THE BRISTOL ROYAL INFIRMARY INQUIRY

2ND STATEMENT OF HELEN STRATTON

I, Helen Stratton, formerly Cardiac Liaison Nurse at Bristol Royal Infirmary, say as follows:

1. This statement is supplementary to my first statement to the Inquiry, numbered WIT 0256, and to my oral evidence given on 8th September 1999, (day 46). Since then I have become aware of the statements and oral evidence of a number of witnesses who have made comments about me. I wish to respond to these.

The usual support I gave to parents

2. Several parents have commented on the support given to them while their children were being treated at the BRI. Their evidence raises a number of issues which need to be clarified. I believe that it would be helpful to the Inquiry if I give a detailed account of my usual routines when providing support to parents.

Accommodation

3. Ward 5 was not designed as a children's ward, and the facilities for parents who wished to stay with their children were regrettably rather poor. There were two bedrooms available for the use of parents in the hospital itself. There was also the "hostel", about 100 yards away from the hospital, with 5 to 6 bedrooms. Separate accommodation was available at the Children's Hospital.

4. When a child was undergoing open heart surgery, one of the bedrooms in the hospital would be made available to the parents on the night before surgery and the night after. The other room in the hospital was available for use by any other parents who had particular need for it, for example, if their child was critically ill in intensive care. At other times, accommodation was provided in the hostel.

5. Occasionally it was necessary to ask parents to move out of a hospital room into the hostel. Some parents, quite understandably resented this, and I felt very uncomfortable asking parents to move. Unfortunately, sometimes there was no real alternative.

6. There was always accommodation available either in the hostel or in a hospital bedroom. I am very troubled to discover that some parents might have been asked to leave their accommodation at an earlier time than was appropriate. I make further comments on this matter below.

7. The booking of accommodation was arranged routinely by the Ward Clerk of Ward 5. I only concerned myself personally with this matter when a problem arose, or when I became aware of a particular need.

The day before surgery

8. Children were almost always admitted to the BRI the day before surgery. I was notified of expected admissions. Typically, parents would arrive with their child at about 11 am. I would introduce myself and explain my role to the parents. Parents usually had questions to ask, and I would either answer these myself or try to obtain the answers from elsewhere. I would show parents around Intensive Care so that they could see the unit and ask any questions about the equipment and the proposed post-operative care of their child there.

9. I would ensure that parents knew how to contact me. I could be contacted at any time by telephoning the hospital switchboard. I carried a bleep, and my bleep was in range when I was at home. The details about how to contact me were in the Heart Circle booklet which was given to all parents before admission, but I would always specifically discuss this with parents and often wrote it down separately for them.

The day of surgery

10. Many parents wished to be with their child from about 6 am on the morning of surgery. Usually the child would need to be taken down to theatre at about 7.30. I always ensured that I was present by this time. All parents had the option of going down to theatre with their child. I had arranged this with the theatre staff and anaesthetists, as detailed in paragraph 16 of my first statement. Most parents chose to go down to theatre but several chose not to. If the parents chose to stay on the ward, I would usually go to theatre with the child and return to speak to the parents as soon as anaesthesia had been induced. Otherwise, we would go down to theatre together. The parents would usually carry their child down. Parents would come as far as the anaesthetic room with their child. Some anaesthetists were happy for parents to stay while anaesthesia was induced, others were not. I would escort the parents from the anaesthetic room at the appropriate time, and return with them to my office, next to the ward. I would give the parents the opportunity to make phone calls, if they wished.

11. At that time I would discuss the timescale for the surgery with the parents. The operations were very lengthy and the exact length was unpredictable. The surgery would usually be complete by 4 pm; but it was then necessary to restart the heart and remove the child from the

bypass machine. I advised the parents to contact me at about 2pm for an update about the surgery, and ensured that they knew how to contact me. I usually then asked the parents "what are your plans for the day?" I often advised them to go out rather than hang around the hospital, because the surgery was so lengthy.

