

**The BRI inquiry into paediatric cardiac surgery in Bristol (1984-1995)**

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**Introduction**

In this statement I comment on Issue I and on aspects of Issues B, E, G, H, J and L.

1. My comments are confined to my experience at the Children's Hospital (BRHSC) between 1988 and 1994. I have not worked at the BRI and cannot make any comment about the bereavement services there. As my work was only at the Children's Hospital and St. Michael's, I had very little contact with paediatric cardiac services, or patients undergoing paediatric cardiac surgery and their families, because most of the work was undertaken at the BRI at that time. The exception was children who were transferred to the BRHSC after surgery. I cannot recall having had any contact with a family involved in paediatric cardiac surgery at the Children's Hospital whilst I was involved in bereavement services there. I describe my various roles and responsibilities whilst employed in the BRHSC and my role in bereavement services in general.

**Background**

2. In about 1984 I obtained a temporary position as a kitchen porter at the BRHSC to cover for an employee who was on long-term sick leave. After my first week the employee was unexpectedly available to return to work. An alternative post was sought for me. I became a full-time relief porter providing portering services at the maternity hospital (later called St. Michael's) and the BRHSC. At that time, each hospital had its own team of porters but there was an additional small team of relief porters who covered both hospitals.
3. In 1986-1987 I changed jobs to work as an auxiliary nurse at St John's Hospital, Axbridge, near Cheddar, working in a geriatric ward, full time, for a period of 12 to 18 months. I cannot now recall the exact dates or periods.
4. I then returned to the BRHSC as an auxiliary in the outpatients department assisting in the running of clinics. The post was part-time, 30 hours per week and, from memory, continued for a period of 12 to 18 months. Again, I cannot remember the exact dates.

5. After this, in late 1988/early 1989, I went back to my initial post as full-time relief porter, again covering both hospitals, BRHSC and Maternity.
6. During the latter period Bill Yates was the Head Porter, but he retired shortly after I joined. Whilst a replacement was sought, Graham Milkins, Leonard Dudridge and I all acted up together and split the responsibilities of the Head Porter between us for about 6 to 12 months. During this time Len and Graham dealt with bereavement services at the Children's Hospital. I took responsibility for portering services at St. Michael's including bereavement. I did not have any involvement in bereavement services for the Children's Hospital at that time.
7. A short time later, probably in 1989, Ray Gilbert was appointed as Head Porter, having previously been employed at the BRI in another capacity. By then I had already been appointed as Deputy Portering Manager. I think that Ray Gilbert's title was correctly Portering Manager, which was equivalent to Head Porter. My recollection is that there was a slight change of responsibilities for Head Porter at this time, but the core roles were essentially unchanged.
8. Ray Gilbert remained as Portering Manager for about one year. He left in about late 1990/early 1991. I took over as Portering Manager or Head Porter in 1991 and left UBHT eventually in 1994. I now work for the British Oxygen Company.
9. Once I became the Portering Manager, I reported to Ian Barrington, who at that time managed both BRHSC and the Maternity Hospital, before the Trust was formed. Prior to Ian Barrington, both hospitals had been managed by Marion Stoneham. For about the last 2 years I was employed at UBHT, in around 1992 to 1994, my immediate manager was Dilys Waterman.
10. The Head Porter, later known as the Portering Manager, was responsible for all of the porters. Portering duties were carried out by lodge porters, who ran the front desk of the hospital, and the house porters responsible for moving, fetching and carrying what was required by or for the medical and nursing staff. Whilst I worked at the Children's Hospital, there were many changes going on with changes of job title and adjustment to roles. It is difficult now to recall all of the detail of this. My recollection is that at the time I was Deputy Portering Manager and then Portering Manager, there were 4 lodge porters at the Children's Hospital, 4 house porters and a theatre porter, totalling 9. In addition, there was an allocation of relief porters, which was 1.5 for each hospital. The relief porters worked as a pool of 3, split between the Children's Hospital and the Maternity Hospital as needed. I would say that there were about 20 porters altogether for the two hospitals.

11. My involvement in bereavement services varied over the years and depending upon which post I held.
12. As a relief porter I was one of several relief porters or lodge porters responsible for the transfer of bodies from the ward to the mortuary, or from the mortuary to the Chapel for viewing, or for release to an undertaker.
13. When I became Deputy Portering Manager, and whilst Ray Gilbert was in post as the Head Porter, I took responsibility for the release of bodies to undertakers. Ray Gilbert saw parents himself. I did not know what he did in any detail. My involvement only started when he handed over to me to deal with the final release of the bodies. I was also responsible for filing the papers, which I discuss in greater detail below. In addition, I was left to run the portering rotas, arrange holidays and holiday cover, and to deal with ordering. I discussed these matters with Ray Gilbert as necessary.
14. When Ray Gilbert left, I attended a meeting with parents with him, with the agreement of the parents. This was the first occasion when I learned what was involved in this role. I describe this more fully below. In addition, Ray Gilbert took me through the paperwork and explained the forms (which I describe below).
15. When I became Portering Manager I was then fully responsible for an important aspect of bereavement services at both St. Michael's Hospital and the Children's Hospital as detailed below. In about 1993 I split and restructured the portering services so that there was a dedicated team for each hospital. From then onwards I dealt with bereavement services only at the Children's Hospital. Those at St. Michael's were dealt with by the head porter there. Over a period of time, I changed the forms that we used, but I discuss this in greater detail below. The other change to my job in about 1993 was that I was also asked to provide support to the person appointed to replace the hospital housekeeper following retirement. When I left the Children's Hospital I handed over the bereavement services to Graham Milkins who was then acting up as Head Porter.
16. When we employed staff we made sure that they were aware that they might be involved in the moving of deceased persons to try to gauge how they would feel about it. A porter was never expected to move a body on his own. There was always another porter or a member of the nursing staff to assist if required.

