Chapter 28 – Concerns 1993

Concerns

The data produced by Dr Bolsin and Dr Black

1 Dr Bolsin stated that the results of his data collection were available in early 1993. Dr Bolsin's evidence was:

> '… [Dr Black] subjected the data to simple statistical analysis. The numbers were small but gave an indication of potentially significant differences between the results of Bristol and the national average comparative data. The indications were that for two operations (Tetralogy of Fallot and A-V canal) the mortality in Bristol was higher than the rest of the country. The initial data also indicated incorrectly that there was a higher mortality for VSD procedures in Bristol than in the rest of the country. When the error in the VSD data was pointed out to Dr Black and myself we withdrew the comparison. The Fontan procedure mortality was the same in Bristol as the rest of the country.'[1]

2 Dr Bolsin continued to collect data on the Arterial Switch programme and showed the initial results to Professor Prys-Roberts, Professor of Anaesthesia at the University of Bristol. Dr Bolsin also went to see Professor John Farndon. Dr Black also showed the data to Dr Sally Masey, consultant anaesthetist.[2]

3 Professor Farndon was appointed as Professor and Head of the Division of Surgery at the University of Bristol in 1988. He indicated in his written evidence to the Inquiry that he was not an expert in cardiac surgery:

> 'My understanding of cardiac surgical procedures in general and their associated morbidity/mortality and, in particular paediatric cardiac surgery, was and is very limited. I would not have known the benchmarks that the cardiac surgeons should have been achieving. Few other surgical sub-specialties have mortality and morbidity to match that of cardiac surgery, … I knew that the cardiac surgeons were submitting data to a national audit where comparisons with other units would be made. The process should have identified problems and corrections to allow closure of the audit loop. When reporting to the Medical Audit Committee I informed them that cardiac surgery were submitting externally. I felt that this national arena was the most appropriate way of dealing with cardiac surgery and provided a secure mechanism.'[3]

1 WIT 0080 0113 Dr Bolsin. See Chapter 3 for an explanation of these clinical terms
2 WIT 0080 0113 Dr Bolsin
3 WIT 0087 0003 – 0004 Professor Farndon

4 Professor Farndon was asked in oral evidence about his knowledge of paediatric cardiac surgery in Bristol in the early 1990s and whether he had heard anything about Bristol's performance. He replied:

> 'It is a very difficult question to answer, because I suppose in hospital settings, one gets a buzz or a ring and some departments are totally quiet and one hears of no reputation or repute, and in others one hears of some anxieties, general anxieties. I cannot honestly recall when I first became aware of others' concern in that area.'[4]

5 Professor Farndon became aware of concerns about the Bristol service early in 1993 when Dr Bolsin came to see him:

> 'In the early part of 1993, Dr Bolsin came to see me to express concern about the results of the treatment of children with congenital heart disease. His main concern focused on mortality rates. I cannot recall clearly now, but I believe that Dr Bolsin declared at that meeting that he had compiled some data. I cannot remember the exact details of the conversation but I would say that the data would need to be validated, shared and owned by all doctors involved in the process of the care of children and a joint decision made as to its validity. I cannot recall whether I saw the data at that time.'[5]

6 Dr Bolsin stated in his written evidence to the Inquiry that he left hard copies of the data with Professor Farndon and that he remembered Professor Farndon saying he would look into the matter.[6]

7 On the data itself, Professor Farndon told the Inquiry:

> 'I find it very difficult to remember exactly what the nature is, and contrary to his [Dr Bolsin's] statement with regard to my own, I do not have and do not remember receiving a folder of data.'[7]

8 Professor Farndon described his meeting with Dr Bolsin in the following exchange:

> 'Q. When I asked you why Dr Bolsin came to you, whether you thought he was coming for general advice or whether he was bringing you particular problems with particular surgeons in particular operations, you said you presumed he was coming for two reasons: (1) that you would be the audit co-ordinator for surgery, and hence I assume would be in a position to give some general advice about the carrying out of audit; and (2) that he had some idea that your stance might be one of equity, and might be one of providing some help in a situation that he found difficult.

4 T69 p. 88–9 Professor Farndon
5 WIT 0087 0006 – 0007 Professor Farndon
6 WIT 0087 0032 Dr Bolsin
7 T69 p. 94 Professor Farndon

'What "help" were you referring to?

'A. The advice that he needed to be sure that everyone could agree his data, and then to benchmark and see whether there was a problem.

'Q. So the help you provided was to tell him, give him general advice about benchmarking his audit?

'A. About the process – advice about audit in general.

'Q. And then telling him to discuss it with the other people involved in the care of children?

'A. Absolutely.

'Q. Which bit of that was the situation, as you put it, that Dr Bolsin found difficult?

