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The great failure

When 16 year old Christian Dam Midtgaard died it was one of the most meaningless and well-documented failures by the Danish health service in recent times. Christian's parents have appealed strongly to the Minister for Health for all of the accident and emergency departments in the country to learn from the mistakes which cost their 16 year old son his life. But so far the system has failed in this task.

By Kasper Krogh, Morten Crone, Line Holm Nielsen, Jesper Woldenhof and Linda Henriksen (photo)

THE LETTER WAS THE CULMINATION of two years of frustration and campaigning to call the system to account. It was a father's attempt to prevent other parents from having to go through the same pain and grief that he was suffering himself.

'To put it bluntly, we are talking about our 16 year old son's unnecessary death in the Accident and Emergency (A&E) Department of Århus Hospital. A major reason for his death is that on 23 September 2005 the country's largest accident and emergency department was not functioning properly,' wrote Peter Dam in the opening of his letter, which he addressed to the most senior figures in the Danish health service.

Peter Dam was appealing to Minister for Health Jakob Axel Nielsen (Conservative), to the President of the Region of Central Jutland Bent Hansen (Social Democrat), who is also the Chairman of the Association of Danish Regions, and to the National Board of Health. The death of his son, Christian Dam Midtgaard, must not be in vain. Peter Dam made reference to the fact that the Patient Complaints Board had just expressed strong criticism of a Falck paramedic and a nurse in the A&E Department who failed to provide his son with the correct treatment. He also pointed out that, highly unusually, the Patient Complaints Board was now also expressing strong criticism of Århus Hospital for a lack of control over the procedures in place in its A&E Department.

'We are of the opinion that this case can and must be used by the health service to improve and raise standards in Danish accident and emergency departments. We find it hard to believe that Århus Hospital's A&E Department is the only one in Denmark to have problems,' wrote Peter Dam.

He called on the top brass of the health service to ensure that lessons are drawn from the experience of Århus Hospital and from the death of his son. The experience should be used to create common guidelines so that every A&E department in the country is able to ensure there is no repetition of the fatal mistakes made when Christian died.

Today Peter Dam can see that the system did not listen when he tried to appeal to it. Over a year later what he had hoped for has not happened. Today there are big differences in the instructions the country's A&E departments have for treating patients who present in a condition similar to that which cost Christian Dam Midtgaard his life in 2005. And this is despite the fact that, according to several experts, this case is a text book example both of how the health service can make mistakes and of how it should learn from those mistakes.

THE CALL CAME SHORTLY after midnight on a Friday night during a rare break in Dr Jens Winther Jensen's shift. He was sitting in the duty office of Århus Hospital's Department of Anaesthesiology when a nurse rang him. He was told that the A&E Department urgently needed his assistance. Dr Winther Jensen ran over to the A&E Department and was shown into a room where there was frantic activity.

ON A TROLLEY in this room lay Christian Dam Midtgaard. He was a 16 year old youth, who thanks to his passion for rowing was on top form physically and had never had anything wrong with him. Now his heart had stopped. His hands were streaked with blue, his face greyish blue and his pupils were fixed and dilated – signs of a severe lack of oxygen. Dr Winther Jensen went over to the trolley. He was 35 years old, but in spite of his youth he was the newly elected President of the Danish Medical Association. Dr Winther Jensen inserted a plastic tube into Christian Dam Midtgaard's airway in order to prevent him from choking on his own vomit. Electrodes, an oxygen monitor and a blood pressure monitor were attached to the patient and a line was inserted into his veins. He received more heart massage and oxygen and he was given adrenaline and atropine to try to restart his heart.

More doctors arrived. For over an hour Dr Winther Jensen and his colleagues attempted resuscitation using heart massage, artificial respiration, electric shocks and large quantities of cardiac stimulants. At around 3 a.m. the doctors concluded that Christian Dam Midtgaard's condition was still critical, but stable enough for him to be transferred to Skejby Hospital. There would be a better chance of resuscitating him there. Dr Winther Jensen sat at the side of the 16 year old as the ambulance dashed through Århus with its sirens wailing. Upon their arrival at Skejby Hospital a larger medical team took over. They put Christian Dam Midtgaard onto a ventilator.

Dr Winther Jensen returned to Århus Hospital to finish his shift. He had finished with his patient and handed him over into the care of other doctors. But his patient had not finished with him. The incident took place back in September 2005. Today, four years later, the case of Christian Dam Midtgaard still pursues Dr Winther Jensen.

'Never before or since have I been involved in anything which can compare with this case – thankfully. The case is exceedingly rare, but that makes it no less important to analyse further, because it is so serious. The greatest challenge in this case is to make a commitment to learn from what happened so that nothing like it can happen again. That is one of the things which motivates me and it should also be one of things that motivates the health service,' said Medical Association President Dr Winther Jensen.