12. At about 1pm I would go down to theatre, to find out how the operation was proceeding. I would therefore have information to give the parents when they telephoned at 2 pm. I would then give more details about when the surgery was expected to be finished, and would remind them that it would then be necessary for the child to be taken off the bypass machine. In most cases, I would advise the parents to return to the hospital at about 4pm.

13. When the parents returned, I would often drink a cup of tea with them. I would then return to theatre to speak to the theatre sister and obtain an update. I would then see the parents again, in the company of the nurse allocated to care for the child on ITU, in order to introduce this nurse, and because parents would often wish to ask detailed questions about post-operative care at this time. If there were problems taking the child off the bypass machine (unfortunately, there often were) we would need to discuss this with the parents and answer their questions. If and when the child was successfully removed from the bypass machine, he or she would be transferred to ITU. I would then usually leave the child in the care of the ITU staff but ensured that the parents knew how to contact me. Every day I did a round of ITU, spoke to the parents if they were there, obtained an update from the staff and ensured that I would be contacted if needed.

If the child died in theatre

14. Sometimes the child could not be successfully removed from the bypass machine but would die in theatre. If the theatre sister told me that the child had died or was likely to die I would usually ask her to ask the surgeon "what do you want the parents to be told?" In almost all cases, if there was very bad news, the surgeons wished to break it themselves. This put me in an uncomfortable situation, since it might take a long time before the surgeon was ready to come up to the ward. I could not break bad news of this kind without the surgeon's authority but it would not be possible to return to the parents and tell them nothing at all. I usually waited for the surgeon in theatre. When the surgeon was ready I would go to see the parents with him.

15. In cases where the child died, the surgeon had usually finished talking to the parents by 9 pm. He would then leave me with the parents. I gave parents the use of a telephone to make any calls they wished to make. I would always give them the option of seeing the body of their child. A typical form of words which I would use would be:

"We are going to wash and dress [name of child]. Would you like to see him/her then?"

Some parents did choose to see the body of their child. Some chose not too. There was no expectation either way.

16. I would also mention the option of a photograph, a hand or foot print, or a lock of hair, typically using the following form of words:

"Some parents think that they would benefit from these. Think about it. There is no need to decide straight away."

Again, some parents wanted this, some did not.

17. Then I would usually ask the parents whether they wished me to stay, or whether they would prefer to be left alone for a while. Most preferred to be left alone. If so, I would return to the theatre and help the theatre staff to lay out the child. The theatre staff, like me, had been working very long hours, would often be very tired and very distressed. At this time, if the parents had requested this, I would cut a lock of hair, take hand and footprints and/or photographs. We would dress the child. Typically, we would use one of the babygros kept in theatre for this purpose, since the child's own clothes would be with the parents.

18. I would take the child in a Moses basket back upstairs, either to the parent's bedroom or to the relative's rest room. It was necessary to be very discrete about this, since the relatives of other patients (adult or child) might be in the vicinity of the ward. I asked the parents whether they wished me to stay, or whether they wished to spend some time on their own with their child. Some parents wished me to stay for a while to help them. For example, some felt uneasy picking up their child at this time.

19. We preferred usually to remove the child's body to the chapel of rest after about two hours. It would usually be about midnight when the porters came to take the body. I then needed to find a way of withdrawing. I would commonly mention the ITU nurse (whom they had met) as a point of contact during the night, and said that I could be contacted if they needed me. I said nothing about death certificates, funeral arrangements etc at this time, unless they specifically asked.

20. The next morning I might need to take another child down to theatre or carry out other duties. About nine or ten I would see the bereaved parents again. I would take them to see the Patient Affairs Officer, whose name was Diane. I would usually leave them there with her. She explained all the practical arrangements which would need to be made, eg. the death certificate and the funeral arrangements. If they wished to see the child's body again that day, either Diane or I would arrange this. The parents would usually wish to leave at about midday.