'A. I do not know.'[8]

9 Professor Farndon told the Inquiry that he was not competent to comment on the data itself:

'… I had nothing with which to benchmark. The concept of some of the operations, the complexity, the outcome measures, are totally unknown to me in my own practice. It does not come across to me in any professional reading or continued education. I have no idea where to benchmark any such data.'[9]

10 Professor Farndon said that his advice to Dr Bolsin at the time would have been:

'… that this data has to be owned and shared and you need to look at what is the mechanism of any problem, if there is a problem, if you are able to benchmark, is there a problem? What are the likely contributory factors?'[10]

11 Professor Farndon took the view that the data should be shared with the surgeons and:

'Not only that; that everyone, before the data gathering had begun, was aware that this was a process of audit and knew that they were contributing to the data and its analysis, so that the data is gathered with everyone knowing, looking at the risk management of patients so that the data can be meaningful.'[11]

8 T69 p. 105–6 Professor Farndon
9 T69 p. 95 Professor Farndon
10 T69 p. 96 Professor Farndon
11 T69 p. 101 Professor Farndon

12 Once Dr Bolsin had raised his concerns, Professor Farndon stated in his written evidence to the Inquiry that he then heard of concerns that other consultants had:

> 'Once Dr Bolsin had come to see me I remember speaking with colleagues (in passing) about the concerns he had raised. I cannot remember the dates or exactly to whom I spoke. I certainly spoke to Professor Angelini, perhaps two to three times, and these were informal "corridor conversations".
>
> 'Other colleagues approached me with concerns about paediatric cardiac surgery. Mr Bryan, Dr Monk, Professor Prys-Roberts and Dr Willatts talked to me.[12] These are the only names I can now recall. I cannot remember the exact details of their conversations. My stance then, as now, was to advise them to produce agreed audit data that everyone could own. This should have allowed discussion on whether there were "problems" or not.'[13]

13 Dr Bolsin told the Inquiry that:

> '… I showed people the data and said "this is the data that Andy Black and I have collected, what do you think of this?"'[14]

14 Dr Bolsin indicated that Dr Masey was the first of the paediatric cardiac anaesthetists to see the data:

> '… because Andy [Dr Black] had literally got it hot off the printer and Sally [Dr Masey] was in the department and he asked her for her comment on it, unsolicited, which I think gives a measure of the openness with which we were doing it in that Andy got the data. His first contact was not "Steve, do you think you ought to show this to your colleagues?" it was "Sally, what do you think of this?" '[15]

15 Dr Bolsin said that he thought that this occurred in 'the spring of 1993'.[16]

16 In her written statement to the Inquiry, Dr Masey confirmed this account:

> 'In the spring of 1993, I discovered by chance about the "confidential audit" being conducted by Dr Bolsin when I was shown, in passing, by Dr Andrew Black, some preliminary results of analysis of mortality in paediatric cardiac surgery. I immediately felt that if this information was being collected that it needed to be accurate. I felt concerned that if it was being collected "confidentially", that this could lead to collection of inaccurate data. I do not recall the exact years to which

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12 Mr Alan Bryan, Senior Lecturer in Cardiac Surgery, University of Bristol and consultant cardiac surgeon, BRI; Dr Christopher Monk, consultant anaesthetist and Clinical Director of Anaesthesia from January 1993–December 1995; Professor Cedric Prys-Roberts, Professor of Anaesthesia, University of Bristol and Honorary consultant Anaesthetist, UBHT; Dr Sheila Willatts, consultant in anaesthesia and intensive care medicine, BRI, and consultant in charge of ICU, BRI

13 WIT 0087 0007 Professor Farndon

14 T82 p. 123 Dr Bolsin

15 T82 p. 121 Dr Bolsin

16 T82 p. 122 Dr Bolsin

the figures Dr Black showed me referred, but do recall that they included some data on Tetralogy of Fallot that included the 1990 figures. This was the year that I knew that the results had been unexpectedly, and unusually, high. There were also data on closure of ventricular septal defects, but I did not study these closely.

