

The BRI Inquiry into Paediatric Cardiac Services in Bristol 1984-1995

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Introduction

1. This statement is made in response to the Inquiry's request for information relating to "Block 4" evidence. It covers aspects of Issues D, E, F, G, I, J, K and L. The Inquiry is already in receipt of my statement dated 17 May 1999 covering Issues B and H. I have prepared separate statements on Issues M and N.

Issue D: Referrals

D1: The identity and the distribution of hospitals (and/or general practices, if appropriate), from which children were referred to:

a. the paediatric cardiologists; or

b. the paediatric cardiac surgeons based at the BRI.

2. Apart from an awareness that the referring hospitals were based in the Southwest region, I have no information or knowledge of this issue.

D2: The judgment or impression formed by referring paediatricians or other clinicians of the paediatric cardiac surgical services provided by the BRI.

3. This is a clinical matter about which I can make no comment. From my position there seemed to be no lack of work at any stage and therefore those referring clinicians must have regarded the services provided by the BRI as appropriate.

D3: The sources of information available to such referring clinicians upon the standards of treatment and care attained at the BRI.

4. I am unable to comment on this issue as I am unaware of the information available to referring clinicians upon the standards of treatment and care.

D4: The factors influencing clinicians, in deciding to refer children to the BRI rather than to other centres performing paediatric cardiac surgery.

5. This is a clinical matter and as such I am unable to comment.

D5: Whether there is evidence to suggest that clinicians based outside the BRI but within its "catchment area" were deciding to refer children to centres other than the BRI; and, if so, why.

6. I have no knowledge of this issue.

D6: Whether any of the paediatric cardiologists based at the BRI decided to refer a child to a paediatric cardiac surgeon outside the BRI; and, if so, why.

7. I have no knowledge of this issue.

D7: The extent of and reasons for tertiary referral from the BRI to other centres of paediatric cardiac surgery.

8. I am unable to comment on this issue as it was not part of the remit for my position as Senior Staff Nurse, G grade Sister or Nurse Manager.

D8: The information (if any) given to parents or guardians at the time of referral to the BRI, upon the services and care to be expected at the BRI and/or at other centres; and the information (if any) given concerning the possibility of referral to other centres.

9. I was not party to discussions between cardiologists referring children to the BRI and the parents or guardians of those children and cannot comment on this issue.

Issue E: Pre-Operative Management of Cases**E1: The arrangements and services available to manage the transfer of sick children from referring hospitals to the BRI.**

10. Children were often transferred from the Bristol Children's Hospital to the BRI. The relative urgency of their transfer would depend upon assessment and categorisation by the paediatric cardiologists and the paediatric cardiac surgeons.

E2: Where children were managed, pre-operatively; and under which clinical speciality.

11. Children were often admitted to the BRHSC for cardiac catheter assessment prior to their intended surgery, to assess the viability of surgery. Children were generally admitted to Ward 5a at the BRI for elective surgery 2 days before their operation. Children undergoing emergency surgery were transferred from the BRHSC to Ward 5a, and could be admitted from there 2 days or even 1 day prior to the operation. Children were also admitted directly from the Children's Hospital and straight into theatre, depending on their condition and the availability of ITU beds.
12. There were times when children were admitted from the BRHSC to Ward 5 ITU and were stabilised in this area prior to going to theatre, which may have been that day or the following day, depending on the child's condition.

E3: The re-assessment of the clinical condition of children admitted for elective surgery, following admission.

13. The usual routine for children undergoing elective surgery was that they were clerked on admission by an SHO. The SHO examined the child and took a full medical history. Tests were requested, such as chest x-ray and bloods. Prior to the surgery, the child was also seen by the surgeon. This usually took place the day before the surgery, sometimes at night with the parents and the child. The anaesthetist also saw children pre-operatively, again usually the day before the surgery. At this time assessment of the clinical state of the child was undertaken by the surgeon and the anaesthetist.

E4: The manner in which decisions to recommend surgery for a child were discussed between paediatric cardiologists and paediatric cardiac surgeons, and other members in the cardiac surgery team; and the means by which such decisions were taken

14. This is not a nursing issue. I believe such discussions took place at the BRHSC, and I imagine that this occurred after the cardiac catheter results were available. I believe the paediatric cardiologist, surgeon and anaesthetist discussed these matters, as they were the surgical team.

E5: Who bore the ultimate responsibility of deciding whether and what surgery was appropriate for a child, who would perform it, and when it should take place.

15. My understanding is that this was a joint responsibility between the paediatric cardiologists and the surgeons.

E6: The organisation and management of theatre lists.

16. There were monthly waiting lists which detailed which patients were coming in for elective surgery. Each surgeon had their own allocated slots and they decided who would go into each slot to be operated on. Each surgeon, I believe, had around 5 operating sessions per week. Some surgeons had all day lists and some had half day lists, depending upon what their special allowance was. Each surgeon filled his session with patients from his waiting list.
17. There were then day to day theatre lists. The surgeon and anaesthetists would decide the order for the operations that would be carried out each day. The equipment required clearly had a bearing on this order.
18. The only time other cardiac surgeons would complete someone else's session was if a cardiac surgeon was on annual leave or study leave, as a slot was then available.

