

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 evidence to be heard in "Block 4". I also make reference to my earlier statement provided to the Inquiry dated 21 June 1999. My comments are, again, confined to my period of employment at the BRI, up to January 1989.

Issue B: The structure of paediatric cardiac surgical services at the representative sites at the BRI and BRHSC, including:

B1f: staffing: numbers, natures of posts held, criteria for appointment and employing body, training and experience, job plans or descriptions and their review, and patterns of deployment (such as the use of shared appointments and the rotation of skilled staff);

2. I refer to paragraph 12 of my statement dated 21 June 1999, in which I refer to the major recruitment drive I organised to staff the cardiac unit as the unit increased in size. When I became Surgical Service Manager (General) in 1986, Julia Thomas, the Senior Sister, was largely managing the expansion. She had previously worked on this with my predecessor, Hilary Dickinson. I am unsure when the expansion planning began, but it was well underway when I took up that post. Works and building liaison had largely taken place, and I did not become involved to any great extent with that aspect. This was appropriate as the Cardiac Unit sisters, Ann Jones, Lynn Dadley, Sheena Disley, Julia Thomas and, latterly, Fiona Young (now Thomas) were hands-on and were better placed to be involved in decisions as to the placement of lockers, gas flow outlets, etc. As Manager of the unit I was not hands-on in the sense of being on the unit on a day-to-day basis and to which such matters were directly relevant.

3. I was heavily involved with Debbie Evans in respect of the staffing of the unit. I knew how many staff I needed. I cannot now recall whether the decision as to the number of staff needed had been taken before I became Surgical Services Manager (General). If I was involved in the calculation of the number of staff then I would have discussed this with Ann Jones, who was responsible for the staff off-duty rota, Debbie Evans and Julia Thomas. The formula that would have been used would have been to review the needs for the unit throughout a 7 day period covering am, pm and night duty with the number of nurses required filled in for each time period. This would have been broken down into the number of qualified and ancillary staff required. The figures would then have been totalled and a percentage applied.
4. Any decision as to the staffing levels would have been made jointly with the Clinical Sister in charge. Miss Janet Gerrish, as General Manager of the BRI, was also involved in this process. She would have taken an overview and made the final decision when the final proposal was put to her.
5. Debbie Evans and I pooled our ideas in respect of recruitment for the expansion. We also discussed the matter with personnel, although I cannot now remember who exactly. As a result of this we decided to set up a study day to encourage recruitment, which I organised.
6. There was a one page advertisement in Nursing Times for additional staff for the expanding Cardiac Unit. The advertisement also mentioned the study day. I cannot now remember how the advertisement was worded, but it would have indicated a preference for nurses with cardiac experience. That was not essential because of the training programme offered, as I have referred to in paragraphs 26 and 27 of my statement dated 21 June 1999. The advertisement would also have referred to paediatric experience being valuable.
7. From memory the study day consisted of 3 or so sessions in the morning and one in the afternoon. I gave a talk about Bristol. One of the sessions would have involved showing potential applicants around the unit, and another showing them around the hospital. Julia Thomas or Ann Jones would have spoken about how the unit was staffed, staffing responsibilities, etc.
8. We did terribly well as a result of the study day in terms of interest and resulting recruitment. The day was a huge success. I think that we recruited nearly all of our staff as a result of it. There had been a brilliant response to the advertisement and potential candidates came from right across the country. Applicants were serious about their applications and in general were of very good calibre.

9. I interviewed the potential candidates with one of the sisters from the unit, never alone. Some nurses I took on straightaway, as soon as their application was processed, and others I filled into bank places and into the surgical units, so that they would be available when the unit opened.
10. Training took place as I have indicated in paragraphs 26 and 27 of my statement dated 21 June 1999. In essence nurses were started at the "shallow end". As their training progressed they moved onwards until they completed intensive care training. A nurse would not take a case on their own in ICU until judged by one of the sisters as competent to do so. Ann Jones was responsible for the off-duty rota and was able to say if a nurse was "too green" to work unsupervised.
11. If there had been a situation where there were too many inexperienced nurses on the unit, then I would have been informed. I would have approached the surgeons, Mr Wisheart and Mr Dhasmana, to say that there were too many inexperienced nurses and they would have to work with us to ensure that there was no impact on patient safety. During my 12 months with responsibility for the Cardiac Surgery Unit, I cannot remember ever having to do this.
12. I had a very good working relationship with the surgeons and there were very good communications. They were sensitive to staffing levels and the implications for maintaining quality of care.