'Dr Bolsin arrived in my office while I was discussing these results with Dr Black and I again asked Dr Bolsin, if he had concerns, why he was not involving his cardiac anaesthetic colleagues, as I had done in 1990 after he had written to Dr Roylance. I expressed the opinion to him that it would be advisable to involve us, his cardiac anaesthetic colleagues. I suggested it would be easier to make sure that information was accurate if all of the cardiac anaesthetists were involved, and also the paediatric cardiac surgeons, and that if genuine concerns were highlighted it would be easier to address these as a group rather than as an individual. The only reason I recall that Dr Bolsin gave me that day as to why he was reluctant to approach the paediatric cardiac surgeons was that he thought that if they knew he was collecting this information they might prevent his access to information. I stated strongly to him that I considered it was inappropriate to collect this information in secret. However, Dr Bolsin continued to say that he felt this was the only way he could get information, as he felt that the paediatric cardiac surgeons did not produce these results themselves, or, if they did, they did not show them to anyone else. I commented to him that I had always been shown the results, but did agree that I could not recall having seen recent results. I said to Dr Bolsin that I had no doubt that if I asked Mr Dhasmana for the recent figures that he would give them to me immediately. Dr Bolsin showed some doubt as to whether the figures would be forthcoming. To test my hypothesis, I approached Mr Dhasmana the following day, and without explaining why I wanted them, I asked to see the most recent surgical results. He apologised that I had not received them earlier, and explained that the reporting date had been changed from the year-end to the end of March, and this had led to a delay in their preparation. He then went on to say that he had just completed the figures, and, as I had predicted, he showed them to me immediately. However, he did ask me not to show them to Dr Bolsin.

'As far as I am aware, apart from seeing the initial data in early 1993, I was never formally shown the results of Dr Bolsin's "confidential audit", although I did ask Dr Bolsin on a number of occasions to inform us, his cardiac anaesthetic colleagues, as to what he was doing, again for the reasons given above.'[17]

17 Mr Dhasmana indicated in a written response that he did not recall this conversation with Dr Masey.[18]

17 WIT 0270 0014 – 0015 Dr Masey
18 WIT 0270 0028 – 0029 Mr Dhasmana

18 Dr Sheila Willatts, consultant in charge of the Intensive Care Unit (ICU) at the BRI since 1985, stated:

> 'I had prolonged discussions with Dr Stephen Bolsin in 1993 regarding the potentially adverse outcomes and the course of action he might reasonably take. I advised as follows … "the issue was principally an audit one, namely that the results needed to be scrutinised, validated and agreed. During 1993 and 1994 I spoke to Professor Prys-Roberts, Professor Farndon and Chris Monk expressing my concerns that the data needed to be verified. I hoped that the results could be examined by a joint meeting of the surgeons and anaesthetists. It was my hope that the surgeons would bring their results to the meeting and the results should be discussed in an open forum. Professor Farndon volunteered his services as a potential chairman for such a meeting as he was not a cardiac surgeon".'[19]

19 In relation to the collection of data by Dr Bolsin and Dr Black, Dr Willatts stated:

> 'I believe that the surgical procedures reviewed and the sources of information were appropriate. If this audit could have been conducted openly with agreement between surgeons and anaesthetists it would have been a much stronger audit as the data would have been openly agreed. However, I do believe that it was impossible to obtain the necessary conditions for such a joint discussion to take place at that time as the strong personalities in cardiac surgery did not agree that this was necessary.'[20]

20 Mr Wisheart was asked about what he knew of the collection of data:

> 'Q. … did you at any time see any data or figures or analyses, however one describes them, which were produced by Dr Bolsin in respect of paediatric cardiac surgery, at any rate before April 1995?
>
> 'A. Not before April 1995.'[21]

21 Dr Stephen Jordan retired in May 1993. He stated: 'I was unaware of Dr Bolsin's audit of cardiac surgery until sometime after my retirement.'[22] In his oral evidence to the Inquiry he said:

> 'A. I saw no data at all. I was unaware at the time, up to the time of my retirement, that he had actually ever produced any data.

19 WIT 0343 0002 Dr Willatts
20 WIT 0343 0002 Dr Willatts
21 T 94 p. 132–3 Mr Wisheart
22 WIT 0099 0027 Dr Jordan

'Q. And you do not recall anyone mentioning such data existing to you during your time in post?

'A. As I have put in my statement, the only possible connection with this is the fact that I think it was Dr Bolsin introduced Dr Black to me and said he understood that I had some information on a computer at the Children's Hospital; could Dr Black have a look at it. I think I took Dr Black up and showed him what the information was. I am not aware of Dr Black ever having used this. That is the only possible connection that I can recall between myself and Dr Bolsin in terms of collecting data and auditing data.'[23]

22 Dr Jordan agreed, however, in the following exchange that he was aware of 'some problems' in Bristol:

'Q. (the Chairman): Just one question from me, Dr Jordan. If an observer having heard your evidence formed a picture that you were someone who, recognising that there were some problems in Bristol, fought within Bristol to effect change while outside quietly suggested or warned people off; would that observer have any right to hold that view?

