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BRK/sd

5 October 1999

Claire Bache  
Medical Records Assistant  
Bristol Royal Infirmary Inquiry  
2-10 Temple Way  
Bristol  
BS2 0BY

Dear Claire

**Re: Review of clinical notes, team No** [REDACTED]

I enclose the completed report forms which as you can see have been filled in at the time of our meeting by hand and I would be grateful if you could possibly arrange for them to be typed. Where the boxes have been left blank this indicates that our team felt that the care was adequate and that there were no relevant comments to make on that particular section.

Our group wished me to write an accompanying letter with the review forms to indicate a number of recurring comments about the care of these patients.

1) In all those cases where the surgery took place at the Bristol Royal Infirmary, our group expressed concern about the lack of evidence of regular input and involvement by members of the paediatric cardiology team in the post operative management of the patients.

2) We were also concerned about an apparent absence of echocardiographic assessment of the post operative patients particularly those in whom the post operative course was not uneventful. In specific patients you will see that we have commented on apparent delays in echo assessment of the patients.

3) It was felt that from a nursing prospective it was difficult to determine the level and quality of pre-operative preparation which the child and parents received.

4) The review is made difficult by a number of recurring issues,

a: notes were not filed correctly in date/time order

b: care plans and evaluation sheets were not always dated and the time not necessarily inserted which made it difficult to always determine the correct sequence of events

c: poor photocopies hampered the review for some patients

d: it was not always possible to determine which individual nurse or doctor was caring for the child.

5) We were unable to comment on whether the experience of the individuals in the team was appropriate for the care of children, for example if the nurse was a registered children's nurse or had special experience in paediatric cardiac nursing and if the junior medical staff had paediatric experience

6) There were a number of instances where we are unsure about the appropriateness of pain management.

7) We felt that the split nature of the sites for care of children's cardiology was clearly hampering the communication between the various professionals within the team and perhaps the co-ordination of the child's care.

8) There were some instances where lack of bereavement care and explanation to the parents was apparent and this might not have been the case had the children been cared for by trained paediatric nurses.

I hope these general comments are of help to you. Please let me know if you need any further information.

Kind regards

Yours sincerely



Dr B R Keeton  
Consultant Paediatric Cardiologist

**Bristol Royal Infirmary Inquiry**

**Review of Sample of Clinical Notes**

**Report from Group on some Overall Impressions after the Review**

**Members of Group**

Mr Christopher Lincoln, Consultant Cardiothoracic Surgeon

Mr Philip Deverall, Consultant Cardiothoracic Surgeon who replaced Mr Lincoln for 1/3 of the Groups work.

Dr Eric Silove, Consultant Paediatric Cardiologist

Dr Michael Scallan, Consultant Anaesthetist

Ms Julie Gifford, Clinical Director, Guy's & St Thomas' Hospital (ICU)

Dr Stephen Gould, Consultant Paediatric Pathologist

There were some consistent impressions which struck members of our Group when reviewing clinical notes.

It was difficult to place these general impressions in any of the boxes on the report forms. We stress that they are based on our interpretation of some of the things that happened during the admission and follow up of some patients.

- (1) There appeared to be significant delays before cardiac catheterisations were planned, especially in patients who had previously had operations. It was not clear to us whether this was clinical policy or related to lack of resources.
- (2) There were rather long delays between the time of the cardiac catheterisation and an operation. Some of the outpatient letters indicated that the waiting list was "tight". We were not certain whether the delays related to the waiting list and to resources or whether some were actually clinical policy.
- (3) There were some situations which our Group considered would have been urgent, in which an operation was significantly delayed and sometimes the patient was even discharged from hospital while waiting for a very urgent operation. It seems to us that most of these were related to the availability of resources.
- (4) In general, investigations appear to be adequate, providing the correct diagnosis but we considered that many were incomplete in not providing all of the details that might have been ideal for a Surgeon to know. This raised the question in our minds of whether the lines of communication between Surgeons and Cardiologists were adequate. Was there sufficient dialogue on clinical problems?
- (5) It appeared that the cardio-pulmonary bypass procedures were done at the Bristol Royal Infirmary which was remote from the Paediatric Cardiology expertise. There also appeared to be a lack of Paediatric Nursing input at the BRI. We wondered whether the split site influenced the quality of medical supervision in the Intensive Care Unit. There was a noticeable absence of Paediatric Cardiological input on the ITU at BRI. It appeared that there were very few echocardiograms ever done on the ITU at BRI.

- (6) We found it difficult to determine who took both medical and nursing responsibility for directing the management of patients on the ITU at BRI and this applied especially to the management of Paediatric patients. We had no problem with the quality of Nursing and Physiotherapy at the Children's Hospital which we considered to be excellent.
- (7) We were disappointed by some of the Pathology reports which did not appear to answer questions that we as reviewers were asking in relation to the death of a patient. We wondered whether the post mortems answered the questions which the Clinicians might have been asking. We wondered whether there was sufficient exchange of information between the Clinicians and the Pathologists.
- (8) All of the above comments led us to wonder whether the whole group of Cardiologists, Cardiac Surgeons, Nurses, Technicians, Paramedical Staff and Pathologists were functioning as a team.

