IN THE LONDON SOUTH EMPLOYMENT TRIBUNAL **CASE NUMBER: 2300819/2019**

BETWEEN

DR CHRISTOPHER DAY

Claimant

and

LEWISHAM AND GREENWICH NHS TRUST

Respondent

WITNESS STATEMENT OF
DR MEGAN SMITH

I, Dr Megan Smith of [redacted] will say as follows:

1. Background

1.1. I am a consultant anaesthetist. I was entered on the GMC's specialist register in 2015 and have worked as a consultant since then. During my training I completed a Patient Safety Fellowship at The Royal Marsden Hospital. Since my appointment as a consultant, I have been a member of my hospital's Serious Incident Review Panel and am currently the mortality lead for the department of anaesthesia with responsibility for investigating any patient deaths. I am also a practising barrister and I carry out expert witness work (primarily in the field of clinical negligence) for claimants and defendants.

1.2. I have become aware of the circumstances of this case through my work with EveryDoctor, a doctors campaigning group through which I have met Chris and become familiar with this case.

1.3. I do not propose to repeat the extensive background to this case. It is set out in the Grounds of Claim before the tribunal.

2. How serious were the protected disclosures made by the Claimant in 2013-2104?

2.1. The substance of the protected disclosures made by the Claimant was that:

2.1.1. Doctor/patient ratios were inappropriately high and a risk to patients at Woolwich ICU;

2.1.2. ICU trainees who were rostered to cover the ICU (as well as critically ill patients on the wards and in the Emergency Department ("ED")) had insufficient clinical experience, training, and competence to fulfil a role of such responsibility which put patients at risk and compromised patient safety;

2.1.3. Senior medical supervision of these ICU trainees was inadequate and a risk to patients at Woolwich ICU which put patients at risk and compromised patient safety;

2.1.4. The Respondents' managers failed to investigate these safety related matters adequately;

2.1.5. The Respondents' managers provided false information about the claimants protected disclosures; and

2.1.6. The Respondent's managers provided false information to those investigating these safety related matters.

2.2. These disclosures were made repeatedly by the Claimant to various members of the clinical and management staff at the Respondent, in particular to:

2.2.1. Dr Roberts in a phone call and email on 29 August 2013;

2.2.2. Dr Brooke in a meeting on 29 August 2013 and by email dated 2 September 2013;

2.2.3. Dr Harding, Assistant Medical Director for Professional Standards in an email forwarded on 3 September 2013;

2.2.4. Joanne Jarrett, the off-site duty manager, in a phone call and email on 10 January 2014 and a further email on 14 January 2014;

2.2.5. In addition, the Claimant informed Joanne Jarrett via email on 14 January 2014 that hospital managers were providing false information and were failing to investigate and deal with patient safety issues in the Respondent's ICU;

2.2.6. Statements made by the Claimant on 3 June to the ARCP panel (which included a senior doctor from the Trust, Dr Harrison) about patient safety at Woolwich ICU, the hospital arrangements for 10 January 2014, the events of that night and subsequently and attempts by Trust management to discredit him and present the issue as his competence rather than patient safety.

Doctor patient ratios

2.3. In 2013, the standards required to be met by ICUs were set out in the document "Core Standards for Intensive Care Units" (the "Core Standards") published by the Faculty of Intensive Care medicine ("FICM"), the Intensive Care Society ("ICS") and a number of other allied ICU professional healthcare groups (see Supplementary Bundle pages XXX).

2.4. Section 1.1.3 of the Core Standards states that:

> *"In general, [the Consultant/Patient ratio should not exceed a range between 1:8 – 1:15 and] the ICU resident/Patient ratio should not exceed 1:8."*

2.5. The rationale for this requirement was that:

"The best current evidence is a Consultant/patient ratio in excess of 1:14 is deleterious to patient care and Consultant well being. However the actual ratio needs to be determined by the following factors:

- *Case Mix*
- *Patient Turnover*
- *Ratios of Trainees*
- *Experience of Trainees*
- *Telemedicine*
- *Surge Capacity"*

[Emphasis added]

2.6. A number of studies have shown that there is a direct link between Patient to Intensivist ("PIR") ratio (i.e., the number of patients an intensive care doctor is caring for) and patient mortality[1]. In one study[2], the association between PIR and mortality was "U-shaped". There was a reduction in the odds of mortality associated with an increasing PIR up to 7.5 patients after which the odds of mortality increased again significantly.