IN ORDER TO UNDERSTAND what lessons can be learnt from the death of Christian Dam Midtgaard, it is first necessary to understand why he died. Only a few hours before Dr Winther Jensen's battle to resuscitate Christian Dam Midtgaard, the 16 year old teenager was at a party. It was Friday evening on the 23 September 2005 and one of Christian's friends was having a birthday party in a village hall in Egå, a suburb of Århus. The parents of the friend whose birthday it was were at the party and were keeping an eye on who came in and how much alcohol was being consumed. Christian was drinking too, as he normally did when he was at a party.

But that evening he experimented with something new as well. A friend took Christian into one of the toilets and asked him if he wanted to try amphetamines. At first Christian said no, but when his friend asked him again he said yes and Christian sniffed a line of the powder. But the powder was not amphetamines. It was brown heroin, and suddenly things started happening very fast. Christian began to feel ill, went outside and after a few steps keeled over onto the road in front of the village hall. A large group quickly gathered around Christian and tried to bring him round. Soon after a male nurse who lived right next to the village hall also arrived and took over. The nurse dialled 112 and asked for an ambulance. He said that it was serious and that the boy was unconscious.

A few minutes later an ambulance arrived at the scene with two Falck paramedics. The more senior of the two paramedics reassured the male nurse that he would take over and, according to his colleague, at the same time he turned away a 16 year old boy who wanted to go with them in the ambulance. This was the boy who had given the heroin to Christian, as was shown, among other things, in a later police interview report in the case.

The paramedic made a number of mistakes which have since been strongly criticised by the Patient Complaints Board and by Falck: He did not carry out a proper assessment of the unconscious Christian. The paramedic did not check his pupils, which, had he done so, could have told him that Christian had taken drugs. He left out a number of other assessments as well, simply thinking that Christian had passed out because he was drunk. In the ambulance he lay Christian with his head facing the side of the vehicle, did not examine the teenager further and took a 'nap' while the ambulance was on its way to Århus Hospital, as his colleague, who was driving the ambulance, later explained during Falck's inquiry into the matter.

In the A&E Department, the paramedic in charge of Christian handed him over to a nurse and explained that the teenager had had too much to drink and was in a deep sleep. Falck later established that the paramedic carried out an 'extremely perfunctory examination and observation of the patient, which is to be seriously and strongly criticised'. The Patient Complaints Board also expressed strong criticism and warned the paramedic that in future he must show greater care in his work.

BUT THE MISTAKES DID NOT STOP at the Falck paramedic. The coordinating nurse that evening asked the Falck paramedic to put Christian on a trolley against the wall of the A&E Department. Here, Christian was attended to briefly by the nurse who left him in the recovery position, with his head turned towards the wall and with a blanket over him. Out in the hall the nurse said that somebody should take a look at Christian when a room became available in the A&E Department. Over the course of the next half an hour, the nurse and two of her colleagues took a quick look at Christian when they passed by him. None of them checked either his pulse or his pupils. The coordinating nurse has since been strongly criticised by the Patient Complaints Board for not having examined Christian properly. Christian could have been saved if he had been examined properly and had been given medicine to counteract the heroin. But that did not happen.

After Christian had been lying in the A&E Department alone for 40 minutes, a nurse discovered that his hand was blue. His face was also blue, he was not breathing and when Christian's pupils were finally checked, they did not react to light. All these were signs of a serious lack of oxygen as

a result of cardiac arrest. Dr Winther Jensen and several other doctors were called and a battle began which went on for several hours.

But it was in vain. When Christian's parents arrived at Skejby Hospital later that night, their son was on a ventilator. Towards morning the doctors established that Christian had suffered severe brain damage due to the lack of oxygen. Peter Dam and Christian's mother, Anne Midtgaard, made the hardest decision of their lives. The ventilator was switched off. Christian was pronounced dead at 14:35 hours on Saturday 24 September 2005.

SINCE CHRISTIAN'S DEATH his parents have campaigned for it not to have been in vain. They have pursued all conceivable avenues of complaint and have appealed to a number of authorities. They say that in spite of all the grief and frustration over their loss, they may find some comfort if some use can be made of Christian's death in future in order to ensure that the system learns from its mistakes.

The 16 year old's death has led to extensive changes – locally at Århus Hospital. Highly unusually, in Christian's case the Patient Complaints Board directed its criticism not only at individuals, but at the system itself. The management at Århus Hospital's A&E Department, in the form of a consultant and a chief nurse, were criticised for the fact that staff in the A&E Department had no clear guidelines on how to treat patients with reduced consciousness.

Medical Director Anne Thomassen explained that, following a major review of the failings in connection with Christian's death, a number of changes have been made: the nursing staff have been sent on a course in acute medicine, and they have been given guidelines on how to assess and prioritise the patients who come into the department. At the same time there are now clear guidelines on how unconscious patients should be treated. An emergency team of specialist doctors and nurses is now on standby and a new room has been set up in the A&E Department for monitoring patients.