21. I would contact the relevant Health Visitor that day to pass on the news and ensure that continuing support was given as necessary. I would also contact the local representative of the Heart Circle. About 4-5 days later, I would send the parents a sympathy card. This would include the telephone number the name of the local Heart Circle contact.

22. I did not seek to maintain contact with parents afterwards, having ensured their community healthcare workers were aware of the situation. This aspect of my practice was supported by Dr Freda Gardner, my supervisor. She advised me that bringing parents back to the hospital on a regular basis often left them with unresolved grief and did not allow them to move on with their lives. In rare cases, I did visit parents again, but only if I was asked to do so for some reason, eg. because they wished me to explain something, or because they were involved with their local Heart Circle.

Specific matters raised in parents' evidence

23. I have tried to remember individual families and have spoken to colleagues to jog my memory. However, in some cases I cannot remember the families upon whose evidence I am asked to comment.

In these cases I can only make reference to my usual practice in the circumstances.

Mr Parsons, Ms Pottage and Mr Curnow

24. My attention has been drawn to the statements and oral evidence of Michael Parsons, Erica Pottage and Malcolm Curnow. These parents state that they were hurried of the premises on the night that their babies died, though they wished to spend the night in the hospital. I do not have any memory of these families.

25. Mr Curnow does not refer to me by name but refers to the "cardiac liaison nurse" (day 3, page 62) and this person has been presumed to be me (see day 46, page 145, line 19). In fact, Mr Curnow's identification of the "cardiac liaison nurse" is an error. The events he described took place on 16th September 1990 (see WIT 0004 0008) before I was appointed, and before there was any cardiac liaison nurse at the BRI.

26. Mr Parsons refers to "the care worker, Helen Strachan". I was questioned about the matters raised by Mr Parsons during my oral evidence (day 46, page 142) on the assumption that this person was me. Since then, I have had the opportunity to check the records which I kept in the "Red Book". I note that a hospital sticker, containing the name and details of Mia Parsons, has been placed in the Red Book (page 163) alongside my records of the other admissions in May 1993. However, there are no notes next to this sticker. There is a handwritten note on the sticker itself, saying *"died in theatre"* but this is not a contemporaneous note. I wrote "died" on the stickers of all children who had died when I went through the red book at a later date, in order to assist Stephen Bolsin with his investigation of mortality rates.

27. The lack of any record next to a sticker is, in fact, unique in the Red Book. It strongly suggests to me that I was not present during this admission. When I was absent for any reason, there was regrettably no specific individual to take over my responsibilities. Members of the nursing staff had to provide care for the parents as well as they could. I often, but not invariably, made some record retrospectively. For example, I would often make a record of the fact that the child's health visitor had been contacted if this duty was carried out by another member of the nursing staff. However, I do not appear to have done so in this case.

28. I note that Mia Parsons' operation was on Thursday 6th May 1993 (WIT 0010 0005, paragraph 12). I do recall that in early May 1993 I attended for a job interview at the Churchill Hospital in Oxford. It is possible that my interview took place on 6th May and I was absent for that reason. It is also possible that I was on sick leave on this date or absent for some other reason.

29. The statement of Erica Pottage refers to "the nurse in charge, Helen Stratton" (see WIT 0260 0003, paragraph 7, also Day 44, page 60, line 21). I have consulted my records in the Red Book for Thomas Pottage. These are on page 174. Also relevant are the records for a patient with the initials CF on the same page, and those for a patient with the initials HS on page 175.

