

6.6 Of the four cases where the teams disagreed significantly (as to whether different management might have or would have altered the outcome), there were two cases where there was only one scoring grade difference i.e. 3 versus 2:

- In one of these (SR4) the anatomy was very unusual and has only rarely been described before – this child died postoperatively. One team was critical of the inaccuracy in pre-operative diagnosis while the other felt the rarity of the condition precluded accurate diagnosis. The decision as to whether this aspect of care might or might not have made a difference in a very rare condition is a moot one.
- In the second case (SR10) the child is alive but has moderate disability following a cerebrovascular accident (stroke). Both teams felt that earlier operation should have been undertaken but differed as to whether this might or might not have changed the outcome.

6.7 We were more concerned, however, about the two cases where there were two scoring grades difference between the teams.

- In the first case (SR5) the child's case was given an overall grade 3 by the first team, and an overall grade 1 by the second team. The child was very ill with particularly small pulmonary (lung) arteries – this makes the technical construction of a shunt very difficult. Even if a successful shunt is constructed it is possible that the pulmonary arteries might not grow. One team was critical of the way the shunt was constructed and about the initial postoperative management. The other team felt the anatomy was so unfavourable that a different technique would not have made any difference. This child died.
- In the second case (SR15), overall care was given a grade of 2 by the first review team and 4 by the second. The child was described by both teams as a very difficult and complex case. One team felt it had been adequately managed but the other believed a different approach by the anaesthetist at the first operation would have affected the outcome in the long term. This child survived the surgery but died some time later following an interventional cardiological procedure to dilate the pulmonary (lung) artery.

6.8 Both these cases highlight our earlier observation that in any retrospective review where the child died, it could be argued that any different management might or would have made a difference.

### **Emerging Implications of the Repeat Review Exercise**

6.9 The repeat review exercise showed a degree of concordance between the teams suggesting that the expert team review methodology is valuable. Further analysis of the gradings and comments on each of the aspects of care, and, potentially further second reviews, might help to establish the extent to which this concordance is reliable or due to chance alone.