Issue C: The Service Provided: Nature and Outcomes

C1: The BRI data: the number and nature of the complex paediatric cardiac surgical procedures performed at the BRI from 1984-1995; and the outcomes achieved by such invention.

13. I have no information on this.

C2: The National context:

- a. The written data or information gathered or published, whether in the years 1984-1985 or subsequently, that would help to establish the range of outcomes obtained by, and/or to be expected of, similar units in the UK (and, in particular, other institutions designated as supra-regional centres for neonatal and infant cardiac surgery) both nationally, and within the BRI).
- b. The availability of such data or information, at the time (both nationally, and within the BRI).

14. In respect of Issue C2(a), I did not work in any other cardiac unit in the UK and cannot comment on this. I do not know what data or information was available and therefore cannot comment on C2(b).

C3: The nature and content of any further information available to members of the paediatric cardiac surgery team at the BRI at the time, that may have assisted them to assess and improve the standard of performance of the Unit, for example:

- a. discussions with colleagues at other centres performing paediatric cardiac surgery, or attendance at conferences;
- b. sharing of data or joint working with other units or centres of excellence.

15. I did not discuss outcomes or performance with colleagues working at other centres carrying out paediatric cardiac surgery, or attend any relevant conferences during my 12 months as Surgical Services Manager (General). If I had spent longer managing the Cardiac Surgery Unit then I would have contacted other national centres or attended conferences. I would have been keen to have found out what other units were doing. At the time I took over management there was such a mode of change in the BRI that with this, and my responsibility for other new units and wards, I was fully occupied. If I had stayed beyond the 12 month period I would have looked at other units as to their training, staffing levels, length of stay of patients in ITU, and bed occupancy.

C4: The limitations upon the reliability and validity of the available data and information.

16. I cannot comment on this.

C5: Whether the sources listed above, and/or expert opinion available to the Inquiry, demonstrate that the mortality and morbidity rates for any type of surgical procedure performed (or any statistically significant portion of the series), fell outside the range of outcomes to be expected of, and acceptable for, a supra-regional centre (or other relevant comparator) within the UK at the relevant time.

17. I cannot comment on this.

C6: Whether the answers to question (5) alter, and if so how, if the work of individual surgeons is analysed.

18. I cannot comment on this.

C7: Whether the limitations of the data available on mortality or morbidity make it difficult, or impossible, to form satisfaction judgements or conclusions upon questions (5) and (6); and, if so, why.

19. I cannot comment on this

C8: Whether any factors suggest, or require the conclusion to be drawn, that the children presenting for cardiac surgery in Bristol were not representative of national trends or norms. Such factors might, for instance, include:

- a. the age of the child at the date of referral for surgery;
- b. the clinical condition of the children presenting;
- c. the age of the child at the date of surgery;
- d. assessment of the merits or desirability of surgery in "high risk" cases.

20. I do not know what the national trends or norms were. It was very much the case that the surgeons received the information on children presenting for cardiac surgery, and decided if surgery was appropriate. Anaesthetists were then involved in assessing the clinical condition of the children. I always felt that the unit was surgeon led and I do not know what exact input anaesthetists had.

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.

22. I had nothing to do with referrals. I knew that referrals came from far and wide across the region but I did not know why. Again, I was aware of referrals coming from BRHSC, but nursing staff had no input into decision making about referrals.

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

23. I cannot comment on this, save to say that Dr Jordan and Dr Joffe worked hand in glove with the surgeons, and communication always appeared to be good.