October 12, 1999

Ms. Una O'Brien,  
The Bristol Royal Infirmary Inquiry,  
2-10, Temple Way,  
Bristol,  
BS2 0BY.

Dear Ms. O'Brien,

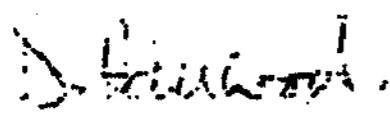
SUBJECT: CLINICAL CASE NOTE REVIEW

Following the review of the case notes allocated to team one some issues emerged that cannot be directly recorded on the response forms. There is a feeling amongst our group that patient care was less than optimal in several cases due to the fact that post operative care was provided in a unit designed and staffed to care for adult patients. This is indicated by some of the comments, mainly in the nursing notes, which make it clear that adult parameters are being extrapolated to paediatric practice. I do not know the ratio of adult to paediatric patients in Bristol during this period, but would expect there were many more adults passing through the unit than children.

The general standard of note keeping in the post-operative period is not of a high standard, and the grade and specialty of medical staff responsible for the provision of this care is not easy to determine. Again the feeling is of children being cared for by staff who are much more used to dealing with adult patients.

Clearly there have been major improvements in both cardiac surgery and the post-operative care of these patients over the past few years and it is sometimes difficult to be sure that judgement is being made using the criteria relevant to the period. Indeed a similar review of other centres work around this time would probably have demonstrated results not hugely different from those achieved in Bristol. It is probably fair to say that improvements in results were being seen in other units towards the end of the period under investigation, many of them related to individual surgeons and investment in better facilities. I understand that these factors are also under scrutiny in a different area of the inquiry.

Yours sincerely,



David Falkworth  
Team Leader,  
Review Team One

DEPARTMENT OF ANAESTHESIA,  
ROYAL HOSPITAL FOR SICK CHILDREN,  
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# Great Ormond Street Hospital for Children NHS Trust

and the Institute of Child Health



Great Ormond Street  
London WC1N 3JH

Telephone: [REDACTED]

JED/hjc

Dr E Silove & Mr L Hamilton  
c/o Bristol Royal Inquiry  
2-10 Temple Way  
Bristol, BS2 0BY

Fax No: 0117 938 8790

14<sup>th</sup> October 1999

Dear Eric and Leslie

## **Re: Bristol Inquiry**

We have reviewed eleven cases (six deaths) as part of the Bristol Inquiry. We have scored the cases according to individual outcome using the guidelines. It should be noted from our scores that an adequate outcome may have been present despite poor management. Thus for example, two cases of atrioventricular septal defect, managed similarly badly were scored differently as one died and one survived. This must be considered if findings are collated and in particular if a numeric scoring system is to be used to assess overall quality of care. Common features in our cases were:

1. Delay in diagnosis, referral and treatment. There was often considerable delay between primary referral and appropriate investigation by the cardiologist. In some cases, despite adequate diagnosis, surgery was delayed to an extent which jeopardised outcome (eg. AVSD). Furthermore, further delays often occurred between referral to the surgeon and conduct of the surgery itself.
2. Cardiological investigation. Even when era is considered, inappropriate diagnostic cardiac catheterisation was common. In our eleven cases, this resulted in delay in treatment and significant morbidity.

Cont....

- 2 -

3. Surgical management needs to be evaluated in the context of the overall team performance. However, there are clear examples of poor surgical decision making as a result of failure to understand the pathophysiology of the congenital heart lesion. Although repairs were often technically adequate, long bypass and ischaemic times in the case of one surgeon (JW) reduced the chances of a successful outcome.
4. Intensive Care at the Bristol Royal Infirmary appears to have been fragmented and insular in approach. For example, failure to anticipate clinical problems, delayed response to post operative problems and failure to involve other team members (eg. cardiology, surgery and other disciplines) contributed to poor overall performance.

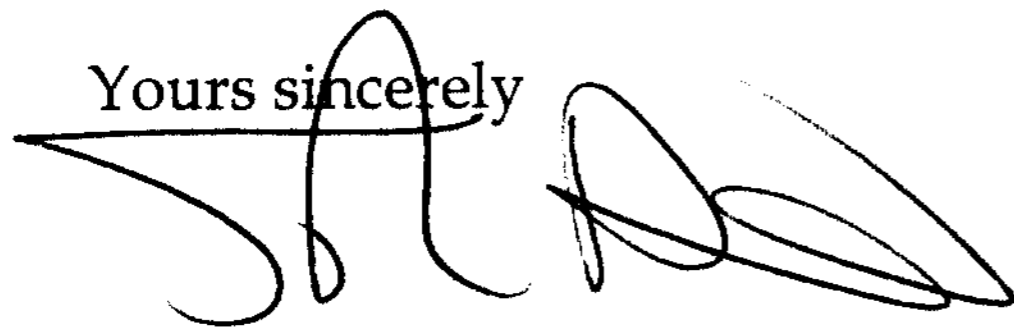
On the positive side, the standard of record keeping, pastoral care and communication with families was clearly high.