19. For both adult and paediatric cardiac surgery, the operating list was drawn up on a monthly basis, planned in the middle of the month for the following month. It was predominately made up of patients from the waiting lists. The secretaries would type up the operating lists together. A few spare slots were left for emergencies, as there was little scope for accommodating emergency patients into the list. They usually had to be slotted onto the end of the day, or even weekends. Emergency patients occasionally had to be operated on in the usual 8am to 5pm operating time and then the waiting list patient had to be cancelled.
20. The surgeons seemed not to discuss with each other the cases they had on particular days, so there were times when a surgeon would have a morning session and one would have an afternoon session and all the cases were high risk or very ill patients. This created pressure on ITU services, as the additional high risk patients would be admitted to ITU on the same day, rather than spread more evenly across a number of days.
21. The SHO made a list of which patient was going into which theatre, and at what time of the day. The order of the list, or the order of the way the patients would go to theatre, i.e. first or second, was decided by the surgeons and the anaesthetist. The anaesthetist's input into the case mix was relevant because there were times when only certain anaesthetists were able to assist with paediatric cases. This led to occasions when patients would have their operation time changed, depending upon the availability of certain anaesthetists. Theatre lists also required alteration, on occasion, if blood products or pieces of equipment in theatre were unavailable, e.g. if homograph or a certain valve size was required and these were not available. The perfusionist would be able to explain in more detail the reasons behind availability or unavailability of certain pieces of equipment.

E7: The mechanisms in place in order to ensure that surgery (whether elective, urgent or emergency) took place at a time regarded by the clinicians at the time as clinically optimal or appropriate.

22. Elective surgery was planned on a monthly basis in advance and was not usually changed unless unforeseen circumstances occurred. These circumstances are as I have described before in paragraph 19, but also occurred when a bed in ITU was not available or if nursing staff were not available. Most elective cases went ahead on time, unless an emergency patient arrived. Emergency cases took place when the clinicians felt the time was appropriate/necessary. There were times when elective patients were cancelled because an emergency patient was so ill that they needed to be operated on at that time. There were other times when the emergency patient was able to wait until the end of the day, when the routine elective surgery had finished. There were also occasions when emergency patients were operated on, on a Saturday morning.

E8: Whether operations (particularly elective ones) were carried out at a time regarded by the clinicians in charge of the child's care as appropriate; or whether the timing of operations was affected by matters such as limitations in the number of beds available in the ICU, availability of nursing staff or other staff, or the requirements of adult cardiac surgery.

23. The majority of elective operations on children were carried out at the time of planned surgery. It was rare that operations were cancelled. Occasionally the operations would be cancelled due to lack of available beds in the ITU or a limited number of experienced intensive care nurses on the ward.
24. Operations were also rescheduled when, for instance, two operations were scheduled in one day and the first operation (whether it was an adult or child) overran, or went past 2 o'clock in the afternoon. The afternoon case was then cancelled because it was likely to overrun past the theatre finishing time of 6 o'clock. This caused much annoyance to the surgeon. The cardiac theatres stopped working between 6 o'clock in the evening and 8 o'clock the following morning. During this time the cardiac theatres have an emergency staffing system. This is purely for emergencies or patients returning to theatre with bleeding. It was, as I recall, rare for a child's operation to be cancelled due to the requirements of adult cardiac surgery. If anything it was usually the other way around - the ITU was perhaps full with 4 or 5 very sick children, and that meant only 3 beds were available for adults. I recall that this did, at times, cause conflict amongst the surgeons, notable only at informal comment level on the ward.

E9: If there were delays in surgery, the effect (if any) of such delays upon the outcome for the children affected.

25. I am unable to comment on this, as it is a clinical issue.

E10: The qualifications, training, experience and skills of the paediatric cardiologists.

26. I am unable to comment on this as I have no knowledge of this issue.

E11: The service provided by paediatric cardiologists in diagnosing or describing:

a. the structure and anatomy of the child's heart and lungs;

b. the clinical condition of the child;

c. the nature of the surgical procedure required, and any complications that might be encountered by the surgeon;

d. the speed or urgency with which any intervention was required.

27. I am unable to comment on this clinical matter.

E12: The protocols or clinical guidelines, machinery, equipment or technical services (e.g. radiological interpretation) available to cardiologists to assist them in this task.

28. I have no knowledge of this issue.

E13: Pre-operative assessment and preparation procedures, including meetings at which treatment and operations were discussed and planned.

29. Whilst I may have been involved when I held the position of Senior Staff Nurse, I have no specific recollection of the process of pre-operative assessment and preparation, or the meetings when such matters were discussed.

E14: Pre-operative observation, assessment and care by the nursing staff and other professions (such as physiotherapists).

30. See my response to E3. The cardiac counsellor, Helen Stratton, saw parents to discuss their social circumstances and the support mechanisms available to them. Physiotherapists also saw the child together with the parents, usually the day before the surgery, to plan how things would take place following the operation.

E15: Liaison of staff with parents; and the participation of parents in the assessment and care of their child.