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

24. The clinicians talked to each other. Nursing staff had no contact with the referring hospitals as far as I know.

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

25. I am aware that bed availability was an influencing factor and I suspect that clinicians' relationship with clinicians at the BRI also played a part. I do not know any detail about this.

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.

26. I cannot comment on this.

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.

27. I cannot comment on this and would not be privy to this sort of information.

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

28. I cannot comment on this.

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.

29. Information given to parents at the time of referral to the BRI would have been provided by the referring clinician. As I was based at the BRI and a nurse/manager not a doctor, I cannot comment on what was said.

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.

30. I was not involved in the transfer of sick children to the BRI. I am aware in general terms that the hospital sending the child would provide the arrangements and information in respect of that patient. Information would be provided to the sister in charge of the unit.

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

31. I cannot comment on this (see above).

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

32. The receiving clinician would be involved in the reassessment following admission. A nurse would be present during such reassessment but it would be for the clinician to write up the examination and any associated matters in the patient's notes. A nursing care plan would be filled in but this would not be in as much detail clinically as the clinician's notes, other than vital signs. The nursing care plan dealt more with the social side of care. For example, maybe a note that a parent was particularly worried, that the child was a bed-wetter, etc.

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.

33. Decisions about surgery for a child were made by clinicians. It was for the clinicians to make the appropriate assessment. It might be that nursing staff were present, but they would not have any input, save in respect of the domestic side as referred to above.

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.

34. Ultimate responsibility was that of the paediatric cardiac surgical consultants. Communication appeared to be very good as between Mr Dhasmana and Mr Wisheart. Each surgeon appeared to know what the other surgeon was doing, although Mr Wisheart appeared very much to be the senior. It was the surgeon's decision as to what surgery took place.

E6: The organisation and management of theatre lists.

35. Theatre lists were surgeon led and then referred to the Theatre Sister. She would comment on whether there were sufficient theatre staff for support. The perfusionists would also comment, but the final say was that of the Theatre Sister.

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.

36. Decisions were made by the surgeons. As far as possible nursing staff fell in line so as to accommodate those decisions. Everybody worked as a team. If nursing staff were told that a patient needed an operation, then we bent over backwards to ensure that staff and equipment were there so that surgery took place when we were told it was needed.

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.

37. Nursing staff were reliant upon clinicians to say how urgent an operation was, or to give an indication as to its urgency. Any operation could potentially be affected by the number of beds and staffing levels, but as I have said, everyone tried to ensure that an operation took place when needed, whether elective or emergency.
38. If nursing staff were in any doubt about the level of urgency, then they would come to me and I would then go to the clinician involved to discuss how urgent the operation was. If I was away, a Senior Sister from my unit would be designated to "act up" in my absence. If he/she felt unable to provide advice or deal with the situation, he/she would approach Debbie Evans for help. I cannot recall that happening.
39. I do not think I had to go and discuss the urgency of an operation with a clinician more than a couple of times. On those 2 occasions I discussed the situation with Mr James Wisheart and he already had a solution in mind. He was very sensible and each case was judged on its own merits. As far as possible arrangements would be made to accommodate each case.

40. It always seemed to be that problems in respect of the availability of beds or staffing levels were never insurmountable. If there was an emergency operation, then it might be that an elective procedure was cancelled, although this would probably be an adult elective procedure. Nursing staff could also be moved to provide appropriate cover if that was the problem. For example, I could move more nursing staff to the "shallow end" of the unit to free up experienced nursing staff to cover the "deeper end". I could also lean on ICU to provide a nurse for 24 hour cover or take someone from the general surgical wards.

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

41. I cannot comment on this.

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

42. I cannot comment on this.

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.

43. I cannot comment on this.

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

44. I cannot comment on this.

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

45. I had no involvement in this. I was aware that nursing staff were present at the bedside when pre-operative assessments took place. Nursing staff also carried out pre-operative observations. Ward rounds took place after the patient had been admitted and there was discussion with nursing staff following the admission. Nursing staff always knew the state of the patient on admission and pre-operatively.

