

UKCSR in this regard has already been mentioned in the paragraph 4 of this statement. Mr Brawn himself has stated in his evidence to the GMC that the data on various surgical activities from other centres were not known at that time (See Annex A: GMC Transcript Day 20, pages 68-70). However I do believe that I would have provided some information to parents if asked. I recall a meeting with parents of a baby with Truncus in 1993, who asked for this information and I could furnish the figures only from the UKCSR. I mentioned centres like GOS and Birmingham without any real data, as no figures were available from these or any other centres in the country. I believe that the parents made their own enquiry and came back to me with their consent to have operation at Bristol.

L4 The professional guidance (if any) available to surgeons, or other advisors, upon the subject of informed consent and quoting for risk.

15. I am not aware of any such guidance issued or made available to me during this time.

L5 and L6

16. I have mentioned details of my practice over paragraphs 2 to 14 of this statement which provides answers to the questions raised in these sections.

17. Finally in response to Mr Whitehurst's letter dated 16 September 1999, paragraph 4, there was no real change in my practice of talking to parents as outlined over previous paragraphs. However there were changes in expectations. My quotations for mortality figures changed over years keeping pace with improvement nationally. To quote an example, in Tetralogy of Fallot a figure of 15% mentioned over mid to late eighties changed to under 10% after the year 1992-93. Similarly in cases of Complete AV canal quotes for the mortality figures came down from 25-30% in late 80's to 20% in 90's.

18. Role of junior staff – Traditionally the junior doctors used to get parents to sign the consent form soon after admission in the ward as a part of their clerking procedure in routine cases. I used to talk to junior doctors on the pathology and reparative techniques along with the risks involved during the ward rounds. Therefore most of junior doctors would have been aware of common routine conditions like ASD, VSD and Tetralogy, after they have spent few weeks in the cardiac unit. They also knew that parents have

already talked to me before in the clinic and have agreed for their child to have surgery. The new SHOs were not supposed to get consent signed on their own. There were always few experienced doctors available in the unit to help the new SHO. In addition I always advised junior doctors in the unit, not to get consent signed if for some reason, I had not seen and talked to parents before or if they had questions regarding any aspect of surgery. As mentioned in the paragraph 2, I used to see parents in the ward before surgery and then have another discussion later on. I would get the consent signed at the end of this meeting, if it was not signed before. There was some change in the ward policy, around 1993 or 1994 when SHOs were asked not to get consent signed, but to leave it to the experienced Registrars or Consultants. In emergency situations I would get the consent signed after my meeting with parents in the ward.

19. The contents of this statement are correct to the best of my knowledge and belief.

Signed:

M. Chasman

Date: 17 Nov. '99