30. I remember that in the Summer 1993 I took two periods of 2 weeks annual leave in fairly rapid succession. I have reason to remember this because it was very unusual to take so much annual leave in so short a period; it used up my entire annual leave entitlement for that year. The first of these was at about this period in July. Looking at the Red

Book, I note that the record for patient CF is extremely brief, only an operation date, 5/7/93, a discharge date, 16/7/93, an indication of the diagnosis and "A/L". I think there is a real likelihood that I was on annual leave for the two weeks beginning Monday 5th July 1993 and ending Friday 16th July 1993. I would then have returned to work on Monday 19th July and made various retrospective notes. It is significant that patient HS's Health Visitor was not contacted until 19th July, and that a Heart Circle grant of £30 was given to HS's parents by "Kathy". Staff Nurse Kathy Warren used sometimes to give Heart Circle grants to parents when I was absent and thus unable to perform this duty myself. My second period of annual leave that summer took place in early August, as indicated in the records on pages 177 and 178 of the Red Book.

31. I have done everything in my power to establish the exact dates of my annual leave and the date of my interview. I have contacted the Churchill Hospital asking whether records exist which will provide confirmation of the date of my interview; unfortunately they have not kept the record of my interview. I have also examined my computer files at that period and requested relevant records from my bank. My solicitor has written to the UBHT and the Heart Circle, asking whether any records in their hands might confirm the exact dates of my annual leave or any other leave at the relevant time. I am very eager to discover the exact dates and any further information obtained will be communicated to the Inquiry.

32. All three of these witnesses have stated that I hurried them off the premises on the night of their child's death. I can say for certain that Mr Curnow is mistaken in his identification of me and there is a real likelihood that Mr Parsons and Ms Pottage are also. This is a matter of

very great importance to me since it would be absolutely contrary to my professional practice to treat bereaved parents in this fashion.

33. When a child died in theatre, it was usual for the parents to spend the night in the hospital bedroom provided and to see the patient affairs officer in the morning, as detailed in paragraphs 19-20 above. Occasionally, parents positively expressed the wish to go home earlier, perhaps because they wished to see other members of their family. However, I must emphasise that this was unusual. I am reported as saying that most parents preferred to leave the hospital immediately (day 44, page 68). I would not have said this. It would not have been true. The majority of the parents spent the night in the hospital.

34. There would be no advantage to the ward if the hospital bedroom was vacated early. It had been booked for the night, and it would be too late to book any other parents in. From my point of view, it was more convenient if the parents stayed the night and the necessary practical matters were concluded in the morning. On those occasions when parents did leave early, I would ensure that appropriate transport was available. I would ring in the morning to ensure that they had arrived safely, to go over the necessary information with them, and to arrange for them to speak to the patient affairs officer.

35. I believe that it is entirely inappropriate for bereaved relatives to be hurried from the hospital premises. I have myself experienced bereavement in a hospital far from home and fully appreciate the importance of this. I am appalled that some parents were apparently treated in this way at the BRI. I must emphasise that I would never have put any pressure on parents to leave, or suggested in any way that this was expected of them.

Mr and Mrs Willis

36. My attention has been drawn to the statements of Mr Stephen Willis and Mrs Michaela Willis, and to the oral evidence of Mr Willis. Unfortunately, I have no specific memory of Mr and Mrs Willis, or of their son Daniel.

37. Both Mr and Mrs Willis make reference to my introducing them to the intensive care nurse while attempts were being made to remove Daniel from the bypass machine. Both state that their hopes were raised when I introduced them to the intensive care nurse, but were immediately dashed when I stated that there were problems. There are three different accounts of what I said, in the transcript (day 87 page 137), in Mr Willis's statement (WIT 0285 0010 paragraph 23) and in Mrs Willis's statement.

38. It was my usual practice to introduce the parents to the intensive care nurse allocated to care for their child. The detail of my practice, in this respect, is indicated above (paragraph 13). I would still introduce the nurse if there were difficulties removing the child from the bypass machine. Difficulties were quite common, and there was still reason to suppose that the nurse would be involved with the care of the child. Even if the child died in theatre, the nurse would still be an important link for the parents during the night, as indicated above (paragraph 19). I can envisage a situation where I might have been open to criticism if I had not introduced the parents to the ITU nurse.

