

The person on the screen behind me was my partner for 32 years. He died suddenly from cardiac complications in the Accident and Emergency department of a major Dublin hospital on 16 January 2009, 14 months ago. He was a wonderful man, loved by many people, and I miss him dreadfully. I share this grief with all who have experienced the loss of a beloved partner, and the support I've had from friends who have gone through this life-changing experience has been invaluable to me.

The words Accident and Emergency imply the possibility of sudden death. This should mean preparedness for this eventuality, in the form of staff training, appropriate accommodation and administrative processes which meet the needs of bereaved relatives. None of these was in place when Pat died. I have spoken publicly about the trauma caused to me by the way in which the event was mishandled, trauma which is separate from the profound grief I feel at his loss. I had the privilege of witnessing my father's death 10 years ago in the hospice at Harold's Cross, and a dear friend of mine is dying right now in the Raheny hospice. In both places, every possible thing is done to ease the effects of inevitable death and loss for both the dying person and their loved ones. Ireland has reasons to be very proud of our hospice system and the wonderful people who work in it.

I thought it would be useful to take you through what happened on the night Pat died, identify problems and propose possible solutions. He collapsed near where he worked in the Abbey theatre on the night of 15 January. Some friends called an ambulance and contacted me. I got to him just as the ambulance was leaving, and was able to travel with him. Pat had suffered a serious heart attack three years previously, and was a patient in another major Dublin hospital, because that was where the ambulance took him on that occasion. He asked the ambulance staff to take him to that hospital on the night of 15th, since all of his records were there and the staff knew him. The distance was more or less the same, but the ambulance men were precluded from going anywhere other than their designated hospital. It would seem to make sense to bring people to the hospital where they are patients, if the time taken to do so does not endanger them.

The A+E at the hospital was not particularly busy when we got there around 11pm. Pat was brought into the critical care part of the facility, an unpleasant corridor off the main A+E. Because our hospital records system is so dysfunctional, there was no possibility of getting his file from the hospital where he was a patient. We badly need a proper electronic hospital records system, which could allow access to patients' records wherever they are. Even though I explained that his heart was badly damaged, no cardiologist saw him until he was actually dying, 3 hours later. When someone comes in to an A+E with a serious pre-existing condition, they should be seen as soon as possible by the relevant specialist.

Pat was given medication to bring his blood pressure back to normal, and seemed to recover. He was fine for around 3 hours, and was regularly checked by the nurses. Then he crashed, at around 2am, and despite attempts to resuscitate him, he died. Before this happened, we became aware of a lot of shouting going on nearby. This was a very drunk man, making a great deal of noise. His behaviour seemed to amuse the A+E staff, and

nothing was done to quieten him. Drunk people cannot be denied medical care if they need it, but there has to be a very good case for isolating them from other seriously ill patients. During the next dreadful hour, another drunk person, a woman, was loose in the A+E, bumping into patients and falling over them. Again, no attempt was made to stop this.

While the doctors were attempting to save Pat, I was put into a small office with one chair, and one of the doctors periodically came to tell me what was going on. It was a very unpleasant environment. Proper accommodation must be provided for distressed relatives of patients. When they finally told me he had died, I was allowed to see him, still on the trolley in the critical care corridor. Everyone fled, no-one stayed near me. It was as if the staff were ashamed of their failure to save him. Staff in A+E departments need to be trained to deal with sudden death, which of course must be very distressing for them. While I wept and begged Pat not to go, I became aware of a person near me. This was a catholic priest, for whom I had not asked. He asked if I wanted him to say a prayer. I did not want to offend him, so I said I supposed it could do no harm. He then referred to me as Pat's daughter, and I asked him, respectfully, to leave me alone.

It should not be assumed that bereaved people want to see a clergyman, unless they ask for one. If they do, the relationship of the bereaved to the deceased person should be correctly communicated. A trained bereavement counsellor would have been much more useful to me in those circumstances.

I phoned my two closest friends, who arrived shortly afterwards. A nurse told me that they would clean Pat up, and we could then come back in and sit with him. We were forced to sit in the main hallway of the department, where the drunken woman continually fell over us. When we went back in to see Pat, we found him being wheeled away by two orderlies who were laughing and joking. **All** staff need to be trained to deal respectfully with people who have just died, although one wonders how this isn't part of common decency.

Pat was taken to the mortuary, a freezing cold room a fair distance away through a building site. The doors of the mortuary were jammed open, and we could only stay a short time with him, which broke my heart. Proper care should be taken to ensure that mortuaries are close to the A+E, and habitable by bereaved relatives.

Because Pat died within 24 hours of entering A+E, a post-mortem had to be carried out. This meant a delay of a day before I could take him home for his wake. The post-mortem report, which I was of course very anxious to see, did not issue to the coroner's office for **four months** after he died. Attempts to contact the pathologist in charge of it met with the assurance the pathologists never talk to relatives. Why not? They are public servants paid by the taxpayer. No-one warned me that there would be this appalling delay in accessing a crucial document, without which a death certificate could not issue. I still don't know why it took so long.

In the aftermath of that terrible night, I visited the hospital with my brother to try to ascertain what exactly had happened to Pat. I was met by a very competent and compassionate A+E consultant, and the young doctor who had been in charge of Pat on the night, who was very nervous. I reassured him that I was not looking for someone to blame, and he relaxed and took me carefully through the events as they had happened. This was very helpful to me and settled a lot of worries that I had had, especially whether he would have suffered for any length of time. I was grateful to both doctors for their readiness to meet me and be as open as possible with me.

