ALTNAGELVIN HOSPITAL HEALTH & SOCIAL SERVICES TRUST

CLINICAL SUPPORT SERVICES DIRECTORATE

MEMORANDUM

To: Irene Duddy

From: Tom Melaugh

Date: 4 November 2004

Subject: INSIGHT PROGRAMME

As requested I have looked at the programme again to see what I feel the issues are arising from it. I have tried to summarise these below.

1. Fluid Management

According to the experts the death occurred because of poor fluid management. They seemed to consistently make a point that the volume or the wrong sort of fluid can be very dangerous, the need to monitor the patient's sodium level appears to come through as an important component in these cases. There also appears to be an underlying message in relation to record keeping so that fluid levels can be properly assessed.

It appears that the management of fluids is something that is covered in medical training but appears to be something that is not carried through into later years with medical education.

On the issue of hyponatraemia there appears to be a difference of opinion as to whether this could happen to anyone or whether certain individuals are susceptible to it.

2. Communications

The theme that came through strongly was the feeling from the parents that they were kept in the dark in relation to what had happened. This led to feelings of cover-up where staff were not providing sufficient information to parents so that they could understand what happened. There may be an issue of a conflict with the need to give parents adequate information for them to understand and the demands placed upon the staff in terms of potential medical litigation.

I noted that some comment was passed on the fact that one set of parents had sought information via the complaints procedure and were told that a full investigation would be carried out. This probably raises an issue about whether or not the complaints procedure is robust enough to manage the most serious of complaints that may be brought.

The issue of medical staff not going into the witness box at the Coroner's Court also featured. There was no sense of explanation as to why they did not go into the witness box and on whose advice they may have been acting.

3. Death Certification

The point was made in the programme that the current arrangements for death certification was open to abuse by doctors. This was something that the Shipman case had highlighted. It may be that we should be looking at some mechanisms internally for the verification of death certificates.

4. Investigations of Deaths in Hospital

Again, some comment was passed on the fact that death in hospitals largely can go uninvestigated in any detail. Much was made of the fact that the Coroner can only investigate if he is told about a particular case.

The independence of such internal investigations was questioned, as was the absence of sharing outcomes with the relatives. In cases where death was unexpected we need to be clear whether they are always reported to the Coroner or whether there is some discretion subject to discussion with the Coroner.

TOM MELAUGH
DIRECTOR OF CLINICAL SUPPORT SERVICES