2.7. It is true that some earlier studies did not demonstrate this effect, however as explained in the *Gershengorn* study, the methods used in some of these studies were flawed or they were not designed to answer this specific question.

2.8. The Core Standards also require:

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[1] For example Neuraz A, Guérin C, Payet C, et al. Patient mortality is associated with staff resources and workload in the ICU: a multicenter observational study. *Crit Care Med.* 2015;43(8):1587-1594 - adjusted risk of dying on a given shift was 2.0 times higher if the PIR was more than 14:1 versus less than 8:1 on that shift.

[2] Gershengorn HB et al. Association of Intensive Care Unit Patient-to-Intensivist. Ratios with Hospital Mortality. JAMA Intern Med 2017;177(3):388-396.

> *"1.1.5 A Consultant in Intensive Care Medicine must be immediately available 24/7, be able to attend within 30 minutes and must undertake twice daily ward rounds.... Consultant Intensivists must be available at all times to offer consultant level care to patients as necessary. Consultant Intensivists participating in a duty rota (including out of hours) must not be responsible for delivering other services, such as emergency medicine, acute general medicine and anaesthesia (including obstetric anaesthesia), while covering the critical care unit."*

2.9. Many of these requirements were repeated in the later version of the Core Standards (The Guidelines for the Provision of Intensive Care Services ("GPICS")) which clearly states that:

> *"The night-time resident to patient ratio should not normally exceed 1:8."*

2.10. These were not new standards in 2013/2014 and have remained the same ever since.

2.11. It seems to me that there are two key issues that arise in relation to the Respondent's failure to meet this standard. First, as can be seen from the Claimant's witness statement, the substance of what he was saying was that at all times when he was working as the resident night time ICU doctor he was expected to cover 18 ICU beds, assess new critically unwell patients on the wards in the hospital and/or in the ED, and review a list of ICU outlier patients on the wards who had been flagged as potentially requiring admission to ICU and therefore warranted close monitoring and regular review.

2.12. The ratio within the ICU (i.e., before any other duties outside the ICU were taken into account) was well in excess of the requirements in force at the time. As stated, those ratios were/are in force in order to protect patients, promote safe patient care and reduce morbidity and mortality. When one then adds into the mix the additional responsibilities allocated to a very inexperienced ICU doctor, those matters can only have been more significantly compromised.

2.13. For the avoidance of doubt, in my view, based on my own practical experience, the ratio of 1:18 in the Respondent's ICU was, prima facie, unsafe and (if more than a one-off incident) was something that was required to be rectified by the recruitment of more (and in some cases more experienced) junior doctors.

2.14. I trained in anaesthesia between 2006 and 2015. In this time, I spent 18 months training in ICU and a further 12 months covering ICU on call out of hours (i.e., overnight and on the weekends). I never worked with such high ratios in the NHS.

2.15. When I was a junior grade anaesthetist (i.e., a year 1 and 2 anaesthetic/ICU trainee) there was always, as a minimum, a senior registrar on shift with me. When I was the senior doctor on shift, unless there were fewer than 8 patients (which was the case in one ICU I worked in) then a year 1 or 2 anaesthetic/ICU trainee would be on shift with me. This meant that ward-based patients requiring review or assessment for admission (or critically unwell patients coming into the ED) would be seen by one of the on shift ICU trainees (usually, though not always, the most senior) and the patients in the ICU itself would be cared for by the other ICU doctor(s) on shift.

2.16. Further, the medical wards and the ED would have their own out of hours teams covering the care of ward patients and those being admitted to the ED. As I understand it from the Claimant's witness statement, this was ordinarily the arrangement at the Respondent, however on 10 January 2013, two of the ward-based doctors did not attend for work. This meant that the already inappropriately stretched ICU doctor had to cover even more ground. In circumstances such as these, I would expect the consultants on call for the specialities in which the two doctors who failed to attend to be called in from home to cover their duties. Whilst unpopular, this is what consultants on call from home are paid to do and, whilst a rare occurrence, in my experience it is what they do when required.

