

combination of the intensivists, (Dr Davies and I), during our three morning sessions, and for the rest of the time, by the on-call cardiac anaesthetic consultant. All had experience of paediatric cardiac anaesthesia and intensive care in their training. My own PICU training and experience included at least 11 months ITU in specialist centres, 9 months neonatal intensive care and 10½ months cardiac anaesthesia which included paediatric cardiac ICU. Dr Baskett had limited recent paediatric experience and when he was on call, an additional consultant was allocated to cover the paediatric work. 24 hour consultant surgical cover was provided by Mr Wisheart and Mr Dhasmana who dealt with their own patients and did not rotate on call. The consultant anaesthetist allocated to cover CICU was not always immediately available - see response to G4.

Non consultant medical staffing: There was a resident intensive care officer for 24 hours a day, as recommended by PICS '92, however these doctors were from the cardiac surgical senior house officer rotation and had limited experience of paediatric ICU. Accommodation for the resident SHO was appropriately very close to the CICU, and he/she was supported by non-resident middle grade anaesthetic and surgical cover on an on call basis. My anxiety at the absence of a resident middle grade anaesthetist and cardiac surgeon was voiced on a number of occasions at cardiac surgical management meetings and to the anaesthetic clinical director, Dr Monk and Dr Coates. Resident middle grade cover has finally been implemented in 1999.

Nursing staff: I was aware that very few of the nursing staff had qualifications in paediatric intensive care, although I did not know the exact number. I believe that many of the nurses had some local training in paediatric intensive care. The PICS '92 recommendations that there be a senior nurse in charge of the unit with extensive PICU experience, and that at least one nurse per shift have a PICU qualification was obviously not met.

- G2: Staffing within the ICUs. Caring for Children following cardiac surgery. Numbers, training experience and skills mix**
- 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.**
- G4: The availability of staff to assess and to meet, following such assessment the needs of any child in ICU after paediatric cardiac surgery.**

2. There was a resident intensive care officer available 24 hours a day, however these doctors were cardiac surgical SHO's and had limited experience of paediatric ICU. Middle grade cover came from the anaesthetic specialist registrar and/or the cardiac surgical specialist registrar. These doctors were not always available during the day as the cardiac surgical SpR was often operating in theatre, and the anaesthetic SpR, normally attached to the CICU, occasionally had other duties to perform such as cardioversions and patient transfers from theatres. At night both these members of the team were non resident. Consultant intensivist cover was only immediately available during the three designated sessions (Tuesday, Wednesday, and Thursday mornings). At other times senior anaesthetic cover was provided by the on-call anaesthetic

consultant. During the day these consultants were always anaesthetising in theatre. I found it difficult and very stressful to look after sick patients on CICU when I was at the same time anaesthetising for cardiac operations. Often I would have to leave my patient in theatre with a trainee anaesthetist while I went to CICU to assess patients. If I was the on call anaesthetist on a Monday, I would wait until my patient in theatre was safely established on cardiopulmonary bypass before visiting CICU for a complete ward round. This round, usually at 10 to 10.30am was fraught with problems, partly due to time pressure, and partly as a result of conflicts with medical management initiated by the surgical registrar round at 8am. (See comments B12 for similar problems with the intensivist's ward rounds). At night the anaesthetic consultants were on call from home. I believe that I was always contactable, when on call, as I carry a radiopager and more recently, in addition, a mobile phone. Consultant cardiac surgical cover was provided by Mr Wisheart and Mr Dhasmana who did not attend the morning ward rounds but usually saw their patients at other more variable times during the day. They were not always available during the day due to theatre, clinic and, for Mr Wisheart, management commitments.

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

3. The consultant anaesthetist who had anaesthetised the child would take the patient back to the intensive care unit, liaise with the on call medical and nursing staff and would be on call that night. Prior to leaving the hospital the anaesthetic consultants would lead a further CICU ward round together with the on call specialist registrars in surgery and anaesthesia, and the resident cardiac surgical SHO. If there were difficult paediatric cases from that day there would invariably be a discussion of the immediate management plan with Mr

Wisheart or Mr Dhasmana at the child's bedside. The following morning the resident would hand over cases to the on-coming team during the morning ward round. If any cases were complex then the anaesthetist involved with the surgery would directly hand over the problems to the intensivist/consultant anaesthetic cover for the day. Liaison between intensivist/consultant anaesthetist and consultant surgeon was not always ideal as the surgeons visited CICU at varying times. If I wished to change the clinical management of a particular case I always endeavoured to seek out and discuss it with the relevant surgical consultant. As I have mentioned before, an open discussion of alternative view points would often follow, and a consensus plan agreed upon. The same courtesy of communication could not always be said to have occurred when the surgeons wished to change the clinical management.