'A. There is some truth in it. I will perhaps give you an example: shortly before I retired I had discussions with cardiologists in South Wales, I think this has sort of been obliquely referred to. Basically they were obviously considering whether they should continue to send patients to Bristol and take on a new cardiologist from Bristol, there was going to be a change anyway and they were being offered, in fact being encouraged to use the service in Cardiff instead. The thing I said to all of them, and I used very similar words but not necessarily identical ones were "You have asked my advice and what you are asking is really what is best for our patients. If I thought that the centre in Bristol was absolutely the best centre in the UK and there was no way that anyone else was going to produce comparable or better results, I would say to you, 'Do not try an untried unit in Cardiff'. Frankly, I do not think I am in a position to say that to you and therefore you will have to make up your mind whether you want to try a new unit or stick with Bristol." I think that is the sort of, if you like, comment I made which indicated that I was not going to go around blindly saying "Bristol is wonderful, keep on sending your patients there".'[24]

23 Dr Susan Underwood, consultant anaesthetist at the UBHT from 1991, stated in her written evidence to the Inquiry:

'I was aware that Steve Bolsin was undertaking an audit of the paediatric surgical work because he told me. He did not discuss details with me or show me the results.

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23 T79 p. 95–6 Dr Jordan
24 T79 p. 188–9 Dr Jordan

'I recall an evening meeting in winter, possibly 1993, where I think all cardiac anaesthetists were present and Steve Bolsin expressed his concern over the paediatric cardiac surgery mortality. The group asked him to produce some data to substantiate it. He did not bring any data to future meetings.'[25]

24 Mr Roger Baird, consultant general surgeon, and Clinical Director for Surgery at UBHT from April 1991 to November 1993, told the Inquiry:

'I was aware that Dr Bolsin had some funding from the Department of Health to enable him to develop audit techniques in cardiac surgery from the anaesthetics point of view. I thought that was a good thing. I did not associate this with anything other than an academic interest in developing audit, at that time. I was not aware of the nature or purpose of the "confidential audit".'[26]

25 Dr Joffe stated that he and Dr Bolsin 'never discussed paediatric cardiac surgical outcomes or services, nor was I privy to his secret audit. Indeed my first sight of his figures was in the *'Daily Telegraph'* and BBC West television, in April 1995.'[27]

26 Dr Roylance was asked when he first knew about the audit:

'Q. When did you first become aware that Dr Bolsin had been collecting, let us call it, "figures" or "data"?

'A. After the visit of Marc de Leval and Stewart Hunter.

'Q. Not before?

'A. No.'[28]

27 Dr Roylance was asked by Counsel to the Inquiry specifically about 1993:

'Q. Did any whisper reach you do you think in 1993 that Dr Bolsin was not only collecting data but analysing it?

'A. No, I did not know about Dr Bolsin's activities until after the external inquiry by Marc De Leval and Stewart Hunter. That is when it emerged and I did not know of his activities before that date.'[29]

25 WIT 0318 0011 Dr Underwood
26 WIT 0075 0035 Mr Baird
27 WIT 0097 0169 Dr Joffe
28 T88 p. 24 Dr Roylance
29 T88 p. 138 Dr Roylance

28 Professor Gordon Stirrat, Dean of the Faculty of Medicine, University of Bristol 1991–1993, told the Inquiry that no one made him aware of the collection of data and that:

> 'I would most certainly have expected Prys-Roberts to have done so … Andrew Black and I have worked together closely for a long time … I would have hoped that he might have felt able to tell me. But his direct line of responsibility was through Prys-Roberts.'[30]

29 Dr Bolsin, in his written evidence to the Inquiry, stated that Dr Black had told him that Professor Prys-Roberts had telephoned Dr Roylance 'and informed him that there was a real and demonstrable problem in the Department of Paediatric Cardiac Surgery'.[31]

30 Professor Prys-Roberts was asked about this in the following exchange:

> 'Q. … Do you recollect having any further information from Dr Bolsin or Dr Black about the process they had been engaged in since the summer 1992?
>
> 'A. I recollect having a meeting with them during which Steve had to leave and go off and left me to look at the data with Dr Black. I cannot recall the date. I know it would have been mid-1993 but probably not earlier and Dr Black showed me the results in tabulated form from a minute-type analysis that he had done. I do not recall doing anything about it at that stage because my recollection is that Andy Black went away and discussed it subsequently with Dr Bolsin, but they did not ask me to take any specific action at that stage.
>
> 'Q. If we go down the page, I think you have already referred to this, we can see that Dr Bolsin there informs us [the Inquiry] of something Dr Black is said to have told him, that you immediately telephoned Dr Roylance; that is not something, I think you have already told us, that you remember doing?
>
> 'A. I do not remember doing it. I have discussed it with Dr Black and he does not remember me doing it in his presence.
>
> 'Q. You say that Dr Black and Dr Bolsin did not ask you to do anything specific?
>
> 'A. No.
>
> 'Q. What was your reaction to the data they had given to you?
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> 'A. My reaction was that the data – which were still not what I could call finalised figures, but they were figures which were much more reasonable, I did not look at them in real detail at the time – that these were simply confirming the conclusions we had come to before, that there was a serious cause for concern.

