Insight - 21/10/04. When hospitals kill

Drip being put in with Mrs C speaking.
— 'above the law' TB
Fatal — Adam Shaun Narrator.
admin. — LC
of fluid. — R Ferguson

* Death of LC.
Replay bits of Mrs C interview
Reconstruction dr o'd + nursing staff.
Stabilised — 1st of many lies by hospital
T'ferred to RVH — left Erne brain dead.
— nothing RVH did do
TB — know why LC died from medical notes.
— wrong fluid + too much
— brain swelled
Dr Sumner — expert witness
— why too much fluid dangerous.
Hospital knew fluids were to blame at time of LC death.
Dr S — has view hosp. will have known LC had hyponatraemia, but too late — also gave too much
Mother knows naught told.
— did not tell C's but instead started to cover up.

* Cover-up
Deeds at RVH edited LC death.
Loophole. — Prof Tony McGleenan
— death cert. process. — needs overhauled.
— too much scope for concealment.
Dr Hanrahan RVH informed coroner of LC death.
— wrong diagnosis - it was Hypo N.
— not gastro enteritis or dehydration or brain swelling

LC – SLT

Hypo Na caused by Gregory wrong fluid + too much.

Dr Sumner confirms this
Dr Hanrahan knew but did not tell coroner
- misled him
- ruled out PM or inquest
- Cgiven incorrect death certificate

RVH own PM but didn't tell coroner results
- PM shows RVH had the answer.

Dr C. Stewart notes for Dr Hanrahan - clinical history of LC.

Insight sought answers from RVH but no explanation forthcoming

Spore to Dr Hanrahan - in car park.
- why not tell coroner?
- not covering up for Dr O'D.
- did not mislead coroner
- inquest admitted LC died due to fluids rec'd but did not tell C family.

Dr O'D lied to C family
- he knew. what killed her

Trust knew + cover up.

Dr McGleenan - beyond Trust internal review no external accountability.

HM - resp for cover up
- unstigated review - failed in all aspects.
- review findings neither PM or indep med rept gives absolute reason why LC died

Dr Evans L rept for C family Feb 2001. Cons. Paed,
- puzzled why reviews did not come to same conclusion
- if he had info to come to definitive cause of death - ~~Trust~~ it honoured to get expert opinion

Dr Sumner - notes show wrong + too much fluid.

Dr Quinn. — Dr E will not consider asking Dr from same area - not independent.

Dr Q report - difficult to be certain of cause of LC death
- report largely discredited
  - not independent
  - no comment on drop in sodium level ~~etc~~
  - fluid intake assessed diff to anyone else looking at notes.
  - Dr Q over 7 hours which reduced intake on paper.
- will not take VCN calls.
  - appropriate to give Dr Q opp to respond.

Dr Q admits not fully independent
- denies it is a med. rept — a case review
- sorry LC died + C family allowed to grieve in private.
- blamed SLT - "sweet talked into writing a summary which is not complete account of discussion I had"

TB - allowed SLT to deny they were responsible for LC death.

Dr Evans - failed in treatment
- failed in investigation
  - shd have got more reports

TB - failed in duty to properly investigate LC death
- ensured no lessons learnt - leave doors open

Complaint handled by B.O'R.

~~B.O'R~~ – investigates ~~deaths~~ complaints
– protects corporate identity.
– conflict of interests.

More lies – promised full investigation which Trust never carried out.

Review + complaint – vehicle for a cover up

The Whistle Blower.
Killed by lethal dose of fluid
Nurse made comment – 'dead any way
– sent to Royal to cover own stuns.

Secret filming. Dr M Asghar – refused to take part but UTV discovered he checked notes – realised LC killed by fluids
Found Dr Malik upset – told Dr A of meeting by with Dr O'D.
Reconstruction of conversation with Dr A + Dr M
– Dr O'D asked Dr M to add to notes
– Dr A – don't do that
– Dr O'D asked Dr M if he had med. insurance + he did put blame on her.

Dr A – wrote to them – hand delivered it but six months later nothing. Late Autumn Dr A threatened to report Dr O'D to GMC so in Dec 2000 Trust went to RCP who gave 2 names to undertake review

Dr S. Shribman – 2 experts but reports confidential
Trust refused to give report to Dr A or tell UTV. Never given to coroner even though all info relevant to case shld be provided

C family went to solicitor. to get answers.

Dr McGuinness - civil action won't necessarily give you answers & why death occurred
Incentive for TST to settle out of court + won't find out what happen or why death occurred
— SLT did this, small amount., NO admission of liability.

Adam Strain
In 1995. AS killed in same way while having a transplant op.
Mum gagged by RVH. + did nothing to educate colleagues. — 2 more deaths from a preventable condition.

The policy-makers
14 months after LC, RF died in Altnagelvin
Two time Coroner told truth + CMO set up gp to look at Hypo N
Dept done nothing to bring two Trusts (SLT + AVH) to a/c. — protected + clouded issue.

CMO blamed Coroner — earlier inquest (BBC NI interview) into LC death might have prevented RF death

CMO inconsistent about when she knew about LC death. — June 2001.
— March 2003.

Dr Jenkins - advisor to CMO - leading group to look at 2 deaths & Hypo N. Sept 2001.
- LC + RF

CMO blames physiological reaction & patients — rarity abnormal reaction seen in a very few children
Dr Evans states this is wrong.
— warned this made by CMO - not a practising clinician

Dr Summer - any child will have reacted in same way if given this fluid + in these amounts

CHO - in 2000 in UK + NI. very few who knew what was going wrong.

, UTN - BMJ article in 1992

May 04 Conor Mitchell. inquest - did not die as a result of fluids by Dr Summer concerned at fluid mangt + work to QUB snr lecturer J. Jenkins. about problems of ignorance of fluid mangt. + that processes need to be put in place. to improve level of knowledge.

Deflect from ~~[illegible]~~ → fluid standard at time of deaths.
truth. → abnormal reaction

Coroner. open inquest when contacted by S. Millar. - concerned after RF inquest.
↙
acted for C family in complaint to Trust

Coroner findings - result of fluid regime
- referred to GMC
- amended death inquest

Drs refused to go into witness box.

Easy to cover up hospital deaths.

Prof McClelland - requirement of state prompt public effective independent investigation working NOT K.

- random process at moment.
  - complaints by family
  - concerns raised by staff
- no auto requirement for hospital fatality to be investigated.

- Publicity → backlash after inquest.
  - coroner letter to IR.

HM turned down interview.
- Why did cover up LC death.

Adh
- tragic death.
- 4½ yrs ago.
- amend practice @ Gmc since then.
- outcome of Coroners Inquest.
  to GMC
- Independent.
- ~~Inquest~~ review.
- no further comment.

Cover up by SLT made sure no one made accountable for LC death.
Dr O'D. referred to GMC (only because case
Dr O'D still working at Gmc on child's ward.
Dr A - gone.
- r/ship deteriorated with bosses
- new life in England.

Warning signs lessons not learnt at Gmc after LC death.
Insight told. of another death. of child
- alarmed staff
- Inquest pending - family asked not told. with Inq. held.

Hospital told natural causes but 2 coron letters (nurse - lose job) Dr A passed on his concerns to his seniors.

Family feel
- greatest diff hospital NOT ack. what had happened
- more respect
- more openly.
  - better placed to move on.
  - no closure