Derby Medical Society Meeting Minutes
21st February 2023
Derby Medical School Lecture Theatre

Medical student elective bursary awards

The winners of the bursary were announced:
Hiba Al-Bharani - Greece to assist in refugee medical care
Alexandra Cassidy - St Vincent's and Grenadines to do O&G
Joseph Norvill - Cebu in Philippines to do General surgery

The winners were not able to attend this evening.

Speaker

Dr Stephanie Smith
Honorary Paediatric consultant QMC, safeguarding lead and magistrate

Thinking the unthinkable

One only sees what one looks for. One only looks for what one knows.

Background
Nottingham graduate.
Consultant in paediatrics from 1996.
Portfolio career as a paediatrician

In 1991 at QMC there was no PICU consultant.

Case scenario of Bradley age 5
Transferred to Nottingham from Grantham Hospital.
Recovered in Nottingham.
Dr Smiths abiding memory is not understanding what had happened and thinking about this for the rest of the weekend.

What happened next?
Informal discussion in the Mess when 4 paediatric registrars flagged up a number of transferred children from Grantham whose medical condition could not be explained.

This group reviewed the notes of the children that they could remember
Children all had a clinical course out of context with their presenting illness.
Professor David Hull listened to these concerns.
Grantham consultants also had concerns.
The police were then informed and the subsequent investigation is known.

Some of the children involved summarised in clinical summary

4 children died: Liam Taylor, Timothy Hardwick, Becky Phillips, Claire Peck
9 children collapsed

Beverley Allitt did not completed all of her nurse training and was working as an SEN
She had a history of self harm
24 ED visits between 1987-91
Poor sickness record 94 days sick in 1990
In retrospect……

She was eligible for parole in November 2021 after serving 30 years but parole not yet considered.

RCN recommendations now in place for nurse staff levels and competencies on paediatric wards.

The impact on so many people was huge - patients, families, staff.

Clothier report after the events was published in 1994

The report had implications for nursing staffing recommendations to this day.
Criticised management and communication in Grantham Hospital.
“from the outset, we must acknowledge, as the report does, that the tragic events in Grantham were with product of a malevolent, deranged criminal mind. Everything must be seen in that light” - Virginia Bottomley, Health Secretary, House of Commons.

There are others……Harold Shipman was estimated to have killed 250 people.
A current trial is ongoing.

Patient Safety

Intentional vs. Unintentional harm
Dr Smith has done a lot of work with patient safety.
We can all get things wrong, to err is human.

Open discussion about errors we can all make.

Lots of studies on patient safety as quoted in Harvard Medical Practice Study (NEJM 1991).
3.7% identified errors in care that had a 13.6% death rate.
Similar results were found in Australian studies.

What is an acceptable levels of complication or risk?
Healthcare risks are much higher than airline risks.

There is a science of ergonomics and human factors
Make it easier to do the right thing
Guidelines and policies
Standardisation of equipment and environment
Open culture to learn from our mistakes as well as errors.
On the whole people come to work to do a good job.

There are a number of patient safety champions:
Don Berwick (President of Healthcare Institute) produced the Berwick report (2013).
Maureen Biagano (President of Institute for Health Improvement).
Martin Bromley (Airline pilot - founder of Clinical Human Factors Group). An advocate for no blame culture.

Top tips

Remain curious and open minded
Think the unthinkable but believe the best
Have coffee and talk
Never work in isolation.

“Patient safety does not depend on measurement, practices and rules, nor does it depend on any specific improvement methods; it depends on achieving a culture of trust and discipline”. - Lucien Leape