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

4. See comments on B12 on the introduction of the first three intensivist's sessions with Dr Davies' and my appointments in 1993. Five morning intensivist sessions were not implemented until 1996.

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

5. My experience was that the paediatric cardiologists were helpful in dealing with problems which arose, and they would always come if they were called although the split site inevitably meant that they were not immediately available.

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.

6. I have commented already upon the training of the nursing staff. A very high degree of precision is required, particularly in the case of neonates who are recovering from cardiac surgery, which does not apply either to older children or to adult patients.

7. Temperature control is extremely important in the management of infants following surgery. In most dedicated paediatric intensive care units the ambient temperature is relatively high. That is generally not possible or convenient where adults are in the same unit, and the difference which the ambient temperature can make to sick infants was not always appreciated in BRI CICU. The overhead heaters used for young children were of an old design, not servo controlled, and in my opinion did not provide a stable enough thermal balance. Recommendations for their replacement do not appear on my equipment lists (see comments F5), as by the time the list was compiled there already had been a decision to relocate paediatric cardiac to the children's hospital. Appropriate humidification of the airway is critical in neonates to a much greater extent than in adults, and the humidifiers present on my arrival in 1993 were not ideal (see UBHT 84 0101). These were subsequently replaced following my suggestions.

8. I would conclude these observations by commenting that in my opinion the nursing staff in ICU did a very good job in difficult circumstances. I also am aware that following Mr Pawade's appointment at UBHT he performed 53 open heart procedures at BRI before the move to the childrens hospital. With the same theatre, anaesthetic, and intensive care staff that Mr Wisheart and Mr

Dhasmana had had previously, there was only one death in this series of 53 (2%) and that was after the child had been transferred back to the BCH PICU.

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

9. See comments on issue F5.

G10: The standards of 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).

G11: The management of discharge and future care.

10. The timing of discharge of children from intensive care and the whereabouts of subsequent nursing were decided by Mr Wisheart and Mr Dhasmana, sometimes after discussion with the intensivists.

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

11. Parents were allowed free access to their child on ICU. I would often speak to them in ICU and try to keep them informed of their child's progress. Informing parents of their child's death was mostly done by the nurses and the consultant cardiac surgeons.

ISSUE H
THE SPLIT SITE

I was always under the impression that the arrangement of managing children and their families in BRI was sub-optimal. I believe I expressed on a number of occasions my preference for moving the entire paediatric cardiac service up to the Bristol Childrens Hospital. I remember being extremely pleased when I heard, shortly after I was appointed, that the entire service was in fact going to move and that a new full time paediatric surgeon was to be appointed.

ISSUE I
TREATMENT OF FAMILIES, INCLUDING THE BEREAVED

If, during the course of the operation, it became apparent that the case was not going well and that there was a high likelihood of the child dying on the operating table, then Mr Wisheart or Mr Dhasmana would usually ask one of the theatre team to contact the CICU nurses who would then liaise with the parents.

ISSUE J
POST-MORTEMs AND INQUESTS

ISSUE K
TRAINING AND RETRAINING

ISSUE L
INFORMED CONSENT

1. See my response under E3.

ISSUE M

REVIEW OF CASES AND MEDICAL AND CLINICAL AUDIT

- M1: The professional guidance available on the subjects of reviews of cases, and medical or clinical audit, from 1984 - 1995.**
- M2: The requirements placed upon clinicians by (a) professional standards and (b) contractual obligations by way of review of cases, and medical or clinical audit, during these years.**
1. The RCA recommendations include the statement that anaesthetists should participate in audit, and that critical incident reporting is essential to enable the highest standards of care to be maintained (RCA Guidance for Purchasers 1994).
My contract of employment with UBHT also included part of an NHD to be used for audit.
 2. Please see comments under issue B5 for my actual involvement in audit and critical incident reporting. In addition, though not a requirement, I also maintained a personal log book of all the cases I anaesthetised during this period.
- M3: The obligations (if any) placed on the BRI/UBHT, by the District or Regional Health Authorities and the DOH.**
- M4: The proper role of the hospital management, and/or the District or Regional HA management, in:**
- (a) ensuring that systems of review or audit were in place, were adequately resourced and were functioning properly; and
 - (b) responding to the results of any audits.
- M5: The systems set up by those managing paediatric cardiac surgical services at the BRI, to ensure:**

- (a) review of the outcome of individual cases; and
- (b) review of the outcome of series of cases.