BUT AT REGIONAL LEVEL – and, in particular, at national level – slower progress is being made in ensuring that the specific and important lessons learned from Christian's death are implemented in the country's other A&E departments. This serves to illustrate just how difficult it is for the health service to ensure that vital information is disseminated to all of the country's hospitals. The case of Christian Dam Midtgaard underlined precisely the need for, among other things, shared medical records and joint acute assessment units where a broadly specialised emergency team of specialist doctors and nurses is ready to receive patients like Christian when they reach A&E.

Dr Winther Jensen has pursued the matter beyond Århus Hospital into his work at the Danish Medical Association. He raised the matter when the National Board of Health prepared a comprehensive plan for the Danish acute care system, which was presented in 2007.

He does not know to what extent the experience from the Christian Dam Midtgaard case has been disseminated to other hospitals across the country. But he does know that it takes too long for the health service to pass on this kind of knowledge.

IN THE REGION OF CENTRAL JUTLAND the case has already been of major significance, according to Director of Health Leif Vestergaard.

‘We can most certainly learn from one another. This case has been a catalyst for work to change acute assessment units everywhere,’ said Leif Vestergaard Petersen.

Both the Region and the National Board of Health regard the standard introduced at the hospital following Christian Dam Midtgaard’s death to be the best possible. There are plans that five of the region’s hospitals should have learned from the experience, implemented guidelines and set up acute assessment units in line with the high standard of the Århus model. However, according to the region’s head of quality Charlotte Toftgaard Nielsen, for the time being this work is only under preparation and has not been implemented, and it is not known when it will be finished.

It will drag on even more when it comes to disseminating this experience at national level. The National Board of Health was subsequently in close dialogue with Århus Hospital to get them to improve the existing procedures. Once that was done, Århus had gone from having nothing to being at the forefront when it comes to instructions on how to manage patients with reduced consciousness. But, according to Anne Mette Dons, head of supervision at the National Board of Health, the Board did not consider that the practice should be rolled out to the rest of the country’s A&E departments:

‘In this case it was our assessment that it concerned a specific and not a general problem,’ said Dr Dons.

According to Dr Dons, it is up to the regions which run the country’s hospitals, and not up to the National Board of Health, to ensure that useful information and best practice are shared and widely implemented.

We are talking about the fact that some good has come of a tragic case. As a citizen, I have to ask: should not such experience be shared and implemented quickly?

‘You are right. There are lessons to be drawn from many places in the regions. The Health Act obliges the individual regions to analyse unintended incidents and learn from them. But we have no structure in Denmark to ensure that solutions to specific problems are implemented in a centralised way overall.’

So, as things stand today, there have been no initiatives to ensure that the specific lessons from the death of Christian Dam Midtgaard and from Århus Hospital’s work to rectify its faults have been disseminated to other A&E departments in Denmark.

As a random survey of 17 of the country’s hospitals conducted by Berlingske Research shows, two out of the 17 A&E departments asked still have no specific guidelines on how to manage patients with reduced consciousness who may be under the influence of alcohol or drugs. A lack of instructions was one of the things which went wrong in the case of Christian Dam Midtgaard’s death. And the Patient Complaints Board ruling in the case found that the country’s A&E departments should have such instructions. Otherwise, the Board found, patients could be put at risk.

BERLINGSKE TIDENDE has shown the results of its straw poll to Torben Mogensen, who is the Vice President of Hvidovre Hospital and one of the country’s leading experts in questions of patient safety. In his opinion, three of the hospitals questioned do not meet the minimum requirements

laid down by the Patient Complaints Board in its ruling on the case of Christian Dam Midtgaard. In addition, the quality of the instructions at the other A&E departments in the country is very variable. This is in spite of the fact that, according to Torben Mogensen, the country's A&E departments see around 100 young people heavily under the influence of alcohol or drugs every weekend.

'According to the ruling of the Patient Complaints Board, the lack of instructions played a major role in the chain of events which cost one boy his life. The managements of hospitals without instructions are therefore running the risk of being subjected to charges as serious as those levelled against the management in the Århus case,' said Torben Mogensen:

'But worst of all: when there are no instructions, there is a risk of a tragedy like the one in Århus being repeated. This needs to be put right quickly.'

In the light of Berlingske Tidende's inquiries, the National Board of Health now wants to write to all of the Danish regions in order to impress upon them the necessity of having instructions which, as a minimum, meet the standard laid down by the Patient Complaints Board in its ruling in the case of Christian Dam Midtgaard. At the same time, the National Board of Health will ask the Medical Public Health Officers to look at the situation in the two hospitals which do not have specific guidelines.

PETER DAM SENT his letter to the senior figures in the Danish health service in July 2008. He appealed for all of the A&E departments in the country to learn from the mistakes which cost his son his life. For the Region of Central Jutland, a lawyer replied on behalf of Bent Hansen. For the National Board of Health, a special adviser replied. Minister for Health Jakob Axel Nielsen (Conservative) never replied to the letter.