30 T69 p. 32 Professor Stirrat
31 WIT 0080 0113 Dr Bolsin

> 'Q. If there was a serious cause for concern, why not ring either Dr Roylance or possibly Mr Wisheart?
>
> 'A. With hindsight I do not know why not. As I have said, at that stage I was not spending a great deal of time in Bristol. I was not involved in the overall process, I knew that others were involved and becoming more involved certainly on the cardiac anaesthesia side and that they were concerned with Dr Roylance.
>
> 'I cannot recollect why at that particular stage I did not take it any further.'[32]

31 Dr Christopher Monk, Clinical Director of Anaesthesia from January 1993 to December 1995, said that he first became aware of the audit: 'I believe in September 1993.'[33] He explained that he found out 'because I went into the perfusionists' room … where their data was recorded and one of them, or one of two people, said to me: "Do you know that Steve is looking at the data and trawling through the patients' notes?" or some similar phrase.'[34]

32 Dr Monk described the audit as 'clandestine' because: 'it did not involve the process of speaking to the consultant anaesthetists providing the anaesthesia or the consultant surgeons who were performing the operations in providing the information'.[35]

33 Dr Monk told the Inquiry that had he known about Dr Bolsin's exercise beforehand:

> 'I think I would have been sympathetic to his intentions, but I think it should have been open as opposed to private in the way that he did it, because, having got the data, it then becomes difficult to disseminate it.'[36]

34 Putting it in the context of the time, Dr Monk said:

> '… you have to look at it in terms of 1992, when audit nationally was only just being introduced. The impressions were that the people who did the work owned the audit.'[37]

35 In his written evidence to the Inquiry, Dr Ian Davies, consultant anaesthetist at the BRI from 1993, stated:

> 'When I worked at St George's as a Senior Registrar and was applying to Bristol, Mr John Parker led me to believe that the Bristol Cardiac Unit was under threat because of the quality of the services provided at that Unit. As I recall, he told me

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32 T94 p. 57–8 Professor Prys-Roberts
33 T73 p. 110 Dr Monk
34 T73 p. 110 Dr Monk
35 T73 p. 111 Dr Monk
36 T73 p. 114 Dr Monk
37 T73 p. 111–12 Dr Monk

that if I had been interested in a career in paediatric cardiac anaesthesia, he would advise me not to go there.'[38]

36 Dr Davies referred to a conversation which he had had with Dr Bolsin prior to his joining the BRI in April 1993:

'In the course of my conversation with him, he told me that the Paediatric Cardiac Surgical Programme was unsatisfactory, and that he was particularly concerned about the switch programme.'[39]

37 Dr Davies went on:

'After I started at BRI, Dr Bolsin spoke to me on a number of occasions about his concerns.'[40]

38 At a meeting of the UBHT Management Board on 7 December 1992 it was noted in the minutes that:

'Dr Roylance advised that Julian Le Vay, a member of a Regional working group set up to look at cardiac services in the Region would recommend to Bristol & District the creation of a second site for cardiac services at Derriford. Dissatisfaction had been expressed about the quality and cost of services offered in Bristol. He would discuss this with Mr Wisheart.'[41]

Concerns about the Arterial Switch procedure

39 On an occasion in 1993, Mrs Mona Herborn, Sister in Cardiac Theatres at the BRI from 1988 to 1998:

'… expressed to Dr Masey, Consultant Anaesthetist, my view that Mr Dhasmana was not capable of performing the switch operation. She then explained to me that none of the switch operations had been straightforward, that many unexpected implications [*sic*] had only been found when the patient was "opened up", which made it very difficult for the surgeon. From this and other conversations with the medical staff, I had to concede that I could not substantiate my concerns with hard facts. I just knew that I no longer wished to be taking part in switch operations. I tried to avoid other paediatric cardiac surgery where I could, but as it was a part of my job, I was not always able to do so.'[42]

40 Mr Dhasmana had some initial success in carrying out the Arterial Switch operation on neonates on his return to Bristol following his visit to Birmingham in December 1992. His first two patients survived. The third died. The third patient had an abnormal