3. Please see issue B5 for my observations on clinico-pathology and mortality and morbidity meetings.

M6: The use made of national or international information, whether from journals, research findings, registers or investigations such as the Confidential Enquiry into Peri-Operative Deaths (CEPOD).

M7: The individuals to whom, or institutions to which, data or results were circulated as a result of such reviews or audits, and the purpose and regularity of such an information flow.

M8: The constraints (if any) placed by confidentiality and/or the assurance of anonymity upon the use of audit data.

M9: The advantages and disadvantages of the attitudes prevailing, at the time, to the use of audit data.

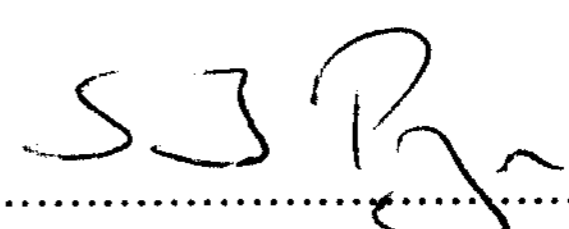
M10 How well the systems of review and audit were maintained, and how they functioned in practice.

4. It is now clear that, by the time I arrived at BRI, the process of regular review of the annual results of paediatric cardiac surgery in an open forum, if indeed it had ever existed, had lapsed.

5. Please see issue B5 and N5 for my observations on the accuracy of the PATS database and of the operating theatre logs.

M11 Whether


- (a) the structures set up; and

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- (b) the manner in which they were, in practice, operated and run, met the professional and contractual standards and obligations imposed on the clinicians and upon the BRI, at the relevant time.

M12: The success or otherwise of the systems of audit and review in place at the time, in: a. improving the quality of care or services; b. detecting any areas or respects in which the services provided fell short of that which was acceptable, and devising and implementing solutions.

- 6. I have described under issue **N5** the limited audit of pediatric cardiac surgical outcomes in which I was involved in 1994.

Signed.....

ISSUE N:

THE EXPRESSION OF CONCERNS

- N1. The parents' perceptions, both positive and negative, of the treatment and care received by their children, including:**
- (a) The nature and form of any concerns that may have been expressed;**
 - (b) The persons to whom they were conveyed; and**
 - (c) The responses to any such concerns.**

Dr Bolsin

- N2. The concerns expressed about the quality or adequacy of paediatric cardiac surgical services by Dr Stephen Bolsin; the nature of those concerns; to whom they were expressed, and when.**
- N3. The nature, scope and methodology of the "confidential audit" carried out by Dr Bolsin (with the assistance of others such as Dr Black), eg: the procedures examined; the data used, and the reasons why such sources were selected; the dates when the results were compiled, and by whom; the persons who were or were not informed that the data was being collected, and why; to whom, by what means, and when, the results were made available; and the merits of the methods adopted.**
- N4. The response to any expression of concern made by Dr Bolsin (whether as a result of the audit data collected, or at any other time), from: a. colleagues (whether anaesthetists, cardiologists, cardiac surgeons, nurses or others); b. the hospital or Trust management (or shadow management, prior to April 1991); c. the Department of Health (see further below); d. any others made aware of Dr. Bolsin's views.**
- N5. Whether such responses (or the lack of them) was adequate and appropriate; and, if not, the nature and importance of any inadequacies or deficiencies.**

1. At some point in late 1993 Dr Steve Bolsin, in the course of an informal conversation, showed me some outcome data which he had gathered in the period October 1990 to July 1992 for paediatric cardiac surgery at BRI. When he first showed me the data, I did not have an opportunity to analyse it properly, but I agreed that the data was worrying. The overall mortality in patients

under 12 months of age was 29% and over 12 months was 12%, though this was not actually calculated in his document. One piece of data which particularly surprised me was that there has been six deaths following VSD repair: my impression, in the short time I had been in Bristol, was that the outcomes from VSD repairs were entirely satisfactory. I did not have the experience nor, at that time, any particular reason to consider the data carefully. I assumed that, as this data was at least twelve months old by the time I saw it, my colleagues were all familiar with it, and that Dr Bolsin was filling me in on some background to events which had occurred before I arrived.