31. Parents were fully involved in the assessment and care of their child from admission to when they were discharged. Parents were encouraged to stay with their children at all times throughout their stay. Initially upon admission, parents were offered the use of the hostel at 66 Horfield Road, which was very near to the BRI. This enabled parents to be close at hand if they lived a distance away. Parents could also stay on the ward if they wished to. There were two rooms, Blaise and Wiltshire, which were specifically for parents of children who had been operated on that day, or if their child was very sick. On occasion, having only two rooms caused some difficulty if there were more than 2 sick children on the ITU, but the majority of the time parents and nurses would make arrangements as to who would have the rooms and for how long.
32. When the children were in the ward area pre-operatively, parents were encouraged to care for them as much as possible, i.e. to bathe them, feed them, and if the mothers were breast-feeding, to encourage them to express milk.
33. When the children were in intensive care post-operatively, parents were again encouraged to wash their child, clean their mouth and help turn them. Parents were also encouraged to play with their child to the degree of having mobiles or reading books or playing music. Generally, they were encouraged to look after the child as much as possible, within the constraints of their child being in an intensive care unit. The nurses were very supportive of the parents involved and with the children in the ITU.

Issue F: Management of Surgery**F1: The qualification, training, experience and skills of the paediatric cardiac surgeons at the BRI.**

34. I have no knowledge of this issue and am unable to comment.

F2: The qualifications, training, experience and skills of the anaesthetists assisting at paediatric cardiac surgery at the BRI.

35. I am unable to comment on this issue save that, to my knowledge, some anaesthetists had specialist paediatric cardiac experience.

F3: a. The qualifications, training, experience and skills of all other members of the surgical team (e.g. nurses and perfusionists).**b. The support and assistance given by such members of the surgical team.**

36. The nurses who worked in the operating theatre were very skilled cardiac theatre nurses. The nurses who assisted with paediatric operations at the table had many years of cardiac nursing experience. There were only a limited number of these nurses, around 4 out of 12 to 14 full-time staff, who worked with the paediatric cases. It was always difficult to staff the paediatric cardiac theatres due to the specialist experience that such nurses needed. They needed theatre experience, cardiac experience and also, of course, paediatric experience. Staff were trained in-house and learnt these skills by working with one of the senior staff, either a sister or an F grade, during these operations. Some nurses and theatre staff did not wish to learn how to care for children and just assisted with adult surgery.
37. Generally the staff supported each other during each procedure. Everyone's role was regarded as equally important to the success of the operation.

F4: How the team in the operating theatre was constituted and co-ordinated and its performance as an integrated team.

38. There were two cardiac operating theatres. One theatre had a bigger anaesthetic room and this was used for paediatric surgery. Theatre nursing was headed up by 3 G grade sisters – one sister was an anaesthetic sister and the other 2 sisters were scrub staff, working with the surgeons at the table. All 3 of them were able to scrub for paediatric cases.
39. As there were three G grade sisters in one area, conflicts at time arose as to who was in charge, as no sister took complete responsibility for the department. I implemented a change to the management in theatres by enabling one G grade sister to be in charge per week, so there was a single point of contact. I cannot recall specifically when this occurred. This enabled anyone, be they doctors, nurses, myself or whoever, to contact the sister in charge regarding any issues which arose. There were, of course, times when one of the three G grade sisters was not on duty, and an F grade would take charge. This was not a problem as they contacted me if they required assistance.
40. The only thing which affected the performance of the integrated teams was when a case was running late and subsequent cases had to be cancelled. It caused conflict because it seemed that the nurses were the ones saying that they were not going to stay and work after 6pm.
41. As time went on one of the sisters (Mona Herborn) refused to operate with Mr Janardan Dhasmana. I cannot not recall when this was, however her request to be taken off the list for Mr Dhasmana coincided with a time when the other 2 sisters began to share the role of surgeon's assistant. At this point the 2 sisters became less involved in the management side and Mona Herborn increased her management role. See paragraphs 20 and 21 of my Issue N statement dated 3 December 1999.

F5: The factors affecting performance in the theatre. Such factors might include familiarity with tasks; design and performance of equipment; hours of work; error management; and so on.

42. When I first became nurse manager in 1992 the theatre was operating from 8.00am to 5.00pm. Cases invariably ran over past 5.00pm, especially when 2 children were operated on in a day. This caused problems with morale, as staff regularly finished work late.
43. If a change occurred in the way surgery was undertaken, staff were trained in that new procedure. For example, Sisters Alison Reed and Onyx Brewin went to Birmingham to observe the switch operations when the procedure was new to Bristol. If new equipment was available for a certain procedure, then staff would be trained in that new equipment. Again by way of example, in 1993 I implemented a disposable chest drainage system, replacing the recycled chest drain system. A representative from the company supplying the new chest drains came to the BRI and gave several training sessions.

F6: a. The existence, extent and awareness of any material differences in the manner (including speed) of carrying out surgery at the BRI, when compared to surgical practices current at the time; and

b. the impact (if any) of such factors upon mortality and morbidity rates.