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

46. I refer to paragraph 45 above.

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

47. Liaison was extremely good between nursing staff and parents. Parents were always there, by their child's side. Any step that took place was carried out with the parents' consent and presence. Parents were encouraged to be involved with the care of their child and provisions were made to accommodate parents. There was provision for overnight accommodation and for families who had to travel from further afield.

Issue F: Management of Surgery

F1: The qualification, training, experience and skills of the paediatric cardiac surgeons at the BRI.

48. I have no comment on this.

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

49. I have no comment on this.

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.

50. I refer to paragraphs 26, 27 and 31 of my statement dated 21 June 1999. All senior and junior sisters concerned with cardiac surgery were appropriately experienced and I trusted their professional judgement. Responsibility for the off-duty rota was that of Ann Jones and it was her decision where to put nurses relative to their experience. If there was any concern as to whether a nurse was appropriately qualified, then this was treated accordingly. Thus, the nurse could start her training again or be moved elsewhere by agreement, as I have set out in paragraph 37 of my statement dated 21 June 1999.

51. The surgical team worked very well together.

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

52. I refer to paragraphs 31 and 32 of my statement dated 21 June 1999. When I became Theatre Manager I introduced rotation of sisters to broaden their flexibility and experience within the unit. I let the new sisters implement changes and these happened to coincide with my own aims.

53. At the same time, the recently appointed Anaesthetic Consultant, Dr Sally Masey used an anaesthetic technique, I cannot now recall whether she used a different combination of anaesthetic drugs or dosages, which led to patients in ICU being extubated within hours of arrival on the ICU. This increased recovery time on the unit and shortened bed occupancy; less time on a ventilator accelerated patient recovery as there were fewer drugs being administered as a consequence. As a result of a patient recovering more quickly from surgery, as well as an increase in patient throughput, there was a resultant increase in the morale of the nursing staff, because they felt that they were able to help more people.

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.

54. Nursing staff performance in theatre was affected by tiredness and morale in general. It is for this reason that an attempt was made to reduce staff hours with the employment of further nurses to accommodate this. To clarify paragraph 31 of my statement dated 21 June 1999, I persuaded Miss Gerrish to increase the nursing establishment figures for us to obtain more staff. This was to enable nursing staff to de-scrub for meal breaks, to allow sleep time after a night of being "on call", and to reduce the length of time on duty.

55. Although nursing staff may have been tired, it must be acknowledged that the nurses were peripheral to the operation. There were rules within the operating theatre which were never varied, no matter how long staff had been on duty. These included the length of time spent scrubbing up; how the equipment was set up; how the patient was placed on the table, including draping-up; where people stand; instrument, swab and needle checks; the reduction of movement within the theatre; and reduction in people entering and leaving the theatre during a case, to avoid the risk of infection. In addition, there were safety checks on the equipment, safety checks at wound closure; and lifting techniques, i.e. the safe transfer of the patient from the table to the bed, and from the theatre to the ward, including equipment required en route. There was also measurement of blood loss and bladder function intra-operatively. These rules are laid down by the UKCC and NATN (National Association of Theatre Nurses) and are always adhered to.

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.

56. I cannot comment on this.

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.

57. My comments are confined to the BRI as I had no involvement with the ICU at the BRHSC. Having completed the intensive care course, I knew that nursing staff should be on a one-to-one basis with any patient in ICU and this was followed at the BRI. Occasionally nursing staff worked two-to-one with a patient in ICU if one of those nurses was in training.
58. I believe there were UKCC recommendations in respect of nursing staff for ICUs and there was a policy and procedure folder on the Unit. There was also, an NATN recommendation in respect of theatre staffing. At **Annex 1**, there is a copy of the NATN recommendation entitled "Staffing in the Operating Department".