We would stress that we are concerned about the possibility that our comments will not remain confidential to the Bristol Inquiry but could be used in medico-legal proceedings. Our judgements were based purely on the records provided by the Inquiry. Individual cases were not subject to the detailed forensic scrutiny normally applied in medico-legal expert reviews eg. intensive care unit charts, co-morbid opinions etc were not necessarily available.

We hope these comments are helpful.

Best wishes,

Yours sincerely



**John E Deanfield - Professor of Cardiology**  
On behalf of Group [REDACTED]

Enc

# The Lothian University Hospitals NHS Trust



## Department of Cardiac Surgery Royal Hospital for Sick Children, 9 Sciennes Road, Edinburgh, EH9 1LF

**Consultant: Mr P S Mankad**

Our Ref: PSM/CB  
Date: 15<sup>th</sup> October 1999  
Secretary: Catherine Boyd

Ms Una O'Brien  
Secretary to the Inquiry  
The Bristol Royal Infirmary Inquiry  
2-10 Temple Way  
BRISTOL BS2 0BY

Dear Ms O'Brien

Please find enclosed the clinical record forms of 10 patients reviewed by my team.

This review was obviously a retrospective exercise. In clinical management, a number of things are more clear in hindsight especially when one is aware of the final outcome. Although this is unlikely to have introduced bias but it often makes one see things in black and white, thereby introducing a more critical approach to the assessment exercise.

Our group has taken this more critical approach to enable us to learn lessons from this inquiry rather than to give benefit of doubt to the organisational aspect of care or to the individuals providing the care at the time. We are aware that even this approach is not beyond criticism but our objective has been to facilitate the process of inquiry to recommend future directions.

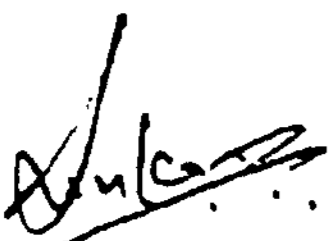
The individual aspects of care are outlined in the clinical record forms. However, some common themes of perceived less than adequate care, questions arising therefrom and overall strategic impact of these themes are outlined below. Please note that the initials in the bracket refer to the patients which highlight the particular theme.

1. "General" delay in the timing of operation (AM, GE and MR). Does this reflect more conservative approach by the team? Or does it show certain amount of lack of confidence? Or does it reflect the sincere views of the clinicians involved in the care at the time?
2. "Relatively long" cross clamp times and circulatory arrest times (when used). However, this is a subjective interpretation of times and surgeons are always going to be on either side of the "so called" average. (DH, MCM and JC).

3. Some inadequacy of Coroner's PM in providing comprehensive information required from autopsy (GE and DC).
4. Need to have a two way clear and free communication between the pathologist and the clinician (surgeon) before and during autopsy (GE).
5. How best to manage extremely rare surgical conditions requiring complex surgical expertise? (OE).
6. What is "informed consent"? Balance between giving too much information to the parents before surgery often generating unnecessary anxiety and too little information that turn out to be the cause of post operative morbidity or even mortality. (DC, OE and GE). How much and how best to document the nature of informed consent?
7. The importance of critical mass in paediatric cardiac surgery not just for the surgeon but for the whole team involved in the care; thus highlighting the need to promote establishment of fewer dedicated paediatric cardiac surgery centres in the country. (GE, MR and GH).
8. The vital role of a dedicated paediatric intensive care unit with comprehensive infrastructure both in terms of human resources and "state of the art technology" looking after post-operative cardiac surgical babies (DC and GH).

I hope this short note will assist Dr Silove and Mr Hamilton in preparation of their report. I will be pleased to discuss any issues with them, if necessary.

Yours sincerely



Pankaj Mankad  
Consultant Cardiac Surgeon

# The Lothian University Hospitals NHS Trust



**Department of Cardiac Surgery**  
Royal Hospital for Sick Children, 9 Selkirk Road, Edinburgh, EH9 1LF

**Consultant: Mr P S Mankad**

Our Ref: PSM/CB  
Date: 15<sup>th</sup> October 1999  
Secretary: Catherine Boyd

Ms Una O'Brien  
Secretary to the Inquiry  
The Bristol Royal Infirmary Inquiry  
2-10 Temple Way  
BRISTOL BS2 0BY

Dear Ms O'Brien

Thank you for your letter dated 11<sup>th</sup> October 1999 enquiring about any of the cases reviewed by my team which might be of particular interest to the Counsel.

A number of common themes are most likely to emerge from this review exercise. However, I feel that one particular issue highlighted by the case of [REDACTED] might be of interest to the Counsel to the Inquiry. This case is not a direct criticism of adequacy of care in Bristol but highlights the need to have a rational, national approach to the management of extremely rare, highly technical and labour intensive high risk conditions.

The discussion of this case may assist the Counsel to get more insight into such problems and will facilitate the debate on who and where to manage these patients plus required resources (financial and other) for the same. Ultimately this case may direct the panel to form a clear and balanced view for the final recommendation.

Please feel free to contact me if you wish to take this further.

Yours sincerely

Pankaj Mankad  
Consultant Cardiac Surgeon