44. I have no knowledge about this issue and cannot comment.

Issue G: Post-Operative Care**G1: The national standards or guidance in existence, in 1984-1995, to shape the organisation, numbers and experience of staff within ICUs such as those of the BRI and the BCH.**

45. I believe that the national standards for ITU staffing levels were a bracket of 5.1 to 7.8 qualified nurses per bed. This provided 24 hour cover at an appropriate level. The figures varied within the bracket, according to the level of complexity of care required within ITU. Depending how ill a patient is, he/she may require one to one care, or may be treated by a nurse allocated to another patient requiring similar levels of care (i.e. one to two ratio). In the ITU at the BRI, we had a ratio of 5.4. This was, I believe, lower than the optimum indicated for pure paediatric units, but reflected the case mix of adults and children we treated.
46. I am only able to comment on the staff and their experience from around 1995. The experienced staff who cared specifically for children were higher grade nurses, either an F grade or a G grade. These staff always had a post-registration qualification, which was normally in adult intensive care, some of them undertaking paediatric courses. The senior E grades who had undergone rotation were also able to care for the children. Rotation was a 3 weeks orientation, undertaken by a nurse who wished to gain more experience in caring for children. A G grade nurse acted as a mentor, and cared and supported the nurse through a planned orientation package. A couple of days a week, Cathy Warren, who was the F grade specialist paediatric nurse, cared for the children in the ITU. Depending on the severity of a child's condition, or the level of expertise that the nurse had, when a child came back from surgery he/she was mainly cared for by Cathy as the specialist nurse.

G2: Staffing within the ICUs caring for children following cardiac surgery: numbers, training, experience and skills mix.

47. See my response to G1.

48. The staff who cared for the children following cardiac surgery were well trained and had experience in caring for children. Nurses would say quite clearly if they did not feel happy with looking after a specific child, and the allocation was then changed if at all possible. If this was not possible, the Sister in charge would ensure that the nurse was suitably supported throughout the shift.

G3: How, if at all, the skills mix and expertise of the ICU staff differed from both published guidance and the standards and patterns to be observed across the country at the relevant time.

49. The overall mix and expertise of the ITU staff differed from published guidelines because the guidelines stipulated that paediatric nurses should at all times care for paediatric patients. However, there was a lack of specialist paediatric nurses in the cardiac intensive care unit. This was because of being unable to attract these nurses to the department, as it was a mixed adult and paediatric ITU. There were two paediatric nurses who worked on ward 5, one who worked in intensive care and the nursery as an F grade – Cathy Warren - and another nurse who was a D grade and who worked predominantly in the nursery. The other staff in the ITU had intensive care training and experience.

50. In my experience with recruiting staff to the cardiac unit/ITU, paediatric nurses were not keen on working in an adult unit because they preferred to care for children. Where the unit is mixed there will, on rare occasions, be no children in the unit and this was not appealing to paediatric nurses.

G4: The availability of staff throughout the 24 hour day to assess and to meet, following such assessment, the needs of any child in ICU after paediatric cardiac surgery.

51. Staff were available throughout a 24-hour period to assess and meet all the needs of an intensive care child after surgery. The staffing levels were no different during the day than they were at night – there was always a one-to-one ratio per patient. The nurses were well trained and experienced. There was always a G grade or an F grade nurse in charge of the shift. Out of hours (i.e. after 6.00pm and before 8.00am) there was an SHO on duty 24 hours a day. The registrars and consultants were also on call and generally available on the unit within 10 minutes if required. (see also my response to G6).

G5: The development and organisation of immediate post-operative care.

52. Generally, the child returned from theatre with the consultant anaesthetist, a senior registrar anaesthetist, an SHO surgical team member and probably a registrar. The consultant usually came into the unit 10-15 minutes after the patient had arrived back in the unit, once the child was set up on whatever machinery was necessary. At times the consultant arrived with the child, depending on the child's condition. The anaesthetist connected the child to the ventilator, and made sure the ventilator was set at the correct rate and settings for the child's size, weight and requirements. The anaesthetist also ensured that the necessary drugs were running according to the correct rate for the child. The SHO would take blood for various tests. Blood sugar and blood gas would be analysed on the ward. The SHO then completed the ITU chart. The anaesthetist gave instructions to the nurse. Usually by the time this had all happened the consultant had arrived and would be checking the chart following the transfer from the theatre to the ITU. The consultant sometimes made changes if appropriate, but would discuss the way forward with the anaesthetist. The cardiac surgical registrars and the consultant paediatric cardiologist were also involved when they saw the child soon after arrival in the ITU. There were also various rounds made during the day.
53. In either 1992 or 1993, an intensivist (I am unable to recall the name) was employed and the management of immediate post-operative care was changed, enabling the intensivist to be responsible for the ITU care. Prior to this, the consultant surgeon was the main person who had control over the management of care.

G6: Liaison between specialities, and steps taken to ensure continuity of care.

54. Anaesthetists performed ward rounds and passed information to one another. There were occasionally problems, for instance at weekends, when a different anaesthetist was on duty who had not met the child earlier in the week. I believe generally that the continuity of care was very good. There was a ward round in ITU at 8.00am every morning when the surgical team would walk round, with the sister in charge, to ensure that the patients were receiving the correct management of care. The surgical team consisted of SHOs and registrars.

55. Nurses worked shifts, usually a late shift followed by an early shift. They often cared for the same patient on both shifts. Nurses enjoyed looking after a specific patient for 3 or 4 days in a row, because they found they got to know the child well and developed a good rapport with the family. There were occasions when a child was very ill or when the parents became very demanding, when the nurses would care for the child for 2 shifts in a row before the allocated nurse was changed. This gave the particular nurse a break from that more stressful situation.

56. After the surgical team ward round, there was a further ward round by the consultant cardiac surgeon between 8.30am and 9.00am. There was then the anaesthetists' ward round at around 10.00am.