2. However, soon after this Dr Chris Monk asked me if I would collect the data for 1993 for all open paediatric procedures. I understood that he was concerned about the accuracy of Dr Bolsin's data, and also the fact that it was out of date. In addition, surgical techniques for the correction of Fallot's tetralogy had changed. My intention, in compiling the data, was to follow the same pattern as Dr Bolsin's material and to obtain information about the outcomes following surgery in all diagnostic groups, and in particular following specific operations: for VSD repair, AV canal, Fallot's tetralogy, and the Fontan procedure, as Dr Bolsin had done.
3. Dr Ian Davies and I began collecting the 1993 data from a number of sources:
 - (1). We reviewed the theatre records which were completed by the theatre nursing staff at the time of each operation. Unfortunately these were not complete or entirely accurate as in some circumstances there was no record of any procedure performed or the wrong operation had been recorded.

- (2). The PATS data base which provided the date of surgery, the name, the operation and the outcome in terms of whether the patient was alive or dead. This data was also incomplete. For example, some names which appeared on the theatre register were not on the PATS register and vice versa. Some patients had the wrong operation date and the outcomes were inaccurate.
 - (3). Helen Stratten was the paediatric liaison nurse who worked with the parents of children undergoing surgery. She compiled a register of all the cases that she dealt with, and this was a useful source which I used to cross reference the data from PATS and from the theatre register.
 - (4). PAS: This was a system used by the ward clerks and enabled me to check whether or not the children had been discharged home and seen in outpatient clinics following surgery. This was an indicator as to whether or not they were indeed alive at the time of discharge.
4. The most difficult aspect of compiling this data for me was to divide it into diagnostic groups, as I am not a cardiac surgeon. Sometimes, the discrepancies in the operation performed made it difficult to determine what the actual diagnosis was. I also tried to compare the data from the United Kingdom surgical register, but those data give diagnosis, not the operation performed. I did not, in my data collection exercise, obtain figures specifically for arterial switch procedures because these had not appeared in Dr Bolsin's data and I was endeavouring to produce something which would be comparable.

5. In early 1994 I attended a regular audit meeting where Mr Wisheart presented the paediatric cardiac outcome data for the year (I believe ending March 1993). I clearly remember being most impressed by the fluency of his presentation, which was done without reference to notes. I have never seen a hard copy of the data that Mr Wisheart presented on that occasion. As he was presenting this data, I was trying to compare his figures with my data, particularly in relation to the outcome for AV canals. In part this was complicated by the fact that my data was compiled from January to December 1993 rather than for the financial year ending March 1993. I also had not appreciated the importance of distinguishing between children aged over 12 months and those under 12 months. I felt, at the conclusion of this meeting that one did need surgical expertise in order to categorise the data properly. I also thought that as the surgeons were collecting the data anyway, and they were in a better position to interpret it, my efforts were unlikely to be helpful. Although I had undertaken this study at Dr Chris Monk's request, he did not ask me about it again, and following this audit meeting, it did not appear to have any great relevance. I assumed, as I believe my colleagues did, that in due course the cardiac surgeons would present the figures for the year ending March 1994.
6. Soon after the audit meeting, Dr Sally Masey told me that patients with AV canals were no longer being referred to Mr Wisheart for correction.
7. However, sometime later, probably in about mid 1994, I returned to my data and tried to re-analyse it and compare it with the data produced by Dr Steve Bolsin. This exercise exposed to me the inaccuracies in data collection.

MORTALITY	BOLSIN DATA	MY DATA
AV CANAL	28%	50%
VSD	13%	3.6%
FALLOTS	28%	0%

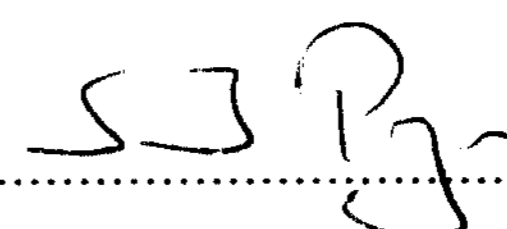
8. On my data, overall mortality in the under 1 group was 24% and over 1 was 6%. This compared with the UK data of 14% and 5% respectively. (UKCSR 1992 - available March 1994).

