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THE SCOTTISH OFFICE

National Health Service in Scotland
Management Executive

COMMON SERVICES AGENCY
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Dear Colleague

THE REPORT OF THE EXPERT WORKING GROUP ON ALARMS ON CLINICAL MONITORS SUMMARY

1. The Allitt Inquiry was established following the trial of Beverly Allitt on 17 May 1993. Ms Allitt was convicted of murder, attempted murder and grievious bodily harm to babies and children at Grantham and Kesteven General Hospital. The Inquiry recommended that an Expert Working Group should be set up to examine the use of alarms on monitoring devices.

2. The Working Group's report which is attached contains recommendations relevant to all hospital and community care settings in which monitoring and therapeutic devices with alarms are used.

Action

3. The recommendations contained in the report should be brought to the attention of all qualified clinical staff who are responsible for delivering day to day care, to managers, technical staff and educators who have a shared responsibility to ensure that appropriate action is taken in response to the recommendations.

Recycled

Other Information

4. Paragraph 4.19 and the back page of the report refer to the Department of Health guidance for reporting of adverse incidents. The Scottish equivalent guidance was issued under NHS Circular No 1991(Gen)24 dated 26 September 1991. This guidance is in the process of being updated and will be re-issued shortly.

Yours sincerely

PAUL WILSON
Director of NHS Trusts

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