**Bereavement services – my role**

17. My overall responsibility for bereavement services was to provide information to parents about their legal responsibilities, and how they could meet them, (e.g., registration of the death); to give practical advice about, for example, making funeral arrangements; and to act as liaison between the hospital, parents and undertakers. I think that the easiest way to describe my role in bereavement services in more detail is to describe it in chronological sequence:
18. I was contacted soon after a death had occurred, by the nursing staff. They would arrange a time for me to speak with the parents. A nurse would be there as well. We would talk somewhere private.
19. On occasions parents would not want to see me immediately after the death. If this was the case they would be asked by nursing staff to either telephone me or contact me at a later stage. In these situations we would be able to collate the information needed to register the death from that held by the nursing staff. I would hold the information and, subject to confirmation from the parents, would deal with the registration of the death if they wanted me to. The hospital only registered deaths where the family lived outside the locality and asked us expressly to do so.
20. In all meetings with parents, whether I saw them straightaway or later on, I would offer my deepest sympathy and indicate that I was sorry that we had to meet under such circumstances. I would immediately try to assess how distraught the family was. I needed to try to assess whether they would going to be able to understand what I was about to tell them or whether it was better to give them a little information now and some of it later. Depending on the circumstances I would provide the following information.
21. I would discuss with the parents their legal obligation to register the death. We would talk through the options depending on whether the family was local or came from a distance. If they came from a distance then I explained that we could register the death they if wished, or else they could go home and do it themselves. I explained that if I was to register the death, then I would need to ask them a number of questions, as these would be asked by the Registrar. I told them that the Registrar would ask them the same questions if they dealt with the registration of the death. The questions included basic information such as full name, date of birth, address and so on.
22. I would explain the process of registering the death. I would also explain that if I arranged the registration then I would not get a full copy of the death certificate because I would only be

acting as occupier, i.e., as the person designated by the hospital managers, to act on their behalf, as they were the occupiers of the place where the death had taken place.

23. I would go on to explain that the undertaker would need to have received all of the paperwork so that the body could be released.
24. I would explain that if the family was entitled to it, then they could ask for payment for transport of the body home, unless they wanted to make their own arrangements with their own undertaker.
25. I told parents that they would need to start thinking about funeral arrangements, although there was no need for them to make decisions at this point. Sometimes, if they asked me to, I would call a funeral director on their behalf.
26. I would end the discussion by giving the parents my direct line telephone number, so that they could contact me again about anything that we had discussed or anything about which they still had to make decisions. I would tell them to let the telephone ring because if I was not there then someone would pick it up and take a message. I promised that I would ring them straight back when I got the message. Bereaved parents were always treated as a high priority.
27. Throughout this discussion, there was no pressure was applied. Some families had already made the basic decisions and knew what they wanted to do. Others simply could not decide at that point. I would tell them that they could go away and think things over, and leave decisions until later. I would, however, say that I needed to know the basic information and their decisions at some point, but they could call me later when they had decided.
28. In Coroner's cases I was aware that some children were transferred from the BRI and from other hospitals to our mortuary, which served as a regional centre. Although I was aware of the fact that bodies came in, because I might be asked to arrange viewing, I had no involvement in the giving of regular advice or counselling for the families involved in these transfers.
29. I liaised with the Coroner's officer to find out when the family would be free to register the death and when the Coroner would be prepared to release the body. What I was not involved in, was talking to parents about post-mortems or whether there would be a hospital or a Coroner's post-mortem. I have no information on this. These were matters dealt with by the medical staff.

30. As previously stated, from about 1993 I only dealt with bereavement services at the Children's Hospital. This was connected with the split in duties between St. Michael's and the Children's Hospital when there was a restructuring to create two completely separate porting services, one for each hospital. The Head Porter for each hospital was responsible for bereavement services in "his" hospital, we covered one another for absences and holidays.
31. On occasions parents would ask what the child would look like after a post-mortem. This question was generally addressed by the nursing staff. Sometimes the parents would want to view or dress the child after post-mortem. We were always careful to warn parents if the child looked different from when they had last seen them. Generally, viewings at St. Michael's were arranged through me whilst I was responsible for bereavement services there. At the Children's Hospital viewings tended to be arranged through the ward nursing staff. I would be asked about the availability of the Chapel, as there was only one Chapel and one mortuary for the two hospitals. The nurses were responsible for ensuring that the child looked nice and was appropriately dressed. It was the Porter's job simply to move the child.
32. Occasionally parents would ask me about the results of a post-mortem. I would tell them that they would receive an appointment in due course to discuss the results with the clinician. I was not in a position myself to provide information about the results of post-mortems, which was always dealt with by the medical staff.
33. I worked very closely with the nursing and Chaplaincy staff at BRHSC and St Michael's in order to provide as supportive a service as possible. I treated bereaved parents with utmost sensitivity and respect at all times.