38 WIT 0455 0006 – 0007 Dr Davies
39 WIT 0455 0001 Dr Davies
40 WIT 0455 0002 Dr Davies
41 UBHT 0058 0031; meeting of the UBHT Management Board; 7 December 1992
42 WIT 0255 0016 Mrs Herborn

coronary arterial pattern that was undiagnosed prior to surgery. Two further patients then died. This prompted Mr Dhasmana to revisit Birmingham for further retraining. He was asked what made him go back to Birmingham in July 1993:

> 'I lost two patients in succession and both of these patients had normal coronary arteries, so in a way, that raised doubt again in my mind that here I was, I did two successful operations, the third did not make it, but it was a highly abnormal coronary artery and probably could be explained in any centre. But the next one survived so I am still happy, I have got, you know, out of four, three survivals. And the next two did not, although of course, with one of them we did have evidence of myocardial infarction, but nevertheless, these two did not and they had a normal coronary artery.
>
> '… During this period, between 1992 and this time, July 1993, I had operated on about 7 or 8 older Switches and they all survived. So that is why, really, I was very concerned that something is probably a little different in neonates which I have not still been able to transfer. That is what was quite worrying me.
>
> 'I told Dr Joffe that, "I am very sorry, it appears that I will not do anymore neonatal Switches" … He said, "Well, it so happens that I was going to get in touch with you". I said "What for?" He said "I have got another patient admitted with a similar problem".
>
> 'Then I narrated again what happened during the day in theatre and he I think tried to probably comfort me, saying "Let us just wait for the post mortem examination and then we can really — ". I said, "Well, I am not taking that next case on".
>
> 'He said "Well, what should we do?" I said "I tell you what. We talk to Birmingham". He said "Well, why do you not do that?" So the next day, I ring Birmingham, I ask for Mr Brawn. It so happened he was nearby … he said "No problem, you know, bring the patient and I will operate here, and I tell you, I have got another patient here, so you will see two patients operated on the same day".'[43]

41 Mr Dhasmana stated:

> 'I re-visited Birmingham in July 1993 accompanied by Dr Undewood [*sic*] and a patient from Bristol that Mr Brawn had agreed to operate on. We had further discussion on the problem being experienced in the unit. We returned to Bristol, re-assured and prepared to re-start the programme. The next neonatal patient survived followed by a further fatality and the programme was ended.'[44]

42 Dr Underwood said that, due to the changes Dr Masey had put in place on her return from Birmingham in 1992, she did not see anything that was really different between the practice in Birmingham and in Bristol in relation to anaesthesia. She said:

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43 T85 p. 48–9 Mr Dhasmana
44 WIT 0084 0113 Mr Dhasmana

'… when I went in the middle of 1993, it was to observe them doing that same thing which Dr Masey had described to me, and I do not remember adding anything different or extra after that particular visit.'[45]

43 Mr Dhasmana was asked what he expected to discover from a second visit to Birmingham:

'What I noticed over these cases is that somehow, from outside and even when I have gone back in, the coronary artery looked in the right place. There was no obvious kink from outside. So I started asking myself whether what I called at that time the "lie", the way they are lying over the heart, have I got the angulation right, and maybe, technically anastomosis fine, and when you are looking at the post mortem, it looks fine, no problem, but the heart did not work. One of the things with anastomosis I think is the coronary artery, which I think is very important.'[46]

Further concerns expressed at Bristol

44 Mr Alan Bryan, consultant cardiac surgeon specialising in adult cardiac surgery, took up his post as Senior Lecturer in Cardiac Surgery at the University of Bristol on 1 July 1993.

45 He stated in his written evidence to the Inquiry that:

'Prior to taking up my senior lecturer appointment, I had formed the general opinion that paediatric cardiac surgery in Bristol may not meet contemporary standards. This opinion was based on general professional knowledge within the field of cardiothoracic surgery and my own perceptions dating from the time of my senior house officer post in Bristol. I was aware that attempts had been made to recruit Mr Martin Elliott … to a Chair in Bristol which had failed. I had also seen disturbing articles in the magazine "Private Eye", I had briefly discussed this question with Professor Angelini [British Heart Foundation Professor of Cardiac Surgery, University of Bristol] prior to taking up my appointment.'[47]

46 Mr Bryan went on:

'Having taken up my appointment in July 1993, some time in autumn 1993, Dr Stephen Bolsin presented to me outcome statistics in relation to specific diagnoses in paediatric cardiac surgical practice, namely Tetralogy of Fallot and Ventricular Septal Defect. I found these results disturbing since the data suggested that the operative mortality of one of the surgeons, Mr Wisheart, in relation to certain operations was well above the national average from the UK cardiac surgical register and was significantly higher than that of his colleague, Mr Dhasmana. At the time, I had no immediate way of clarifying whether the