G7: The assistance provided by paediatric cardiologists. The impact (if any) of the fact that these cardiologists were based in the Children's Hospital, upon the availability of such assistance.

57. Dr Jordan and Dr Joffe visited the children post-operatively. Dr Alison Hayes and Dr Rob Martin visited the children most days whilst they were in the intensive care unit at the BRI. I was unaware of any impact, either negative or positive, the paediatric cardiologists being based at the Children's Hospital.

G8: The extent to which the demands or requirements placed upon ICU nurses and other staff by paediatric cardiac cases differed from those imposed by adult cardiac cases or other cases commonly encountered; and the steps taken to address any issues that might arise out of such differences.

58. The demands placed on the nurses by having children in ITU may have been different from the adult patients because the parents were with their child almost around the clock. This meant that, not only was the nurse caring for the child, but they were also looking after the parents. There were also social problems to take into account, such as where parents were separated or divorced. The nurse would become the go-between which of course caused added stress for the nurse involved. Helen Stratton and Helen Vegoda helped tremendously, by supporting the family and also, to an extent, supporting the nurses.

59. A child's condition often changed more rapidly than an adult's. When caring for children following surgery, the nurses had to be extra vigilant to ensure that any slight changes in the child's condition were noted. If the parents needed support, then this often meant that the nurse had to divert her attention away from the child to the parents. At times this became quite difficult and stressful.

G9: The supply and maintenance of proper and adequate equipment to the ICU.

60. Following cardiac surgery a patient needs various support equipment, such as a ventilator to support their respiratory status, and syringe pumps to enable inotropes and various other drugs to maintain an adequate cardio-vascular status. Up until 1992/1993 equipment was bought on an ad hoc basis when it was required. There was no specific equipment plan. The Heart Circle, a local charity, was very supportive of ward 5 and frequently bought and paid for equipment that was required. They bought many syringe pumps as well as some of the children's ventilators. The planning of equipment purchases came in about 1993, when intensivists were introduced. I have referred to the purchase of new syringe pumps at paragraph 58 of my statement to the Inquiry dated 17 May 1999. The General Managers at the time, Lesley Salmon and then Rachel Ferris, enabled the unit to have the capital funds to ensure the equipment was safe and adequate. There were 2 ventilators specifically for children, I believe they were called Bear Cubs. The Servo C ventilators could also be used for children. Previously, ventilators were not as sensitive as they are today, but nowadays ventilators are far more advanced. I would never say that there was inadequate equipment in the Cardiac ITU, as I believe the equipment was of a standard that was safe at all times.

G10: The standards and post-operative care delivered at the Infirmary and the Children's Hospital; (including such matters as post-infection rates, and the general standard of hygiene and cleanliness).

61. I am unable to say whether post-op infection rates were any different from anywhere else. The general standard of hygiene and cleanliness, as far as I was aware, was very good and children rarely developed wound infections in Ward 5.

Issue I: Treatment of Families, including the Bereaved**I1: The nature, extent and adequacy of the services that were established to inform/support and counsel families with children receiving surgical cardiac care at the BRI, whether before, during and after surgery.**

65. When children were seen as out-patients, a Counsellor, Helen Vegoda, was available to support and counsel parents regarding pre-operative care and explain the procedures at the BRI. Helen was not a nurse so she had a limited insight into what happened post operatively but she was able to give an informed lay view, which was quite useful to parents as a first idea of what would happen.
66. In 1990, Helen Stratton became the Ward 5 Cardiac Counsellor. She also attended the out-patient clinic at the Children's Hospital for a short period of time. She was able to give a very good account of what would happen with a child when they came for surgery at the BRI. Helen was a nurse and also trained in cardiac intensive care, so she had a good insight into how the child would be cared for following surgery, although this may not have been discussed at the initial out-patient's appointment.
67. When the child was in Ward 5, Helen Stratton was available to give the parents support and she did this very well. Jean Pratten, who was Chairman of the Heart Circle, also visited parents.
68. The social work department also played an important part in the welfare of parents. The social workers were very much involved with some of the families needing financial or other support, which included social difficulties. Helen Stratton liaised very closely with the social workers.

I2: The nature, extent and adequacy of the services that were established to inform, support and counsel families with children who died or suffered permanent disability after receiving cardiac care at the BRI; including liaison with community and social services.

69. Parents of children who died whilst on Ward 5 had support, firstly from the nurse and the sister on the shift who would have been caring for the child. The surgeon talked to the parents. Also Helen Stratton or Helen Vegoda were available to offer support. When the parents returned home, I believe Helen Stratton informed the GP. The GP would then be able to offer parents support at home if it was required. This also gave the parents information about some of the other bereavement services which were available in the community.
70. I am unable to comment on the services offered to the parents of children suffering disability following cardiac surgery, as they were transferred back to the Bristol Children's Hospital and went home from there.

I3: The financing of the support and counselling services.

71. Both Counsellor posts were initially funded by the Heart Circle. Helen Vegoda's post was made permanent (I am unsure when, as she was employed by the Bristol Children's Hospital). Helen Stratton's post was for 3 years, funded by the Heart Circle.
72. There were other counselling services available within the Community, although I do not know how they were funded. Freda Gardner was a social psychologist and she was funded half by the University and half by Ward 5. I cannot recall when she formally started her work with Ward 5, but I think it was around 1995. Prior to this her involvement was informal. She also saw some of the parents, but her role was mainly to support the staff.

