

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

NHS during the relevant period as to which incidents should be report to the Chief Executive, or what specific action should be taken.

4. Under the Chief Executiveship of Dr Roylance, it was a matter for the professional responsibility and judgment within Clinical Directorates as to what was drawn to the attention of the General Manager by the Assistant General Manager; or in turn by the General Manager exercising discretion as to what matters should be drawn to the attention of the Trust's Chief Nurse Adviser or Director of Operations; and in turn whether those matters needed to be drawn to the attention of Dr Roylance as the Chief Executive. In my role as the Trust's Claims Manager, it is my judgement that this informal system worked extremely well for reasons which I shall describe below.
5. In practice, the system was predominantly used by ward nursing staff to describe minor untoward incidents to patients who slipped or fell out of bed. When major accidents or near misses occurred a very much more accelerated process took place in addition to the immediate form filling and witness statement. If a serious near miss occurred which involved medical staff, and was due to some factor other than human error then consultants would contact their Clinical Director immediately, in addition to the General Manager. It would be likely that the Medical Director would be involved at Trust Board level in addition to the Chief Nurse and Chief Executive.
6. I can find no written policy relating to the period 1984 to 1995 on the reporting of accidents and untoward occurrences. The informal procedure I have described above was written after consultation on its accuracy with Ian Barrington, Manager of Children's Services, who has been involved in operational management over the period of time covered by the Inquiry. I have described the levels of reporting recalled by myself and confirmed by both Ian Barrington and Rachel Ferris, Manager of Cardiac Services, who is another manager of longstanding experience in the NHS.
7. There were no local working definitions of "untoward incident" or "near miss". The definitions used were those in Circular HM(55)66. Indeed, I would suggest that there was much merit in this national and uniform policy, in view of the rotation of junior medical staff. In referring to a near miss involving equipment and human error by medical staff above, I was intending to differentiate between the failure of a piece of