45 T75 p. 99 Dr Underwood
46 T85 p. 50–1 Mr Dhasmana. See Chapter 3 for an explanation of clinical terms
47 WIT 0081 0023 Mr Bryan

results presented to me were accurate or not since I had only just taken up my appointment. I was also aware at the time that there was considerable concern being expressed by a number of senior colleagues including Professor Angelini, Professor Prys-Roberts, Professor Farndon and Dr Monk. I have subsequently learned from Mr Wisheart that some of this data, in particular that relating to VSD, was incorrect.'[48]

47 Dr Bolsin said that, in September 1993, he spoke to Professor Angelini regarding the data which had been collected. Dr Bolsin said that he did this because:

'… I discussed it with Andy Black and we both felt that the peculiar sensitivity of the surgeons may have been related to the fact that there is, as you may or may not know in medicine, rivalry between specialist groups. There is a particular rivalry between surgery and anaesthesia because probably they work so closely together. Surgeons do not like to be told what to do by anaesthetists and anaesthetists do not like to be told what to do by surgeons and it is legendary and it exists.'[49]

48 In his written evidence to the Inquiry, Dr Monk stated that:

'After a number of personal requests, SB [Dr Bolsin] brought his data to me in the Department of Anaesthesia, I believe in October 1993.'[50]

In his oral evidence, Dr Monk put the number of requests at three or four.[51]

49 Dr Monk said that he did not take the data to either Mr Wisheart or Mr Dhasmana because 'the audit I got was not verified',[52] but said that he: 'spoke to them both about my concerns'.

50 Dr Monk went on:

'I did not feel that it [the audit data] was strong enough, robust enough, that I could take it directly to Mr Wisheart and say: "Here you are", because I think that he would have raised points that I could not answer about: "How did the audit take place? How was it performed? What were your criteria for selecting these epochs?" Therefore, very quickly I would be unable to make the point I wished to make.

'… What I wanted was to produce a forum where initially the cardiac anaesthetists spoke about the data, and I asked Steve, and we discussed the need to present the data to the cardiac anaesthetists, and he appeared to agree with me, but we did not achieve it. We had meetings and Dr Bolsin did not come …'[53]

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48 WIT 0081 0023 – 0024 Mr Bryan
49 T82 p. 132 Dr Bolsin
50 WIT 0105 0020 Dr Monk
51 T73 p. 115 Dr Monk
52 T73 p. 119 Dr Monk
53 T73 p. 120–1 Dr Monk

51 Dr Bolsin was asked in the following exchange about presenting his data to colleagues:

> 'Q. … did he [Dr Monk] or did he not suggest to you that it would be appropriate to present your data to a meeting of the anaesthetists?
>
> 'A. I do not think so because if he had said that I would have prepared overheads and I would have been prepared to go to a meeting that anybody arranged.
>
> 'Q. He has suggested that there were meetings and you did not come.
>
> 'A. What sort of meetings has he suggested they were?
>
> 'Q. He is talking about meetings of the anaesthetists, as I understand his evidence. I have read you out the passage and you will have to rely on that.
>
> 'A. Yes, I mean they were not formal meetings. Certainly I never received a request to present this data to the paediatric cardiac anaesthetists.'[54]

52 Dr Bolsin was asked:

> 'Q. Do we leave it like this; you had data in a form which could have been appropriately discussed at a meeting. That, as it happens, you did not take any initiative to go to a meeting of anaesthetists to discuss it?
>
> 'A. Yes, I think that is a fair summary.'[55]

53 Professor Angelini told the Inquiry that in November 1993 he had talked to Mr Jaroslav Stark, Consultant Cardiothoracic Surgeon at Great Ormond Street Hospital, (amongst others) about the data which Dr Bolsin had given him:

> 'Q. … Did you compare the data that Dr Bolsin had given you with the returns to the cardiothoracic register?
>
> 'A. No. I cannot remember if I did. Probably I did not.
>
> 'Q. Could you have done so?
>
> 'A. Yes, I could, but I did something even better than that.

54 T82 p. 128 Dr Bolsin
55 T82 p. 131 Dr Bolsin

'Q. Which was what?

'A. I went to see Mr Stark at Great Ormond Street because I was aware of the fact that Mr Stark had information on what the performance of various units in the country were, and this was for two reasons: (1) because somehow he had been part of some government panel; (2) because he had recently given a speech at the European Association of Cardiothoracic Surgeons. He was the honorary guest of the President, where he had presented data, albeit anonymous, on cardiac surgery in the United Kingdom and he had specifically pointed out how centres which were not doing enough cases had worse performance and so forth. So he really was the person, in my view, who knew everything of what was going on in the UK in paediatric cardiac surgery.

'Q. So you went to see Mr Stark at Great Ormond Street?

'A. Yes.