I4: The priority afforded to support and counselling work by hospital management and clinical staff.

73. Freda Gardner's post was well planned, as a response to staff needs, and I believe Rachel Ferris organised the budget to be used to fund half of that post. I believe that both the General Managers were supportive of the counselling work done by these other professions.

15: Whether staff coming into contact with parents who were under stress because of the nature and severity of their child's condition, or who had lost children, showed appropriate sensitivity in their dealings with such parents; and, if not, the importance and effect of any such failures.

74. I would consider that all staff who came in contact with parents under stress were supportive and showed appropriate sensitivity towards them.
75. I believe that generally the more experienced nurses were able to call on their experience to be more supportive of parents. Some staff who had not had dealings with parents often found these situations difficult to handle and may have come over as slightly abrupt to a parent. However, this did not mean that the nurse lacked sensitivity.
76. When a nurse had cared for a child over a long period of time, the nurse became very upset when a child died. The nurse had to come to terms with her own grief over the child and sometimes may have looked slightly withdrawn to the parents, because she was coping with her own feelings. I believe that the more experienced nurses, i.e. the sisters, were able to cope better with their own feelings and so were better able to support both the parents and the other nurses. The services of Freda Gardner and Helen Stratton were called upon to run support groups to teach staff how to deal with their own feelings and to support parents who were coming to terms with the loss of their child. The groups were initially on a weekly basis, but these reduced to monthly meetings, with optional "ad hoc" meetings on an "as required" basis.

Issue J: Post-Mortems and Inquests**J1: The nature and extent of the responsibilities of (a) hospital staff; (b) hospital pathologist; and (c) HM Coroner to report and investigate deaths.**

77. I cannot comment on this issue.

J2: The functions of post-mortems and inquests in helping to establish the cause of death of a child or the adequacy of the surgical or other services provided.

78. I cannot comment on this issue.

J3: The extent to which post-mortems and any inquests held upon children who died following complex cardiac surgery at the BRI performed such a function.

79. I cannot comment on this issue.

J4: Whether consent (if required by law) to (a) hospital or coroner autopsies was properly and sensitively sought; and, if consent was not required, whether proper and adequate information about this matter was given to parents, in an appropriate fashion.

80. Consent to autopsy was obtained from the parents at the time the surgeon informed the parents that the child had died. The surgeon was accompanied by a nurse and often one of the counsellors. This issue was always discussed carefully and with compassion. The surgeon told the parents that a coroner's autopsy was required by law if the child had died within 24 hours after surgery. The surgeon would at times ask the parents for their consent for a hospital autopsy to be performed. The surgeon would carefully discuss the differences between a Coroner's and a hospital autopsy. If a hospital autopsy was to be performed then a consent form was signed and dealt with appropriately. I do not recall there was ever a problem. I think this matter was always dealt with very carefully and compassionately by the surgeon, and by the nurse, who was able to support the parents appropriately.

J4: Whether consent (if required by law) to (b) the retention of tissue and/or organs of the body was properly and sensitively sought; and, if consent was not required, whether proper and adequate information about this matter was given to parents, in an appropriate fashion.

81. I did not know that tissues or organs were retained. I had not even considered it until it was announced in the media. It was not something that was discussed by the surgeon with the parents when discussing Coroners' or hospital post-mortems.

Issue K: Training and Retraining**K1: The support and assistance made available to all members of staff, to help them keep abreast with developments in clinical practice; and the use made of such facilities.**

82. In order to keep abreast with developments in clinical practice, I began the Diploma in Nursing in 1987, and completed it in 1990. I was the second sister at that time to undertake the Diploma in Nursing. This training enabled me to expand my knowledge in analysing research and examining evidence based practice. The Diploma introduced me to various journals and other aspects of nursing care. I was able to have a study day per week to attend this course. Other staff I recall were able to attend study days, whether in-house in the hospital or externally at other hospitals. This was to learn what other current practices were taking place, and to enable them to keep up to date with clinical practices.
83. Together with Sheena Disley, another Sister who had completed the diploma, we implemented care plans for Ward 5b and 5a, with the help of a group of sisters. This made the nurses look at the practice being undertaken. I am unable to recall exactly when this occurred.
84. Up until intensivists joined the Cardiac Directorate in or around 1992/93, I recall that most clinical developments were made and influenced by the surgeons. When the intensivists joined the department, they had a different perspective on things such as pain and sedation management. Various changes were implemented, which were more evidence based, and practices from various other centres were adopted.
85. As the 1990's progressed, I recall nursing training changed into project 2000. Nurses were coming out of training having had research experience and a different outlook to questioning practice. Nurses, if they are unsure of how to proceed with certain care, were able to look in journals and find evidence of what other centres were doing.

86. I was aware that the consultants attended conferences and had study leave. When Professor Angelini joined the department, the profile of research was raised enormously. He employed research registrars who worked in the department and who started undertaking research and trials on patients. These doctors then brought in articles from various medical journals. Staff from all disciplines discussed issues relating to patient management and looked at the best approach to care.