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

59. I refer to my comments in paragraph 58 above. There was one-to-one nursing cover for patients in the ICUs. The skills mix was reviewed by each Sister in charge on a daily basis to ensure there were enough appropriately trained nurses on duty to cover ICU. I refer to paragraph 26 of my statement dated 21 June 1999 in respect of the induction training programme. The same training regime applied in respect of ICU. However, if a nurse had attended an ICU course then less induction training might be needed. Each case was taken individually.
60. On occasions nursing staff would go to BRHSC to the paediatric ICU as part of their training. There were also relevant lectures given by medical staff which nursing staff attended.

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.

61. I refer to paragraph 58.

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.

62. A nurse was always available on a one-to-one basis on cardiac ICU. The nurse was always appropriately trained and if there was a child on ICU then the nurse had paediatric experience. The nurse may not have had paediatric certification, but would have had appropriate training and experience. Those nurses that I knew would not have undertaken one-to-one patient care if they were unhappy about doing so because they did not have the appropriate training or skills to look after that patient properly.

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

63. Post-operatively patients went to cardiac ICU immediately. Initially they were looked after by 2 nurses until their condition stabilised. One nurse would then be with that patient constantly until the patient was extubated, and was then deemed high dependency.

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

64. The physiotherapists were brilliant in the unit. They would be around the ward and liaised very well with medical and ward staff. Nursing staff had a very good working relationship with the support services.
65. Liaison between BRHSC and the BRI was as good as could be expected given the practicalities of a split site.

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.

66. I did not have any direct contact with the paediatric cardiologists. As far as I was aware there was no problem at ward level with the fact that cardiologists were based at BRHSC. If there had been any problem or difficulty I am sure I would have been told by the ward sister.

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.

67. The difference with children was that they took longer post-operatively to stabilise and be extubated and so occupied ICU beds for a longer period. This meant that an appropriately trained nurse with paediatric experience was required to be with that child for a longer period. During my time as Manager for the cardiac surgery unit this was nothing new. The need was met in terms of nurse staffing. I left it to the clinicians to work around the availability of beds.

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

68. During the expansion of the cardiac unit more equipment was purchased for the unit and this was catered for in the expansion budget. I do not know the detail of this as arrangements were in hand when I arrived and I was not there when the expanded unit actually opened.

69. Liaison with Medical Engineering who serviced equipment was very good. If there was any problem they could be contacted by telephone/bleep and full-time cover was provided. The Theatre Sterile Supply Unit was also available and provided equipment to theatre staff as and when required.

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).

70. There was a Control of Infection Sister, Annette Viant. She was a Nursing Officer. I believe she collected data as to post infection rates, although I had no involvement with her at ward level.
71. There were procedures in place to control infection outbreaks. For example, I am aware there was a blue folder on wards which set out the procedure.
72. I am aware that during my time there were instances of wounds becoming infected. Where there was wound infection, there was liaison between ward nursing staff and theatre staff so that matters could be reviewed, such as sutures used, gloves used, skin preparation carried out, and antibiotics in the wound. Airflows within the theatre were standard. I do not believe there were any airflows on the ward during my time. Ward staff would be better placed to comment on this.

73. During my year as Theatre Manager there were 2 things that affected the general standard of hygiene and cleanliness in the Cardiac Surgery Unit. Firstly, there was dust and noise created by building works. Secondly, domestic services were contracted out of house. Although there were no particular issues as to hygiene and cleanliness on Ward 5, I know that there were some complaints in cardiac and generally about the out of house contractors. The complaints were unusual. They included such things as blood spots and dust on the floors. There were regular meetings with the supervisors of the contractors to try to address concerns.

G11: The management of discharge and future care.

74. This was dealt with by medical staff.

G12: Liaison of staff with parents; and the participation of parents in the assessment and care of their child.

75. The exact detail of what occurred is best dealt with by the Sister in charge of Ward 5 at the relevant times. I am aware that nursing staff frequently sat in on meetings between consultants and parents, but a lot of the time parents were seen by consultants alone.
76. As I have said previously at paragraph 47, parents were encouraged by nursing staff to participate in the care of their child as was appropriate. Notes on parental involvement and discussions would have been made on the nursing care plan/Kardex and should have been entered into the patient's notes by the medical staff.

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.