N6. If the response was inadequate or inappropriate, the reasons for these inadequacies or deficiencies.

Other Hospital Staff

N7. Whether other personnel employed within, or associated with, the BRI expressed concerns upon the performance of the paediatric cardiac surgery unit; and if so, to whom; as a result of what event or events; in what terms; and when.

9. Shortly after my arrival in BRI I set about trying to improve the standards of service provided in cardiac anaesthesia and intensive care (see response to B5 & B6). I knew that there were problems with the overall outcome for children from the data that Dr Bolsin had collated, and the data that I had obtained, but felt I lacked accurate up to date data. Naively, I expected the most recent annual results (93/94) to be formally presented by the surgeons at a mortality and morbidity meeting as soon as they were available. I expected there to be a full and honest appraisal of any problems identified, be they institutional, individual or procedural. This presentation never took place. By

Signed..... 

mid 1994, I was still waiting for the cardiac surgical data for the year ending March 1994, and I felt a deep sense of frustration at the lack of hard evidence on which important decisions could be based.

10. In June 1994 I anaesthetised a 14 month old child for an arterial switch procedure who died. I spoke to Dr Monk after this and expressed my concerns about the outcome in this type of complex procedure. It was following this episode that the letter which appears at UBHT0061006, 007 was written. I believe it was drafted by Dr Bolsin and it underwent a number of revisions, but I and my colleagues were signatories and I endorsed its contents. I hoped it would lead to an open discussion and a review of up to date and accurate outcome data.
11. By mid 1994 I, and my colleagues were asking the surgeons, via Dr Monk, to present the figures for the year ending March 1994 as soon as possible. We assumed that the data would be presented at the next audit meeting but in fact, it never materialised.
12. In late 1994 I attended a meeting at Dr Joffe's house; this was the first multi-disciplinary consultant meeting to discuss paediatric cardiac issues, since I joined the BRI; It marked the resumption of a previous series of regular meetings attended by surgeons, cardiologists, and anaesthetists. I cannot recall precisely who was at this meeting, but I know that Mr Dhasmana was there, and I think I Dr Underwood, Dr Masey, Dr Martin and Dr Hayes were also present. I do not recall the details of the meeting, but I know that at some point the discussion turned to the performance of switch procedures. Concern was expressed about the poor outcomes in neonatal cases, and I recall that Mr

Dhasmana reluctantly agreed that he would not continue to operate on neonates requiring this procedure. He was confident that he could continue to operate on non-neonates, provided the anatomy was well defined.

13. In January 1995, I learned that a switch procedure had been scheduled. I probably obtained this information from discussion amongst my colleagues following publication of the monthly operating schedule for January which included Joshua Loveday's operation. I, and my colleagues, were concerned that this procedure was going ahead, bearing in mind that we still had not had full information about the outcome data of this, and other complex paediatric procedures.
14. Dr Sally Masey, Dr Sue Underwood and I were invited to a meeting the day before Joshua's planned operation. We felt frustrated by the lack of evidence available, and therefore decided to gather all the available data we could on the switch procedure at Bristol so that, when we attended the meeting we would be in a position to express an informed opinion about whether or not Joshua's surgery should proceed.
15. Dr Sue Underwood obtained data from the operating theatre records and her own, and Dr Masey's log books. This data appears at GMC 0016/0062, 0016/0063, 0016/0064. I then reviewed the figures and inserted the outcome "alive" or "dead" using the same sources as I had at the beginning of 1994. The data revealed a total 37 patients in the period 1989 to 1994. This data was transcribed into a document resembling that which appears at GMC 0016/0072, although that page has been revised to take into account some errors I had

made. This document also sets out the figures from the UK cardiac surgical register for the years 1990, 1991, and 1992.