87. When I became Nurse Manager I encouraged staff to undertake the Diploma and the Degree in nursing. I undertook some of the Degree modules myself, but with work commitments I felt that I was taking on too much and dropped some of the modules. I have always encouraged nurses to undertake extra training. There are, of course, financial constraints, but there are usually ways of getting around those.

88. When developments were taking place in theatre, with such procedures as the switch operation, Mr Dhasmana and two of the theatre staff went to Birmingham to look at how this procedure was undertaken there.

K2: The process of appraisal and training required of a paediatric cardiac surgeon in 1984-1995, before embarking on an advanced operative procedure not previously performed by him.

89. I have no knowledge of this issue and am unable to comment.

K3: The extent to which those obligations were affected by the fact that:

a. **the procedure was new, and not well-established elsewhere, or (conversely) that it was well-established elsewhere;**

b. **there was an absence of "local" skill or advice, so that any assistance must necessarily have been obtained from outside the institution in question.**

90. I have no knowledge of this issue and am unable to comment.

K4: The professional or contractual obligations regarding such appraisal and training imposed upon a paediatric cardiac surgeon (both at the BRI, and generally within the UK).

91. I have no knowledge of this issue and am unable to comment.

K5: The professional obligations or duties (if any) placed upon the person or persons carrying out, or assisting with, the retraining of a professional colleague.

92. I have no knowledge of this issue and am unable to comment.

K6: The responsibility borne by:

a. a paediatric cardiac surgeon;

b. an anaesthetist;

c. other members of the surgical team (perfusionists, nurses, etc.); or

d. referring cardiologists

for ensuring that all members of the surgical team were properly trained to assist at new procedures not previously carried out at an institution.

93. As I have said previously, Mr Dhasmana went to Birmingham to observe Switch operations. As far as I am aware, surgeons were able to watch operations and as soon as they felt able they began carrying them out themselves. I am unsure whether Mr Wisheart undertook extra training at that time. I helped Mr Dhasmana with arrangements for the 2 nurses who went to Birmingham.

K7: The professional or contractual standards or obligations (if any) regarding the organising or undertaking of such further training imposed upon the individuals listed at (a) - (d) above.

94. Other than recognition that continuing professional obligations, such as keeping up-to-date with patient safety issues, remained present at all times, I make no comment regarding this issue.

K8: The nature and extent of any further training undertaken by all members of the paediatric cardiac surgical team at the BRI, before embarking on any new surgical procedures.

95. Nurses in the surgical team at the BRI were taught new surgical procedures by the surgeons. This training involved nurses observing procedures prior to assisting on them.

K9: Whether such further training met the requirements of the professional or contractual standards or obligations.

96. Such professional nursing standards and obligations as may have existed at the time were met because the nurses would only undertake procedures if they felt able to do them and had the support of the surgeons and the registrars.

K10: The steps to be taken by a paediatric cardiac surgeon to ensure that his surgical technique and/or clinical skills was and remained adequate to the task of performing procedures which he was accustomed to carrying out.

97. I am unable to comment upon this issue.

K11: In particular, the steps to be taken to:

- a. **evaluate and assess his own performance;**
- b. **maintain competence; and**
- c. **embark on retraining (whether as a matter of routine, or in response to specific concerns about his ability to perform particular procedures).**

98. I am unable to comment upon this issue.

K12: The professional or contractual obligations (if any) regarding such evaluation and retraining imposed upon a paediatric cardiac surgeon (both at the BRI, and generally).

99. I am unable to comment upon this issue.

K13: The steps that were, in fact, taken by paediatric cardiac surgeons at Bristol to ensure that their surgical techniques and/or clinical skills were and remained adequate.

100. I am unable to comment upon this issue.

K14: Whether such steps as were taken met the requirements of the professional or contractual standards or obligations current at the time and the extent to which those actions conformed to accepted practice.

101. I am unable to comment upon this issue.

K15: The responsibility borne by members of staff (such as the paediatric cardiac surgeons, the anaesthetists, other members of the surgical team, or managers) in ensuring that all members of the surgical team were, and remained, properly trained and skilled.

102. It was the responsibility of the Nurse Managers and Sister to ensure that all members of the surgical team remained up to date with their training. My involvement was to ensure that the nurses were trained sufficiently to carry out the procedures required in the theatres. If new nurses joined the cardiac theatres they were trained by other cardiac theatre nurses, again by the orientation process.

K16: The professional or contractual standards or obligations (if any) regarding the organising or undertaking of such training imposed upon staff members, both at the BRI, and generally.

103. Staff were able to receive training to the level required by their post, by for example theatre courses and in-house training.

K17: The continued professional education and training undertaken by members of the paediatric cardiac surgical team at the BRI.

104. Nurses were trained to the level that was required in the cardiac theatres at the time. I cannot now recall if they left the cardiac unit and went elsewhere to learn any new procedures, apart from the one visit to Birmingham previously mentioned. Other cardiac surgeons joining the department asked for different techniques and the nurses were taught by the surgeons. When Professor Angelini and Mr Alan Bryan joined, they invited surgeons from other hospitals in England, America, Italy and other places to the cardiac unit to discuss new techniques and new styles of operating. An example would be the off bypass procedure and the left ventricular reduction procedure. Professor Angelini invited several people to come to the BRI and demonstrate these techniques in or around 1994. This led to developing a culture of sharing expertise amongst the surgical staff.