39. I would not have given a prognosis regarding Daniel's chances of survival. I was very aware that this was not my role and, indeed, the surgeons at the BRI were very strict on such matters (see paragraph 48 below). Therefore, I definitely would not have stated, as reported in

one account of the conversation, “only a miracle would save him” (WIT 0221 0012 paragraph 10). I would, however, have indicated, if authorised to do so, that there were difficulties in removing the child from the bypass machine.

40. I always tried to be sensitive and honest with parents, and not to give them false hope. If anything I said on this occasion had the effect of raising their hopes, I can only express my regret.

41. It is suggested that I insisted that Mr and Mrs Willis see Daniel’s body. My usual practice is indicated in paragraph 15 above. I always offered parents the option of seeing their child but made no effort to persuade parents if they did not wish to do so. If parents were unsure, I did sometimes say that some parents had told me that, while they felt unsure about it at the time, they felt they had benefited from seeing their child. However, I always emphasised that the choice was theirs.

42. I note that Mrs Willis states that she is pleased that she saw Daniel, though she would not have done so if “the staff” had not “insisted” (WIT 0221 0012 paragraph 13). It is possible that the parents were unsure about this matter, and that there was some discussion with various members of staff. Since I do not specifically remember this family, I cannot make any further comment.

43. Mr and Mrs Willis agree that they were glad of a lock of Daniel’s hair and a footprint, but did not wish to have a photograph. Mrs Willis says that, personally, she did not want the photograph and never looked at it (WIT 0221 0012 paragraph 14). Mr Willis states that “they insisted on taking a photograph of Daniel” (WIT 0285 0012 paragraph 26) and indicates that this was sent to them after they returned home (day 87, page 142).

44. We would not take photographs of a child unless the parents agreed. However, if parents were unsure about whether they wished to have a photograph or not, we sometimes took one so that, if the parents later decided that they would like it, we could give it to them. Most parents who wanted a photograph took it with them. There were however a few occasions (about 4 or 5) when parents subsequently asked for a photograph which had been kept by the hospital. When this occurred, I never sent the photograph through the post, but always delivered it in person or gave it to a member of the Heart Circle in that area.

45. It is possible that the photograph was left behind by the Willises in its envelope in their room, identified as their property and sent to them without being opened. I would not have done this, as I would have been aware of the significance of the unopened envelope. However, I was not responsible for clearing the room. I do regret any distress that was caused.

<u>Mrs Jane Chapple</u>

46. My attention has been drawn to the statement of Mrs Jane Chapple. I am mentioned by name in this statement and criticisms are made of me (see WIT 0347 0010 paragraph 20 and 0015 paragraph 29). However, I note that Laura Chapple was not admitted to the BRI until August 1994. I left the BRI in March 1994. Therefore, Mrs Chapple's identification of me is an error.

<u>Mrs Tracey Clarke</u>

47. My attention has been drawn to the evidence of Mrs Clarke, and also to the discussion of Melissa Clarke's care during Dr Bolsin's evidence.

Dr Bolsin and the expert witness Dr Sumner discuss the lack of communication with parents while Melissa's condition was deteriorating on ITU (see day 81, page 63-67).

48. I remember this patient because at the time there were a number of very sick children on the Unit and Dr Bolsin and I talked about this issue at the weekend in question. Her condition had seriously deteriorated on ITU and this had not been discussed with her parents at all. Unfortunately, intensive care nurses at the BRI were often in fear of giving any information to relatives in the absence of the consultants. This contrasts with the teamwork on intensive care units at other hospitals where I have worked.

49. It would have been inappropriate for me to give any prognosis about Melissa's condition to her parents. I therefore arranged for Dr Bolsin to speak with them. It was not unusual for me to instigate meetings between parents and consultants when I felt that the parents lacked accurate information about their child's condition. This was not an easy task. However, the anaesthetists (in this case Dr Bolsin) were usually willing to talk to parents at my request.