16. At the meeting, Mr Dhasmana also produced data and it was his figures which identified the three errors in my original paper. Subject to that, our figures tallied exactly and the amended version is as appears in the papers. Mr Dhasmana had produced some hand written figures and he subsequently produced a type written sheet which includes Joshua Loveday's operation.
17. My recollection of that meeting was that, although we, the anaesthetists, had been very concerned about the absence of available data on which to make any sort of informed decision, we now did have some figures which appeared to be not dissimilar from those in other parts of the country. However, in the context of the concerns which had been expressed, I was of the view that it would be preferable for this patient either to await the arrival of Mr Pawade or to be transferred to Birmingham. However, Dr Martin, the cardiologist involved, explained that Joshua's condition was poor and he required urgent surgery, such that it was not reasonable either to defer operating until May or to transfer him to Birmingham. I had to leave this meeting early, but at the time I left my understanding was that, since Mr Dhasmana's recent survival rates for children over a year old appeared to be within the range of other UK centres, and given the apparent urgency, the operation was to go ahead.
- N8. The response to any concern expressed by any staff employed within, or associated with, the BRI, from: a. colleagues; b. the Regional or District Health Authorities; c. the hospital or Trust management (or shadow management, prior to April 1991); d. the Department of Health (see further below); e. professional or statutory bodies (eg the Royal**

Colleges); to the extent that any of these bodies were contacted or approached.

18. I believe that during 1994 Dr Chris Monk faithfully presented to Mr Wisheart and Mr Dhasmana the collective concerns of the cardiac anaesthetists, myself included, relating to our anxiety to discuss the latest annual outcome figures and the overall performance of the cardiac surgical unit. In addition, I believe that Dr Monk discussed with Mr Wisheart and Mr Dhasmana the content of the letter that all the cardiac anaesthetists had written to him outlining our concerns with the arterial switch program and our request for a thorough review (UBHT0061006, 007). I was not aware of any response from the surgeons on these issues.

N9. Whether such responses (or the lack of them) were adequate and appropriate; and, if not, the nature and importance of any inadequacies or deficiencies.

N10. If the responses were inadequate or inappropriate, the reasons for these inadequacies or faults.

The Trust Management

N11. The nature of the concerns about paediatric cardiac surgery at the BRI (if any) relayed to:

- (a) the Hospital Audit Committee;
- (b) the Hospital Medical Committee;
- (c) the Chief Executive of the Trust;
- (d) the Trust Board.

N12. The other sources of information to which these bodies had access (eg, audit data, newspaper or magazine articles), that might reasonably have suggested cause for either concern about, or investigation of, paediatric cardiac surgical services.

N13. The extent to which these potential sources of information were in fact considered.

N14. How (if at all) the bodies described at 11(a) - (d) reacted to any concerns expressed to them.

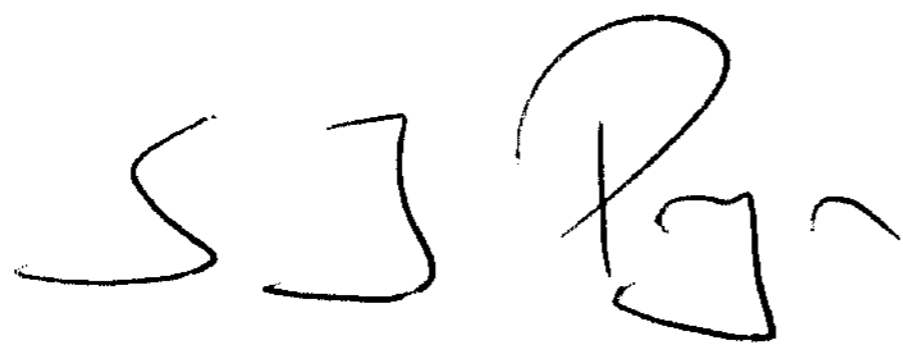
- N15. Whether such responses (or the lack of them) were appropriate.**
- N16. The formal or informal managerial, disciplinary, or regulatory structures existing within the BRI, through which issues of the adequacy of paediatric cardiac surgical services and/or issues of professional inadequacies or incompetence could have been raised and addressed; and the strengths and weaknesses of these systems.**
- N17. Whether any of these mechanisms or structures were invoked; and, if not, why not.**
- N18. Whether any of these mechanisms or structures should have been invoked.**