Trainee experience and competence assessment

2.17. The CCT in Intensive Care Medicine that was in force in 2013/2014[3] stated, in relation to out of hours work by trainees, that:

> *"...it is important to ensure that any new aspects of emergency work are undertaken initially with close clinical supervision."*

2.18. It is worth noting that for any doctor who has no ICU experience at the start of their placement, almost every clinical scenario that they are exposed to will represent "*new aspects*" in relation to which "*close clinical supervision*" would be required. In my view it is self-evident that a doctor with no ICU experience cannot be left alone unsupervised out of hours. In addition, "*close*" supervision cannot be provided by a doctor who is on call from home. In anaesthesia, there are 4 categories of supervision (these or their equivalents were in place in 2013/2014) and are as follows[4]:

1	Direct supervisor involvement, physically present in theatre throughout.
2A	Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals.
2B	Supervisor within hospital for queries, able to provide prompt direction/assistance.
3	Supervisor on call from home for queries able to provide directions via phone or non-immediate attendance.
4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols.

2.19. A "brand new" ICU doctor (or doctor in any speciality in which they have no prior experience) in the first weeks and months of that practice will, in my opinion, fall

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[3] https://www.ficm.ac.uk/sites/ficm/files/documents/2021-10/cct_in_icm_part_ii_-_assessment_system_2019_v2.4_final_0.pdf

[4] https://rcoa.ac.uk/training-careers/training-anaesthesia/2021-anaesthetics-curriculum/2021-curriculum-assessment-2

within the equivalent of level 1 supervision. As they progress (and are formally assessed to have met the standards set out in the FICM curriculum), they will progress to level 2. I have never worked in a hospital where an ICU or anaesthetic trainee in the first year of their speciality training was expected to work with level 3 supervision out of hours.

2.20. In my view, the additional guidance supports this position. The Core Standards state that:

> "*An ICU resident may be a medical trainee, SAS doctor or Advanced Critical Care Practitioner. It is not appropriate for a Foundation Year doctor to be left as the sole resident doctor on an ICU. There must be immediate access to a practitioner who is skilled with advanced airway techniques.*"

2.21. In addition, the Core Standards state that:

> "*Critical Care trainees must have appropriate experience to work in a critical care unit.*"

2.22. A 2011 European Society of Intensive Care Medicine study[5] (on which doctor patient ratio recommendations were in part based) recommended as follows re medical trainees working in ICU both in and out of hours:

> "*Medical Trainees*
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> *Trainees in medical and surgical specialties (e.g., anesthesiology, internal medicine, pulmonology, surgery) may, after 2 years of training in their primary specialty and within the frame of their specialty, work in an ICU under clearly defined supervision.*
>
> .....
>
> *Continuity of medical activity.*

[5] Valentin A, Ferdinande P. Int Care Med. 2011; 37(10) Volume 37: 1575-1587

The continuity of medical care in the ICU during nights, weekends, and holidays is assured by the regular medical staff of the ICU on a 24 h/day basis [22–24]. They can be assisted by skilled and experienced residents from other departments with basic training in intensive care medicine, provided there is a back-up of the regular staff around the clock [25–28]. This activity needs to be considered in the calculation of requested regular staff."

2.23. All of these standards were/are in place to ensure that the care delivered to patients is safe and appropriate. When ICU trainees first begin their training, they are unlikely to possess many (or any) of the core lifesaving skills and competencies that a qualified higher level ICU trainee or consultant possesses. This means that it is completely inappropriate for these trainees to be left alone to manage the ICU out of hours until the department is satisfied that they possess the required levels of skill and competence.

2.24. Emergency intubation and stabilisation of acutely unwell patients is a core part of the job of an ICU physician. These are not procedures that can wait 30 minutes until a consultant who is on call from home out of hours is able to reach the hospital. This is why there is a requirement for immediate access to a practitioner who has advanced airway skills.

2.25. Doctors with the level of experience that the Claimant had at the time in question would not have (and would not be expected to have) anything other than basic airway and lifesaving skills. These can save a life as a temporising measure, but definitive airway access (tracheal intubation) and cardiovascular resuscitation have to be secured quickly or the patient will come to harm. These skills (which are routinely provided by the ICU team) are far more advanced and can only be gained by those new to ICU by being taught and fully supervised in performing them until they have achieved a prescribed level of competence (in 2013/2014 the criteria for such competencies were set out by the Royal College of Anaesthetists (in conjunction with a number of other Royal Colleges) in its extensive "CCT in

Intensive Care Medicine)"[6]. There is simply no way that any ICU doctor in their first weeks and months of practising ICU medicine can be competent enough in these skills to warrant being left alone with sole responsibility for the management of critically ill patients.