I have subsequently been contacted by the person in the hospital responsible for end-of-life issues, and I hope to meet her to discuss my experience and propose some improvements. I appreciate her contacting me, and will do anything I can to ensure that others do not have to endure what I did on 16 January 2009.

I realised soon after Pat's death that I needed bereavement counselling. There was a highly recommended free group bereavement service in the city, but I would have had to wait more than a month to join it. I found an excellent counsellor through my own contacts, but she is expensive, and her fee is not reclaimable from VHI. Free bereavement counselling services need to be provided by the state.

I needed to speak to the consultant responsible for Pat's care in the hospital where he had been a patient, to be sure that everything that should have been done for him as a patient had been done. Because she had left that hospital some time before to go into private practice, I had considerable difficulty in contacting her. Eventually, however, I got to see her, and she helpfully got his file from the hospital and went through the details of his heart condition and the reasons for his death. This was of great help to me. She subsequently sent me a bill for a large fee, which I declined to pay.

*

According to the National Audit Report on dying in hospitals, while 74% of those who died were admitted through A+E, often inappropriately, only 4% of deaths occurred in A+E. This is a small proportion of the whole, but that is no reason not to improve processes for deaths in Emergency departments. From my own experience, I can sum up the following proposals. The first three are about improving life-saving potential. The rest cover environment, communication and administrative processes:

- That patients with pre-existing conditions be taken by ambulance crews to the hospitals where they are patients, as long as this does not endanger their care;
- That relevant specialists see patients with serious pre-existing conditions as soon as possible after their arrival in A+E;
- That a proper inter-hospital electronic medical records system be established, so that patients' records can be immediately accessed wherever they happen to be;
- That out-of-control drunk people in A+E departments are kept separate from seriously ill patients, and attempts are made to minimise the disruption they can cause;

- That proper accommodation is provided in A+E for bereaved relatives;
- That clergy are not sent to bereaved relatives unless they request them; their services should be offered, but if declined, not supplied; if clergy do attend bereaved persons, they should be correctly briefed as to the relationship between them and the person who has died;
- That **all** staff, including orderlies, are trained in how to behave in the presence of someone who has just died and their relatives;
- That mortuaries are near the A+E, comfortable and appropriately heated so that relatives can stay as long as they wish;
- That post-mortem reports are produced in a timely fashion, say at most one month after death, and that pathologists break their vow of silence and begin communicating with bereaved relatives;
- That consultants responsible for the care of someone who has died make themselves available to bereaved relatives as soon as possible after death to explain any medical issues that need elucidation;
- That free bereavement counselling services be provided nationwide by the state.

Most of these proposals chime with what the National Audit report contains. A lot of these things are to do with attitude, imagination and empathy. People who have not experienced sudden bereavement may find it hard to imagine what it's like. Many people luckily go through their lives without suffering such trauma. Death frightens everyone, with some remarkable exceptions, and most people, including hospital staff, do not wish to contemplate it until they have to. Our culture is increasingly death-denying or death-trivialising, and this makes what is, after all, a perfectly natural event - the one thing guaranteed to come to us all - distant, frightening and affronting.

Yet, in Ireland we still know how to deal with the aftermath of death better than most other developed countries. Wakes are still popular, funerals well-attended, comfort, consolation and practical help forthcoming from families, friends and communities in wonderful profusion. Celebration of the life of the person who died can go on over a period of days, giving powerful psychological support to the bereaved. Month's minds and anniversaries are other mechanisms which help with grieving. Letters, cards and emails arrive to console and help the bereaved. The very best of what we are emerges at these times.

I can perfectly understand how hospital staff can find the deaths of some of their patients extremely distressing, but it is inevitable that it will happen, and it must become an accepted part of hospital life. If we can start to imagine the place where a person dies as a sacred space, and treat it and all connected with it accordingly, perhaps hospitals can re-integrate this literally life-changing event into their philosophies of care, and provide the sustenance to themselves, their patients and the bereaved that makes death bearable rather than unbearable, and perhaps even, if we all try hard enough, transcendent.

This is probably the last time I will speak publicly in detail about Pat's death. I am honoured to have been asked to contribute to today's proceedings, and will do whatever I can to help the Hospice movement, for which I have enormous respect and admiration. Now that I have written it all down, I want to put it firmly in the public domain, and I hope that my experience will be of some help to those who are trying to change end-of-life care for the better. I now need to continue with my own grieving, with the help of my wonderful family and friends, and not to remain fixated on the night of 16 January 2009. Pat created an impressionist garden full of bluebells at our home in the North Strand, and they are just now out in all their glory. His ashes are buried in the garden among them, and I go out in the mornings to commune with him in the middle of his lovely creation.

I want to finish by reading you a poem written in Pat's memory by a friend of ours, Paul Durcan, which means a great deal to me. Pat was a painter, and Paul cherishes a few small paintings he gave him.

Death of a Miniaturist

'He painted small paintings for his friends'

At the crack of dawn one week to the day he died
From a top-storey window of a terraced house
I glimpsed Pat O Faolain in black crombie, black fedora
Tip-toeing across black ice on Charleville Mall.
It was as if he had been skating all his life,
A seventeenth-century Dutchman who by one of those archetypically
Drastic, mundane slashes of fate and circumstance
Found himself having to dwell in Dublin in the late twentieth century.
He had his hands deep in his pockets,
A city late edition rolled up under his arm,
By dint of his cello knees keeping his balance
And his violin elbows,
His Father Christmas white beard tacking to leeward and away.
A gentleman, you would say,
But a player also,
Such casual elegance,
A man of style
From the inside out,
A cove,
A night personage going home at dawn,
Skating black ice under a chalky, pink, amethyst, blue-white sky.