The Department of Health and others

- N19. The concerns about paediatric cardiac surgery at the BRI (if any) relayed to the DOH and the Supra-Regional Services Advisory Group; the nature of those concerns, and the dates at which they were expressed.**
- N20. The other sources of information to which these bodies had access (eg, contractual performance data, newspaper or magazine articles, DOH statistical data), that might reasonably have suggested cause for either concern about, or investigation of, paediatric cardiac surgical services.**
- N21. The reaction of the DOH and/or the Supra-Regional Services Advisory Group to any such expression of concern; and whether it was adequate or appropriate.**
- N22. The existence of any suggestion, prior to the decision to de-designate all centres in April 1994, that the BRI's neonatal and infant cardiac surgical services should be de-designated because of concerns that the centre no longer met the criteria for designation; and, if so, the grounds for consideration of such de-designation.**
- N23. Whether in 1984 – 1995 the district or regional health authorities were, or should have been concerned, about the performance of the paediatric cardiac surgical unit at the BRI, as a result of the information held by such bodies and/or their powers and responsibilities.**
- N24. Whether in 1984 – 1995, healthcare professionals in other hospitals or healthcare organisations had expressed concerns about the paediatric cardiac services at the BRI; and, if so, to whom had such concerns been expressed and with what results (if any).**

N25. Whether in 1984 - 1995 other professional associations (such as the Royal Colleges) or statutory bodies, were, or should have been concerned, about the performance of the paediatric cardiac surgical unit at the BRI, as a result of the information held by such bodies and/or their powers and responsibilities.

The contents of this statement are true to the best of my knowledge and belief.

Handwritten signature in black ink, appearing to read 'S J P' with a flourish at the end.

7th Oct 1999

CURRICULUM VITAE - S J Pryn

PERSONAL DATA

Name:	Stephen John PRYN
Address:	[REDACTED]
Born:	September 8th, 1958, Cheam, UK
Marital Status:	Married
Spouse:	Nikola (RGN, full time housewife)
Children:	Three sons
GMC Registration:	2737207 (full)
MDU Registration:	166556C

EDUCATION

Secondary School:	Malvern College, Worcestershire, England 1972-75
Undergraduate University:	University of Cambridge, England Jesus College, 1976-1979. BA (Medical Sciences/Pharmacology 2 ¹)
Medical School:	Addenbrookes Hospital Medical School, University of Cambridge, England 1979-81, MB BChir cam 1981

GENERAL and BASIC SPECIALIST TRAINING

Pre-Registration:	Addenbrookes Hospital, Cambridge, England February 82-July 82 (Surgery)
	Queen Elizabeth II Hospital, Welwyn Garden City, England August 82-January 83 (Medicine)
SHO & Registrar:	Southampton General Hospital, England February 1983-February 1989
	Accident & Emergency, Orthopaedics, Anatomy (SHO) 13 months Paediatrics/Neonatology (SHO) 12 months Anaesthesia (SHO) 25 months Anaesthesia (Registrar) 20 months Anaesthesia (Locum Senior Registrar) 2 months

ACADEMIC APPOINTMENTS

Instructor:	Paediatric Anaesthesiology University of Michigan, Ann Arbor, USA
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March 1989-June 1990 (16 months)

HIGHER SPECIALIST TRAINING (ANAESTHESIA & ITU)

Senior Registrar: RHCH Winchester, England
July 1990-Nov 1990 (5 months SR locum)

Wycombe General Hospital, England
December 1990-December 1991 (13 mo. SR)

Alder Hey Hospital, Liverpool, England
March 1991 (2 week SR secondment)

John Radcliffe Hospital, Oxford, England
January 1992-July 1993 (19 months SR)

Specialist Accreditation: December 1992 (HST/OX06/Pryn)

SPECIALIST CARDIAC, PAEDIATRIC, AND ITU EXPERIENCE - PRIOR TO CONSULTANT APPOINTMENT (SUMMARY)

Paediatric Anaesthesia	26 months	5 months Southampton 16 months USA 5 months Oxford
Cardiac Anaesthesia & ICU (adults & children)	10.5 months	5 months Southampton 2 weeks Alder Hey 5 months Oxford
Intensive Care	11 months	(+ 18 months DGH SR) (+ 6 years on call cover) 3 months Southampton 8 months Oxford
Neonatal Intensive Care	9 months	8 months SCBU 1 month neonatal surgical unit Southampton

CONSULTANT APPOINTMENTS (ANAESTHESIA)

Cardiothoracic anaesthesia	John Radcliffe Hospital, Oxford, England May 1992-June 1992 (2 months locum)
Cardiac anaesthesia & Intensive Care	Sir Humphrey Davy Dept of Anaesthesia Bristol Royal Infirmary, England August 1993-Present

QUALIFICATIONS

Medical Qualifications:	MB BChir cam, 1981. FMGEMS (ECFMG), 1987.
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Specialist Qualifications:

Paediatrics: DCH (Diploma Child Health) 1985.
Anaesthesia: FRCA, 1988.