2.26. By way of comparison, anaesthetic trainees, some of whom often have extensive experience in other areas of medicine, are not (and were not in 2013/2014) permitted to work alone until completion of an initial assessment of competencies. This happens at 3 months and relates to the most straightforward and simple of elective surgical patients who are neither acutely unwell nor physiologically unstable. These trainees are not permitted to provide solo out of hours cover in this time and, in reality, during the first year of their training they are paired on call with a much more senior, experienced, and skilled trainee. Trainees have to learn by experience as well as by study, but that experience must be gained in a supervised manner and, initially, that supervision must be direct rather than distant. To do otherwise is to put patient safety at risk.

In my view, the supervision referred to above, in addition to the provision of "*immediate access to advanced airway skills*", cannot be fulfilled by an anaesthetic registrar who is covering emergency surgical cases (rather than on duty in the ICU) working solo out of hours. They may well be in theatre with a patient under anaesthesia. That patient cannot be left unattended. I have worked in hospitals where an anaesthetically trained junior who was covering the ICU would temporarily "swap places" with the anaesthetic registrar in order that the latter could assist with a complex or extremely unwell patient, but that was not possible in the Claimant's case as he was not trained to care for an anaesthetised patient in theatre.

2.27. In my experience, either there is a more experienced senior doctor also on shift in the ICU to guide, support and teach the junior trainee, or the anaesthetic on call

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[6] See footnote 3.

team is comprised of a senior and a junior doctor, the latter being capable of being left alone with a patient in theatre for short periods in order that the former can go and assist in the ICU.

Inadequate senior clinician supervision

2.28. The SUI reports (see Supplementary bundle) indicate that there was no (or no robust) assessment of junior doctors' ICU competencies before they were left alone out of hours in the ICU. This is both illogical and inexcusable in my opinion. The requirements in force at the time were clear in relation to the level of experience required of trainees. If competence is not provisionally assessed, then there is no way of knowing whether it is safe to leave trainees alone on shift with critically ill patients. The two avoidable deaths in the SUIs indicate strongly that it was not. This is information that should have been obtained and acted upon before a patient (let alone two patients) came to harm.

Failure to investigate adequately

2.29. See section 3 below in relation to this.

Provision of false information

2.30. Whilst I cannot comment directly on whether false information was provided by managers about the patient safety incidents, and/or whether there was a failure to investigate and deal with patient safety incidents at Woolwich ICU, , I can say that as a member of a Serious Incident Review Panel the provision of false information is inappropriate, unprofessional, likely to be unlawful and render an institution in breach of its own policies, procedure and codes of conduct as well as its statutory obligations. It should also be a serious disciplinary matter. Covering up incidents is unlawful and, as was found by Sir Robert Francis QC in his report of the Mid-Staffordshire Inquiry, is likely to lead to patient harm.

3. **The Respondent's response and the SUIs**

3.1. I now turn to the issue of how I would have anticipated, from my own experience, the disclosures to have been responded to by the Respondent, and the implications of the SUIs that post-dated the disclosures as referred to by the Claimant.

3.2. As a result of the events of 10 January 2014, the Claimant logged a Datix (serious incident) report. Datix is the incident reporting system used by the NHS. The NHS has a standardised framework for the investigation of incidents. The framework in place in January 2014 was the NHS Commissioning Board's "Serious Incident Framework - March 2013"[7] (the "Framework"). A serious incident is defined in the Framework as:

> *"an incident that occurred during NHS funded healthcare…, which resulted in one or more of the following;*
>
> - *unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;*
> - *a never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death. (See Never Events Framework);*
> - *a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;*
> - *allegations, or incidents, of physical abuse and sexual assault or abuse; and/or*
> - *loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation."* [Emphasis added]

[7] See Appendix 1

3.3. In my view the repeated provision of inadequately experienced ICU juniors, the persistent breach of doctor-patient ratios in force, and the incident of 10 January 2014 each fall within the definition of a serious incident.