Mr Paul Bradley

50. My attention has been drawn to the statement and oral evidence of Mr Bradley. In his statement at paragraph 68, Mr Bradley states that he and his wife had some difficulty communicating with me.

51. I remember this family. They were a deeply religious family and I did feel that they had expectations of me which I could not meet. I remember discussing this with my supervisor, Freda Gardner. I offered them all the help and support I could and tried to ensure that they

received the best support available from other staff. I spoke to Rob, the hospital chaplain, and arranged for him to see them. They had a close relationship with Helen Vegoda, due to Bethan's previous admissions to the children's hospital. I encouraged them to maintain their contact with Helen while they were at the BRI.

Mr and Mrs Darbyshire

52. My attention has been drawn to the statement of Mr and Mrs Darbyshire and the oral evidence of Mrs Darbyshire. I have tried my best to remember this family but unfortunately cannot. It appears that they had established a strong relationship with Helen Vegoda in the course of Oliver's previous admissions to the children's hospital. As stated above (paragraph 51) it was my usual practice in these cases to encourage parents to maintain their links with Helen during their stay at the BRI.

53. The Darbyshires say (see WIT 0125 0014 and day 5, page 144) that I ignored them on the day of their admission. It was my routine (see paragraph 8 above) always to introduce myself to parents on the day of the child's admission; I would certainly have done so if I was present in the hospital and notified of their arrival.

54. It is also stated (day 47, page 146-7) that when I did introduce myself to the Darbyshires, I immediately addressed them as follows:

"I can tell you don't like me. I do not really care what you feel about me. I have been told, I have had this reaction from other parents, and I really do not care".

I can say with absolute certainty that I never addressed any parent in this fashion.

55. However, I note that the date of Oliver Darbyshire's admission was Thursday 15th July 1993 and the date on which it is alleged that I spoke the above words was Friday 16th July 1993. I refer to paragraphs 29-31 above. I believe that I was on annual leave on those dates, and did not return until Monday 19th July, when I would have met the Darbyshires for the first time. Therefore, I think there is a real likelihood that the Darbyshires are mistaken in their belief that I was present on 15th July or had any dealings with them on 16th July. It is possible that they confused me with another person or persons.

56. The Darbyshires say (see WIT 0125 0017 and day 47, page 165) that I gave offence, by proposing to carry Oliver down to theatre (on 20th July 1993). This was never my practice. My assumption was always that the parents would wish to carry their child down to theatre. All the parents that I accompanied to theatre did so. I had put considerable energy into persuading staff to agree to a policy of allowing parents into the theatre suite, and the point of this would have been largely defeated if they had not been able to carry their child down.

57. Finally, I note (see day 47, page 165-6) that the Darbyshires were apparently asked to leave the anaesthetic room before anaesthesia was induced. As stated above (paragraph 10), unfortunately not all anaesthetists were happy for parents to stay while anaesthesia was induced. On those occasions, it fell to me to escort the parents from the anaesthetic room.

58. I am very sorry that this family feel that there needs were not met during their stay at the BRI.

Matters raised in the evidence of staff

59. My attention has been drawn to the statements and oral evidence of Jean Pratton, Helen Vegoda and Fiona Thomas. It is clear that some confusion surrounded the nature of my responsibilities and those of Helen Vegoda. Having read this evidence, I would like to make some further comments on this matter.

How Helen Vegoda's post and mine should have been co-ordinated

60. There was a very great need for additional support to be provided to the families of children undergoing heart surgery. Both Helen Vegoda's post and mine were created with a view to meeting that need.

61. The additional support was needed mainly for the families of children who would receive treatment at the BRI. The Children's Hospital was staffed with nurses trained in children's nursing, and systems at that hospital were very well set up to deal with the needs of families. Unfortunately, this could not be said of the BRI. Also, children undergoing open heart surgery at the BRI were at much greater risk of death than those receiving cardiac treatment at the Children's Hospital. In my view, it would have been appropriate if both Helen Vegoda and I had concentrated on the needs of the families of children who would have open heart surgery at the BRI.