77. I was not directly involved with information, support and counselling provided to families for children receiving surgical cardiac care at the BRI. Ward staff would be better placed to comment. I am aware in general that families were counselled and were well looked after on the unit. I refer to paragraph 25 of my statement dated 21 June 1999.

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.

78. I repeat my comments in respect of Issue I1. In addition, I am aware that there were religious services on offer, although I cannot now recall the detail of this.

I3: The financing of the support and counselling services.

79. I was not involved in this.

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

80. This was not a matter that I addressed. I am aware that it was reviewed at a higher level of management.

I5: 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.

81. The sisters in the cardiac unit had been in their positions for a long time. They were well trained and experienced, and were well capable of dealing with sensitive matters. If there had been any lack of sensitivity on the part of nursing staff then I would have expected to have heard about it. Even if a comment had been made direct to a ward sister, I would also have expected to have heard about it. During my time as Theatre Manager or Surgical Services Manager, I received no report of any incident of insensitivity by nursing staff in their dealings with parents. This aspect of the job was particularly emphasised to more junior nurses during their training/orientation programmes.

Issue J: Post-Mortems and Inquests

82. I have no comment on this as it was not something in which I was involved.

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.

83. Senior nursing staff were already trained but there were management courses available. I made sure that all newly qualified sisters attended a first line management course. This was a procedure I adopted for the whole of my unit. If I was away then I would use sisters from other units to cover for other wards so as to broaden their experience. If any senior member of staff wanted to visit another hospital, for example Brompton or GOS, then I supported their request. The request would be made to me and then I would pass it on to Debbie Evans. As I recall, most of the senior staff did visit another unit and money for this was always provided. Management courses were provided in-house for different levels of qualified staff.
84. In respect of junior staff, lectures were provided by medical staff in the unit. These were provided by different levels of medical staff, from Consultants to juniors. Sometimes they were given by surgeons, other times by anaesthetists. Formal lectures were at least weekly and available to all staff who could be spared to attend. Lectures were held during staff shift overlap time to enable as many people to go as possible. Somebody from the Cardiac Unit would always go and the intention was that they would bring back information to those who had not been. The types of subject that were covered were surgical procedures, anatomy, physiology, and anaesthetic-type lectures, e.g. blood gases, ventilation, perfusion, drugs and resuscitation. There were also lectures given for nurses training on the ICU course which would take place on the unit. These were provided by medical staff, and nursing staff could sit in on these. The ICU course had lectures which were specific to cardiac surgery and often used the classroom in the unit.
85. If any junior member of staff wanted to visit another cardiac unit then I would have said yes. I was supportive of any aspect of training provided the Unit was covered by adequate staffing. I cannot now remember whether I did have a request from junior staff to attend another unit, although I think that junior members of staff did visit other units. I certainly never blocked anyone's request for additional training. On no occasion did Debbie Evans say there was no money in the training budget to fund additional training, although the funding was limited.

86. In respect of skills, I was reliant on the sisters to inform me of any skills shortage. I would have expected Ann Jones, who was responsible for the off-duty rota, or one of the other sisters to inform me. During my time I heard less from Julia Thomas as she tended to manage skills shortages in the same way that I would, although she did not keep me as well informed.

87. If there was a perceived staff shortage then, as I have set out in paragraph 11 above, I would discuss this with the appropriate clinician. Usually the clinician would have a solution. If necessary I could draw from staff on the general surgical unit.

88. Overall the Cardiac Surgical Unit did not have a problem with staffing levels. There were short term problems, for example when there were a number of staff off for various reasons at the same time, e.g. sickness, annual leave, training etc.

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 cannot comment on this.

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 cannot comment on this.

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 cannot comment on this.

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 cannot comment on this.