3.4. Under the heading "Common Governance Principles" (page 11), the Framework sets out the way that an organisation should respond to an individual incident as well as how it should be able to detect trends and specific areas/themes of concern. This is of relevance in the context of the two SUIs mentioned in the Claimant's witness statement. Where two incidents resulting in the death of a patient occur in the same unit within a relatively short time of one another, and the level of experience and competence of the junior doctors on duty, coupled with the manner of their support and supervision by seniors is identified as an issue, I would expect, per the Framework, for those responsible for serious incident investigations to be capable of identifying a potential theme or pattern and acting accordingly.

3.5. Page 16 of the Framework shows a flowchart of steps required to be taken when a serious incident occurs. Similarly, page 18 sets out the steps to be taken when a serious incident occurs. Under the heading "Immediate action for providers" it states that:

> "*A safe environment should be re-established as soon as possible.*"

3.6. I am unaware whether the staffing ratios were flagged by any member of staff other than the Claimant prior to him first raising the issue in August 2013. I note the reference in SUI 656 (see paragraph 7.2.4) to chronic issues with 100% bed occupancy and extreme pressures on the ICU and its staff which suggests that this was at least known to be an issue, even if it had not been logged as a serious incident affecting patient safety (which, in my view, it should have been). However, as soon as the matter was raised in this manner by the Claimant I would have expected immediate action to have been taken. That action should, in my view, have included some or all of the following steps:

3.6.1. Immediate recruitment of appropriately qualified locum ICU junior doctors to reduce nightly ratios to the recommended levels;

3.6.2. Medium term recruitment of appropriately qualified ICU junior doctors to reduce nightly ratios to the recommended levels;

3.6.3. In the event that either/both of these steps were not possible, the requirement for the on-call ICU consultant to be resident;

3.6.4. In the event that 3.6.3 was not possible, the closing of ICU beds to bring the ratios to a safe level.

3.7. Step 3.6.4 would be an absolute last resort which would necessitate that critically unwell patients admitted to the ED would have to be stabilised by the in-house ICU team then transferred out to an ICU with available beds. Whilst ideally there would always be ICU beds available for any patient who needs one in the hospital that they first attend, that is simply not the reality of the NHS in the last decade or so. ICU bed numbers have fallen, and demand has increased. As a result, patients are routinely transferred out of one hospital with no free ICU beds to an ICU that does have capacity. It should be noted that the availability of an ICU bed is a function not only of the availability of a physical bed and bedspace in which to care for the patient; it is also a function of the staff available to deliver that care. It is routine to "close" ICU beds if there are inadequate nursing staff to care safely for the patient. The same should be true in relation to the routine availability of ICU doctors.

3.8. As stated above, there is evidence that ICU doctor to patient ratios of >1:8 are detrimental to outcomes and patient safety. I am aware of a number of SUIs that happened in the Respondent's ICU in the months after the Claimant's August 2013 disclosures and before the Datix report lodged by him in January 2014. Both of these incidents occurred out of hours, and both seem, in part, to have been caused by the clinical inexperience of the doctor on duty, coupled with inadequate/deficient support from the on duty consultant. The inexperience of the ICU doctors being used at night was explicitly raised in the Claimant's August 2013 protected disclosure.

3.9. For example, in relation to SUI 596, the investigation concluded that:

"The ICU resident discussed the patient by telephone with his consultant. However, as the resident failed to appreciate the severity of Mr A's condition, the communication failed to result in an escalation of care."

3.10. Similarly, in SUI 656:

"This calls into question the competency of the practitioner who inserted the drain and requires analysis of the systems underpinning how competency is established, and the robustness of supervision from senior clinical staff"

"The investigation found that there had been no formal assessment by the Trust of the competency of this clinical fellow to undertake the insertion of a chest drain (on a background of lack of formal competency assessments for common procedures within the critical care unit)"

"7.2.4 Working conditions within Critical Care unit and unit culture

Occupancy levels around 100% have existed for prolonged periods at the QEH ICU and indeed surrounding units recently. This investigation has highlighted the pressures that exist within the QEH site related to activity, capacity and service demands which continue around the clock and mirrors a national awareness of the need to expand the capacity of critical care services. It can be very difficult to maintain a robust safety culture when unit occupancy runs consistently at 100% with severe pressure on beds. This is demonstrated by the apparent increased tolerance of out of hours procedures due to high demand upon ICU care which has become almost normalised, whereas there is good evidence that non emergency procedures tend to have better outcomes if undertaken during hours when more senior staff are available."