**Issue I: Treatment of Families, including the Bereaved****Issue 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**

34. I have described in outline my role and involvement in the provision of bereavement services at the Children's Hospital. I emphasise again that I had very little contact with families whose child had undergone paediatric cardiac surgery, and none that I can remember. As indicated above, I had no involvement in the obtaining of consent for any post-mortem, whether hospital or Coroner's post-mortem. This was dealt with by the doctors. The medical staff also spoke with the family and completed the death certificate, any form for cremation, and any post-mortem form.

**Issue 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**

35. As described above, as a relief porter my only contact with bereavement services was, like all porters, to assist in the moving of bodies from the ward to the mortuary, from the mortuary to the viewing room, and then to arrange transfer to private undertakers.
36. Before Ray Gilbert had been appointed as Head Porter, the registration of deaths, if parents did not want to do it themselves, was carried out by a senior administrator in the hospital. This job was then handed over to the Portering Manager. Ray Gilbert dealt with it when he was Head Porter. My only involvement with the paperwork at that stage was limited to the holding of death certificates and providing the certificates to families when they came to collect them.
37. As previously indicated, the paperwork essentially consisted of the death certificate completed by the doctor, any post-mortem form completed by the doctor and the family, any cremation form completed by the doctor, and then the registration of the death obtained either by the family or by me on their behalf, if requested. When I took up the Portering Manager's post, I implemented changes which improved the service to parents. It was necessary to develop some kind of checklist, so that all of the basic information was obtained and recorded in one place. This was partly so that I could ensure that we had everything that we needed for the process to run smoothly, and partly so that when I was away those deputising for me would have a useful guide of exactly what needed to be done and what stage had been

reached in the process. I prepared a generic checklist covering pre-24 week fetuses, stillbirths, neonatal deaths, children, adults and Coroner's cases.

38. There was a brief period of time when I had no deputy. At that stage it was decided that the key staff in each hospital should be trained in the aspect of bereavement services provided by me. This was discussed with the Chaplains. We decided to involve as many staff as possible so that they could offer support and advice to families. The aim was to provide a more holistic service. We wanted to ensure that both nursing staff and other porters would be generally more aware of the service, and that there would be more people around who knew what was involved so that they would be able to assist and provide cover where necessary.

**Issue 13: The financing of the support and counselling services**

39. I cannot provide any information on this issue.

**Issue 14: The priority afforded to support and counselling work by hospital management and clinical staff**

40. When I took up post as Head Porter I was sent on a counselling skills course for 4 days at the BRI, which was particularly helpful. This was in about 1989. My first line manager, Ian Barrington, was very supportive of the bereavement services. Later my line managers were Sarah Hoyle, who was Hospital Manager at St. Michael's from the advent of the Trust in April 1991, and then Dilys Waterman. Both were similarly helpful and supportive of the bereavement service. Nursing staff contacted me promptly when there was a death and assisted me in every way so that between us we could provide an efficient and sympathetic service to parents at a very difficult time for the family.

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

41. Staff were always sensitive and caring to the needs of patients and families. I felt that they were dedicated and compassionate in all situations.

**Issue B: The BRI and its Paediatric Cardiac Surgery Unit**

**Issue B10: Complaints procedures available to referring clinicians, and to members of the public, on the standards of treatment and care attained at the BRI**

42. I cannot provide any information on this issue.

**Issue B12: The culture of the BRI, as expressed in such matters as:**

**(f) the attitudes towards patients who complained of poor service or care;**

43. I cannot provide any information on this, as I did not work at the BRI.

**Issue E: Pre-Operative Management of Cases**

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

44. I cannot provide any information on this issue as I had no involvement in the clinical care and treatment of children.

**Issue G: Post-Operative Care**

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

45. I cannot provide any information on this issue as I had no involvement in the clinical care and treatment of children.

**Issue H: The Split Site**

**Issue H1: The extent to which (if at all) the quality of care offered was adversely affected by the fact that paediatric cardiac surgery and immediate post-operative care were carried out within a cardiac theatre and ICU catering for both adults and children.**

**Issue H2: Communication and collaboration between the ICU of the BRI and the paediatric ICU of the Children's Hospital; and transfer of children between the two sites.**

**Issue H3: The response of the clinicians and the management of the BRI to any problems created by the split site**

46. I cannot provide any comments on this issue, as I was not involved in transfer arrangements during care and treatment, which was a matter for medical and nursing staff.

SIGNED

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MR FRANK LONG

DATED

: 21/10/99. ....

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