Bekæmp Meningitis – The Inquests

Before the first formal day of the inquest, we were invited to attend a pre-meeting with the chair and co-chair in order to discuss procedure, process, confidentiality and such like. It was a remarkable meeting. We were very frank, and openly stated our concerns and suspicions. The co-chair, a doctor with responsibility for patient safety, was moved and began to cry. She emphasised that she might not know the political motives behind establishing the inquest, but as far as they were concerned, their mission was very clearly to save lives.

Later during the meeting we made a request to have management consultants specialising in implementation co-opted to the inquest, as we didn’t want conclusions and recommendations to just stay on paper. We also asked to have a representative from the official Danish Association for Patient Safety on the board, as we felt we lacked the experience and competences to take on the burden to represent all future patients. Both requests were granted without hesitation.

At that meeting the initial seed of trust between us was sown. The inquest meetings themselves were interesting but hard. Experts from infectious medicine, emergency services, Hospital ER, etc. were gathered, but even as lay-men we were actually able to contribute much more than we had dared hope for. My wife and I never cried during discussions, even when detailing Hans’ final minutes, saving the tears for what became our traditional private post-meetings visits to Hans’ memorial.

The final report contained 10 strong action plans, all of which already have been or are in the process of being implemented. One of the action plans from the first inquest was the creation of eLearning modules for front-line medical personnel who provide triage, visitation or treatment to meningitis patients. We are currently acting as advisers to the administering authorities, advising on the content, focus and structure of the full course. We are in the process of reviewing the first beta version of the course. Other steps included a new policy to never send a possible meningitis patient home from hospital, unless positively identified as not being infected and a changed policy causing an increase in 2017 (compared to 2016) from 300 to 600 doctored-accompanied ambulances being sent to suspected meningitis cases in the region.

The second inquest looked at how to improve the general learning system, as well as the culture within which it exists. We had featured in a number of articles in national newspapers. Medical journalists and doctors joined the public debate and shared between them our opinions on the conflict between the regulative authorities and the medical practitioners and about striking the balance between sanctions and learning. We were subsequently invited to sit on the board of this inquest as well. It produced various action plans; some very specific, others more general, some long sighted, and some with a shorter implementation timeframe. For each action plan, a working group was established, and we sit on two of these.