4. **The public statements of the Respondent after the settlement agreement reached in October 2018, and their description of the Claimant's allegations**

4.1. As explained above, whilst mistakes and accidents do happen in the NHS, they are not common and, in particular, events causing severe harm or death are rare. As such they must be investigated in a timely fashion as required by the publications already referred to.

4.2. The allegations raised by the Claimant would be of grave concern to any medical professional and any serious incident/governance/risk manager. The primary concern would be for the safety of the patients in the ICU, particularly given subsequent (apparently avoidable) patient deaths. However, the institution ought also to have been extremely concerned about reputational damage and its standing with those commissioning its services with whom it would have had legally enforceable contractual agreements. I would expect an immediate and thorough investigation to have been initiated. That investigation should have been conducted in accordance with the Framework and it should have reported to the Respondent's serious incident review panel with actionable suggestions for remediation within the timescale set out in the Framework.

4.3. In light of this and the conclusions that I have reached above, it seems to me that the Respondent's press statements and statements on its own website at best underplay the seriousness of what was occurring in the ICU and at worst were misleading in relation to the same. By way of example:

4.3.1. "*The external investigation found it had been appropriate for Dr Day to raise his concerns and that the Trust had responded in the right way*". This does not seem to me to be an accurate characterisation of the conclusions of the external investigation review panel.

4.3.2. "*Some of the publicity around this case has incorrectly made a link to the findings of a peer review of the critical care unit at QEH undertaken by the South London Critical Care Network in February 2017… It is important to be clear that these were not the same issues that Dr Day had raised in January 2014, which related to junior doctor cover on the medical wards*" [emphasis added]. It is clear that the matters raised by the Claimant related primarily to chronic and unsafe understaffing issues within the ICU together with junior doctors' inexperience in ICU medicine rather than to junior doctor cover on the wards. The latter was one aspect of one of the protected disclosures that he made, but in my view, it was not the thrust of that disclosure which again related primarily to the serious patient safety implications of chronic understaffing in the ICU. The single incident in which two junior doctors failed to turn up for their shifts occurred on 10 January 2014. In my view it is inaccurate to describe this single incident as "simply" a matter relating to junior doctor cover on the wards. If the resulting staffing shortage means that an inexperienced ICU trainee not only has to cover over the double the number of patients in the unit than is permissible according to then extant core standards, as well as critically ill patients on the wards and in the ED, but now must also fill the gap left by those who were absent, then that is much more serious. Safety on what was already an inadequately staffed ICU must, by definition, also have been compromised by having its single junior doctor spread even more thinly. The Claimant's concerns, communicated over a long period of time prior to and after the incident on 10 January2014, related to chronic understaffing of the ICU out of hours, and the risk to patients that posed. Concerns of this nature are not something that are "usual" or "commonplace" in the NHS. They are serious; the evidence is clear that mortality and morbidity in ICU patients increases as staffing falls (see above). An institution that sought (or seeks) to play down or dismiss such enormous systemic failures as a "one-off" incident should ring alarm bells for clinicians, commissioners, and regulators alike.

4.3.3. *"We have always been clear that we did not treat Dr Day unfairly on the grounds of whistleblowing and that we investigated his concerns thoroughly and appropriately."* I think that, in light of the guidance set out above relating to the handling of serious

incident reports, it is not open to the Respondent to assert that the Claimant's concerns were investigated thoroughly and appropriately. The report that was commissioned in 2014 by the Respondent appears to accept and condone the running of the ICU in breach of expressly stated national standards that were put in place in order to ensure that ICU patients received excellent and, arguably more importantly, safe care. The conclusions of the 2014 report are, in my view, completely at odds with these evidence-based principles and are entirely inconsistent with the principles of the delivery of safe and excellent patient care.

I confirm that this statement is true to the best of my knowledge and belief.

Signed  .....

Name **DR MEGAN SMITH LLB, Barrister, MBBS, FRCA**
Consultant Anaesthetist

Dated 20th May, 2022.

Appendix 1

Serious Incident Framework - March 2013