HONOURS AND AWARDS

Open Entrance Exhibition, Malvern College, 1972
 Honorary Scholarship, Malvern College, 1975
 Duckworth Entrance Exhibition, Univ. of Cambridge, 1976
 Duckworth Scholarship, University of Cambridge, 1977
 Duckworth Prize for Medicine, University of Cambridge, 1978
 MA cam, 1983
 Registrar's Prize, Wessex Anaesthetists in Training, 1988

MEMBERSHIPS OF PROFESSIONAL SOCIETIES

British Medical Association
 Fellow Royal College of Anaesthetists, London
 Association of Anaesthetists (of Great Britain and Ireland)
 Association of Cardiothoracic Anaesthetists, UK
 Difficult Airway Society
 Intensive Care Society

BIBLIOGRAPHYPublications in Scientific Journals (Peer Review):

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STEPHEN JOHN PRYN
ANAESTHETIST'S LOG 1993 - 1995

The following comments relate to my personal log only from the time I was appointed in Bristol in August 1993 to the end of 1995. A copy of this log is attached.

1. The primary purpose for which the data were logged.

This is a private and personal log of activity to chart my clinical professional development and to keep an eye on the number of specific procedures undertaken. I also made some notes on how I anaesthetised difficult cases, should I be called upon to repeat the procedure. I noted the early perioperative deaths of which I was aware.

2. Additional purposes for which the data were logged.

After October 1993 I recorded the inotropic support needed to wean children from cardiopulmonary bypass as an aid for the management of future cases.

3. The processes used to log the data.

Direct written entry in to the log on the day of, or very soon after, the operation.

4. The scope and coverage of the log.

All cases anaesthetised from 1992 to the present day (with some gaps in 1997/98).

5. The content of the data logged, in terms of data items and their definitions. Please identify any changes in data items or definitions over the period.

Name, age, ASA grade, operation, urgency (CEPOD definition), notes.

6. The data validation (of any) carried out, and by whom.

None.

7. The completeness and quality of data logged. This should include, as far as possible, an overall statement on completeness and quality together with a statement on any year in which these factors may have varied, and whether this affected data validity.

The log is complete for the period 1993 to 1995. Although I omitted the names and ages of some of the adult patients.

8. Any arrangements for routine data analysis.

None.

9. Any arrangements for dissemination of the data and data analysis.

None. As explained above, the log was maintained for private use.

10. Illustrative examples of practical applications and uses made of the data.

Identifying the total number of children anaesthetised to gauge my continuing paediatric experience. An aide memoir to guide the inotropes required for paediatric cardiac cases.

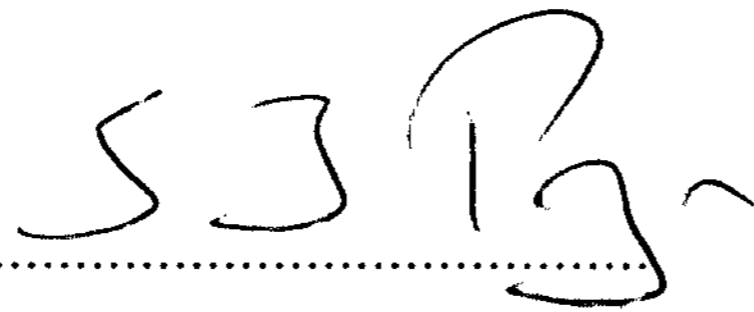
11. The estimated costs to BRI/UBHT of data logging and analysis.

None.

12. Your views on the strengths, weaknesses and limitations of the anaesthetist's log system, and any ways in which the log system could have been improved.

The log was for my personal use only. Its strength is my ownership of the data. Its weakness is that the notes section refers to items of interest to me only. Perhaps a formal annual assessment of current practical experience of procedures as part of a professional development scheme would be useful. It would soon identify instances where experience levels were falling off.

Signature



Stephen John Pryn

Dated

7th Oct 1999