62. In my view, I should have routinely become involved with the families at the stage of cardiac catheterisation. I could have performed a useful role, answering parents' questions myself, ensuring that the parents knew what questions to ask and obtaining answers for them.

63. Also, it would have been possible for me to assess the particular needs of families at an earlier stage. I could have built up a picture of the parents and the family support network, and of particular needs, for example the needs of other children, and the needs of a new mother who might be lactating and still in need of post-natal care. I could have formed an impression of the extent to which individual parents wished to be involved with the medical details of their child's care. From an early stage, I could have formed an impression of the family's coping strategies.

64. This assessment would have helped me when providing support to families during surgery and during the period of intensive care. It was very hard for me to make an adequate assessment of the needs of families when I did not become involved until the day before surgery. I have read a transcript of the discussion on Day 91 of the Inquiry about communication with parents, including Dr Houston's description of the role of the Cardiac Liaison Nurse (see Day 91, pages 42 and 43). I believe that this underlines the importance of my having access to the parents at the earliest possible stage either in the community or in the children's hospital on their first visit.

65. So long as the families coping strategies were working, I see no value at all in "counselling". The services of a counsellor are not required routinely in these circumstances, and might well be damaging. However, if, at any point, I had the impression that the family's coping strategies were not working, counselling might become appropriate. I note that Helen Vegoda identified her role as that of "counsellor" (WIT 0192). It would have been useful to combine my specialist nursing role with that of a qualified counsellor to whom referrals could be made. This would have been compatible with limited hours and availability. I now understand from Fiona Thomas's evidence (day 32, page 57) that

Helen was often not available for various reasons, including lack of motor transport.

66. There were many non-specialist tasks which we could have shared. It will be clear from the account of my daily routines above that I was often required to work extremely long hours.

Helen Vegoda's "Areas of concern"

67. In her additional statement, Helen Vegoda has disclosed a document called "Areas of concern" (see WIT 0192 0250). This lists several grievances against me. She states that she used this document as a basis for a discussion with Julie Vass. This document was never discussed with me and I was never aware that these issues had been raised or acknowledged. I do not consider that the grievances expressed in this document were justified. However, I do not propose to debate these matters here since it is unlikely that this would be useful to the Inquiry. In retrospect, it might have been helpful if we had had the same manager, so that matters of this kind could have more readily been resolved.

Additional points

68. Having read these statements and transcripts, I would like to make the following additional points:

69. I always took an unobtrusive approach to care of the parents. I was advised to do so by my supervisor, Dr Gardner, because the parents were healthy people, although coping with extremely difficult circumstances. I still believe that this approach is appropriate. However, I am concerned that I was sometimes inaccurately described

as a “counsellor”, which might have caused misleading expectations of the role I would perform.

70. It has been said (correctly) that I experienced stress and fatigue during my employment at the BRI, as a result of the emotional demands made on me. My response to this stress was to seek supervision, which is the norm for mental health workers. I believe that this was the appropriate course of action. I wish to emphasise that, with the support of my supervisor, I was able to continue to perform my duties in a professional manner. It might be helpful if the Inquiry seeks written evidence from Dr Gardner about the support and advice she gave me.

71. In the job at the BRI, I invested a great deal of emotional energy and time to try to make things easier for parents in an environment which was hostile to change, and in which support for parents was not a high priority. Given my experience of dealing with relatives in past positions, and my own personal experience of bereavement, I would never knowingly upset or behave inappropriately towards parents whose children were undergoing dangerous surgery, or who had been bereaved. Having read these statements and transcripts, I am aware that many parents felt that the support they received was inadequate. In some cases this has been partly attributed to me, though there are cases in which I have been misidentified. Where parents believe that the support I gave was not adequate, I can only apologise. I always did my best in what were often extremely difficult circumstances.