K18: Whether such continued education and training met the requirements of professional or contractual standards or obligations imposed at the time and the extent to which it conformed to accepted practice.

105. I have no particular knowledge of this issue, save for my personal view that promotion to an F grade nurse required the completion of the theatre course.

K19: Whether it is (a) inevitable; and (b) acceptable, that a surgeon carrying out a new procedure will experience a "learning curve" during which his competence or results may fall below the standards achieved by a surgeon who has carried out a reasonable number of these procedures.

106. I am unable to comment upon this issue.

K20: The relationship between learning curves, and maintaining minimum acceptable levels of performance.

107. I am unable to comment upon this issue.

K21: The steps that can be taken to minimise the length of a learning curve, and to ensure that all relevant lessons are learnt as soon as possible.

108. I am unable to comment upon this issue.

K22: How an acceptable learning curve may be defined, prospectively.

109. I am unable to comment upon this issue.

K23: the steps that can and should be taken to protect a patient, during the term of a learning curve.

110. I am unable to comment upon this issue.

K24: The information, tools and professional guidance available to the medical profession, to assist in the task set out at (19) to (21).

111. I am unable to comment upon this issue.

K25: The extent to which the profile of an acceptable learning curve (if such exists) may legitimately be affected by:

- a. the fact that the procedure is innovative and not well-established elsewhere;
- b. the balance between the expected benefits of the new procedure, and the benefits likely to be obtained by the best alternative course of action;
- c. the explanation of the risks given to the parents, guardian or child concerned.

112. I am unable to comment upon this issue.

K26: The evaluation of the likely "learning curve" made by the paediatric cardiac surgical team at the BRI, before any new surgical procedure was embarked upon.

113. I am unable to comment upon this issue.

K27: The steps (if any) taken, whether by such a surgeon or any other member of his unit, to monitor whether any adverse outcomes of a new surgical procedure were:

a. a product of the process of acquiring sufficient experience at performing a new procedure; and/or

b. whether, if so, the process of acquiring such experience or skills was progressing at an acceptable rate.

114. I am unable to comment upon this issue.

Issue L: Informed Consent**L1: How, and when, parents, guardians or (if appropriate) children should be informed of the risks associated with surgery.**

115. My involvement was on Ward 5 only. Parents/guardians were told again of the risks associated with the surgery when they saw the consultant surgeon, usually the night before the operation. The risks had been discussed previously in the out-patient clinic. The out-patient appointment may have been some time in the past and the child's condition may have changed, so the risks may have needed to be re-defined. The parents either saw the surgeon by themselves, or sometimes with a nurse or one of the counsellors.

L2: The use to be made of:

- a. national data;**
 - b. international data ;**
 - c. the institutional record;**
 - d. the surgeon's own personal record;**
 - e. information upon the condition of the child;**
 - f. the opinion of the children's team;**
 - g. the opinion of any specialist nurses and/or family support services;**
 - h. any ethical advisory committee that may exist;**
 - i. written information or leaflets;**
- to the extent that these are or should be available to the surgeon or others advising on procedures and risks.**

116. I am unable to comment in any detail on this issue because, whilst I did attend such meetings in my role as Staff Nurse or Sister, I cannot recall the detail and content of the conversations which took place.

L3: The nature of the obligation of a surgeon, or other advisor, to refer to factors such as:

- a. the extent of the institution's experience in performing the procedure in question;**
- b. the extent of the surgeon's personal experience in performing the procedure in question;**
- c. the fact that other institutions within the UK are known to have higher - or lower-risk records in the procedure in question than those that the surgeon would be obliged to quote as the risk if the procedure were carried out at his own place of work.**

117. I am unable to comment as I have no knowledge of this.

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

118. I am unable to comment as I have no knowledge of this.

L5: How the paediatric cardiac surgeons at the BRI, or other advisors, treated the various factors referred to at (L2) and (L3) above when giving estimates of risk. The factors that were used, and how to arrive at any estimates given and their adequacy.

119. I am unable to comment as I have no knowledge of this.

L6: What parents and guardians attending at the BRI were told, and how were they informed, as to the risks associated with surgery, including the risks of:

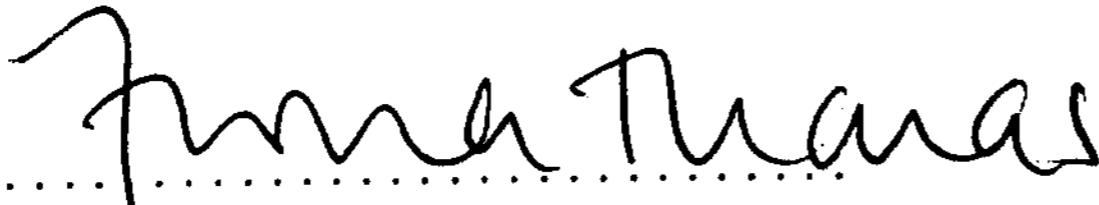
a. mortality;

b. morbidity, especially neurological deficit;

c. likelihood of future surgery or protracted drug regimes being needed;

d. other side effects or complications of surgery; and/or alternative treatment methods or the merits of non-intervention.

120. This was for the surgeon to explain. Nurses sometimes attended these discussions, but it was not part of their role to contribute.

Signed 
Fiona Vicki Thomas

Dated 23.12.99

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