

The BRI Inquiry into Paediatric Cardiac Surgical Services 1984 – 1995

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I have been asked to provide a statement dealing with matters surrounding the reporting of accidents and untoward occurrences.

1. I attach at **Annex 1** the text of the Ministry of Health Circular HM(55)66. This is generally not known within the NHS by its short title, but by the lengthier coverage in the first line as “Reporting of Accidents and Untoward Occurrences”.
2. The United Bristol Hospitals (and more recently the United Bristol Healthcare NHS Trust), as in all of the other many hospitals I have worked in around the country in the last 37 years, has followed this Department of Health instruction. The Circular is, of course, written very much in the management style of the 1950s. In essence, though, the procedure had not changed by the period of time covered by this Public Inquiry.
3. To describe it in the management terms of those times, all incidents were reported to the Hospital Administrator. Before the change to general management, patients’ incidents statements generated by nursing staff would normally have been considered by a senior nurse in the nursing office (in other words the Nursing Officer or Senior Nursing Officer) before being given to the Hospital Administrator. In current terminology this translates into initial consideration by the Clinical Nurse Manager, and the report being given to the Directorate Manager, or in a larger Directorate to the Assistant General Manager of the Directorate. There was no formal policy in the