appear to be 'awake' and chirpy with his eyes open.

Mr DICKS was placed in his own room and during the last couple of days of his life he was placed on a syringe driver and diamorphine was administered. The family were not told why, nor did they see a doctor.

At this point Mr DICKS was bed bound.

On the day of his death Mr DICKS didn't wake up. The family stayed with him until 2200. They left to travel to their nearby homes and a few minutes after arriving were notified by the hospital that Mr DICKS had died.

The family wish to be notified by letter followed by a visit to provide more detail if required.

DOCUMENT RECORD PRINT

Officer's Report

Number: R11E

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 18/12/2002

Sir

Re. Action 205.

I visited Mrs. Sandra TAYLOR of Code A on Tuesday, 17th December 2002 (17/12/2002). Mrs. TAYLOR has given her contact numbers as H Code A and W. Code A . Mrs. TAYLOR stated that she had contacted the police regarding the death of her father at the Gosport War Memorial Hospital in 1999 after hearing of the investigation in the media. She also stated that her younger brother, Leslie DICKS of Code A had attended a meeting at Whiteley, Fareham along with other concerned relatives.

Mrs. TAYLOR gave the circumstances as follows. Her father, Cyril Aubrey DICKS (b 17/03/1914) was a retired painter and decorator living in Pier House Residential Home, Lee on Solent. His GP was from the Lee on Solent Practice in Manor Way, Lee on Solent. Mr. DICKS was admitted to the Royal Navy Hospital Haslar around the 14th December 1998 (14/12/1998) suffering with a chest infection. Mr. DICKS was transferred to Daedelus Ward at the Gosport War Memorial Hospital about two weeks later for recuperation. At this time Mr. DICKS appeared to be making a full recovery.

Within a few days Mr. DICKS appeared to be heavily sedated and did not recognise his relatives during visits. Mrs. TAYLOR is not aware what medication if any her father had been administered but cannot remember seeing any drips until the last few days of his life. Mrs. TAYLOR did question staff at the hospital as to why her father was so sedated and was told words to the effect of, "Oh, he is just not so good today." During the first few weeks at the Gosport War Memorial Hospital relatives noticed that although heavily sedated he would often be sat in a chair, but after this he was always just lying in bed.

On the 22nd March 1999 (22/03/1999) Mr. DICKS died, the cause of death was given as Bronchial Pneumonia and the death certificate was signed by Dr. BARTON. Mr. DICKS was cremated.

Mrs. TAYLOR and the rest of the family thought the circumstances of her father's death strange but had absolute trust and confidence in the hospital. It was not until the media coverage that they doubted the hospital and came forward.

I have informed Mrs. TAYLOR that this is an on going and probably long term investigation and I gave

her a contact number for Operation Rochester at Hulse Road.

Code A

Expert Review

Cyril Dicks

No. BJC/17

Date of Birth: Code A

Date of Birth: 22 March 1999

Mr Dicks was admitted to the Gosport War Memorial Hospital on 28 December 1998. On admission he was doubly incontinent with a urinary tract infection and had a indwelling catheter.

It is recorded in the Medical Notes that he had a number of falls where he only sustained minor cuts and bruising whilst at Gosport War Memorial Hospital.

The Notes recall on 4 January 1999 that he remained poorly and was not eating or drinking well.

The expert review notes that Mr Dicks was deteriorating gradually following admission and then rapidly over the weekend of 20/21 March 1999.

Although there is no record available in the medication cards or in the medical notes one nursing record states that subcutaneous analgesia and Midazolam was started on 20 March 1999.

The experts conclude the care on the ward was reasonable and that it was likely that Mr Dicks would have died no matter how well he was cared for.