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. Whilst I was Theatre Manager I do not recall there being any new surgical procedures introduced. From my recollection, the arterial switch programme was already in place.
94. If there had been any new procedures then I believe the clinicians would have informed me. In addition there would often be a requirement for new equipment to be ordered for theatre and I would be aware of this. I would expect the theatre sister to come to me to discuss any new procedure if that had staffing implications, whether in respect of training or any other aspect. When new procedures were introduced in general surgery then this created a buzz of excitement and I was quickly aware that something new was happening.
95. Don Caddy, Chief Perfusionist, was responsible for recruitment and training of perfusionists. This had implications for staffing in general terms because on one or two occasions there was not a qualified perfusionist available and this affected the theatre lists. If lists had to be altered to suit the perfusionists, nurses would have to be found to staff the lists but since nursing staff had to be available 24 hours per day, the perfusionists' activities made little difference to the nursing staff levels.

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.

96. There was and is a professional duty for a nurse to have noted any new procedures or concerns if a clinician was carrying out a procedure or performing a procedure in a manner not seen before. As I have said, if there had been a new procedure being carried out on the Cardiac Surgical Unit I would have expected the Theatre Sister to have been made aware, and then it would have been reported to me. I cannot recall any such report having been made during my 12 months as Theatre Manager.

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.

97. I cannot comment save as set out above.

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

98. I have no further comment.

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.

99. I have no comment on this.

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).

100. I have no comment on this.

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).

101. I have no comment on this.

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.

102. I have no comment on this.

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.

103. I have no comment on this.

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.

104. In respect of nursing staff there were in-house staff development interviews with follow-up. Recommendations and a method would be adopted following this interview to deal with any concern that a member of nursing staff was falling short of the mark. If nursing staff had concerns as to a member of the medical team, then I would have expected that concern to be addressed to the Theatre Sister and then to me. I would have passed this concern to Debbie Evans, and would have expected her to pass it on to Janet Gerrish. During my time as Theatre Manager there were no concerns raised with me in respect of the paediatric cardiac surgeons' skills, or the skills of any member of the surgical team.

105. In respect of the training of nursing staff in general, I refer to my comments above.

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.

106. I cannot comment in respect of medical staff. In respect of nursing staff there was a professional obligation and a contractual obligation to maintain standards, both in respect of undertaking training that was available and imposing training upon staff who needed it.

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

107. I refer to my previous comments in respect of training for nursing 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.

108. I believe that the continuing education did conform to accepted practice of the time. If I had been responsible for the Cardiac Surgical Unit longer then I would have looked at widening training opportunities by sending nursing staff to the larger units at Papworth, Oxford and London.

109. It is part of a manager's professional obligation to keep up-to-date with what is going on and current practices elsewhere. As far as I was aware, the training carried out by nursing staff for the Cardiac Surgical Unit conformed to accepted practice at that time.

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.

110. I cannot comment on this.

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

111. I cannot comment on this.

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

112. I cannot comment on this.

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

113. I cannot comment on this.

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

114. I am not in a position to comment.

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

115. I cannot comment on this.

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.**

116. I cannot comment on this.

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.

117. I cannot comment on this.

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.**

118. I cannot comment on this.

Issue L: Informed Consent

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

119. I had no knowledge of the information provided to parents or guardians of the risks associated with surgery. Nursing staff may have been present at the time, I did not hear of any concern or complaint arising from how clinicians discussed these matters with parents. The primary responsibility for obtaining consent lay with the medical staff.

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.

120. Nursing staff were usually present when a patient's case was discussed. This was more so in the Cardiac Surgical Unit than any other. Nursing staff were very much part of the team and gave input to a discussion where appropriate. Certainly, if there was any change in a patient's condition from admission onwards, then the onus was on the nurse responsible to notify the surgeon or anaesthetist of this.

L3: The nature of the obligation of a surgeon, or other adviser, 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.**

121. I cannot comment on this.

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

122. I cannot comment on this.

L5: How the paediatric cardiac surgeons at the BRI, or other advisers, 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.

123. I cannot comment on 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.**

Issue N: The Expression of Concerns

126. I cannot comment on this issue. There were no particular concerns about the standard of care and treatment, or outcomes, expressed to me, or of which I became aware, whilst working at the BRI.

Signed.....
ALISON MARY RIDDIFORD

Dated 7.12.99

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