'Q. I think you said at the GMC that that was in November 1993?

'A. Yes, that is correct, 17th November, something like that.

'Q. Did you actually physically show him the data Dr Bolsin had shown you?

'A. No, I did not.

'Q. Why not?

'A. First of all because I did not think it was fair to take stuff which in a way had been given to me in a sort of confidential matter, and also because I knew that Mr Stark was fully informed of what was going on. He had pictures of information of all the United Kingdom data.

'Q. You said that this data had been given to you in a confidential matter?

'A. Yes. I mean, "confidential"; "do not take it out of your own institution and show it to everybody". … Incidentally, even at a later stage I was accused of having done this.

'Q. How did you know how confidential the data was that Dr Bolsin gave you?

'A. I mean, I guess it was relatively confidential because if it had been given to 5 or 6 people, I do not know, how can you describe "confidential"? But I thought that it was really not appropriate at that stage to take it out of what was our institution. I had gone to see Mr Stark to ask advice from a senior paediatric cardiac surgeon who was well informed of what was going on nationally on how I should act, if anything, in trying to resolve this problem.

'Q. Did you discuss with Dr Bolsin how secret this data was?

'A. No.

'Q. Did you tell Dr Bolsin you were going to see Mr Stark?

'A. I do not think I did until I came back. When I came back, I told Dr Bolsin and I told Professor Farndon, and my senior lecturer, Mr Bryan.

'Q. What did Mr Stark say?

'A. The conversation took place in his office and effectively I said to him that I have come to him for some advice as a senior person, since he was a very senior person in the business. I said that there had been data suggesting that the mortality was high. Also, my perception, after having spent a year in Bristol by that time, was that mortality and morbidity was a much different story to what I was accustomed to. He said that he was aware of those problems. Indeed, he showed me some of the slides which he had presented at the European meeting, saying "You are not telling me anything new because I have done an analysis" and demonstrated that centres which do not do a great volume of work, like Bristol, will have worse results than specialised centres which do a lot more operations. We discussed these aspects, after which I said to him, "What would you advise? You are a senior man, what would you advise me to do?" He said he thought the best way would have been for me to go back to Bristol, to my head of department —

'Q. Who was?

'A. – the Professor of Surgery, Professor Farndon, and in a way present him with the problem, telling him I had discussed things with Mr Stark, and he said, "I am sure you can resolve this matter in-house. Failing that, you may have to ask for some external help." There were some other issues discussed —

'Q. Just pause there a minute. What did you understand by "external help"?

'A. I mean somebody senior like Mr Stark coming in and having a look at what we were doing.

'Q. Did he mention anything about sending patients from Bristol to Great Ormond Street in the meantime?

'A. No. What he said, I think, it was that if we have a problem with a patient that needed urgent treatment, certainly this could have been done at the GOS.

'Q. Did he mention the ability of clinicians in Bristol to go with those patients to GOS?

'A. I think he said that, also because in the case of Mr Dhasmana, he had already worked for a year at the GOS.'[56]

54 Mr Stark, in a written comment on Professor Angelini's written evidence, stated:

'I do remeber [*sic*] meeting with Prof Angelini. He came to see me at GOS to discuss Congenital Heart Surgery at Bristol. I do not recall the exact date

'It is correct, that I did not offer formal retraining for the Bristol team. Retraining as such was not organised by the Colleges nor by the Sociaty [*sic*] of Cardiothoracic Surgery at that time. Although today there is much talk about retraining, the practical aspects of retraining have not been worked out yet.

'I do recall that I have suggested that my coleagues [*sic*] and myself would be happy to operate [on] children with the diagnoses, with which the Bristol team was experiencing problems. I have mentioned, that if they decided to send some patients to us, the surgeons or any other member of the team would be most welcome to come with the patient to see the way how we handled such problems at GOS.'[57]

55 Professor Angelini responded to Mr Stark's comment in the following exchange:

'A. … What he did not mention – I am sorry, what we did not discuss – I have not seen this yet, I am seeing it now. What we did not discuss, which was highlighted at the GMC trial, was the fact that he never offered to retrain people and I stand to what I said: there was never any offer from him to retrain people. What he said is correct —

'Q. Have a look at the previous paragraph, Professor, that may help.

'A. "It is correct that I did not offer formal retraining", yes, that is right, I am glad he said that.

'Q. So are you and Mr Stark on the same wavelength?

'A. I think so, yes. I do not have any problem with this.

56 T61 p. 73–7 Professor Angelini
57 WIT 0073 0111 Mr Stark

'Q. The suggestion that patients and clinicians might go to Great Ormond Street, that Mr Stark made to you, to whom did you communicate that offer in Bristol?

'A. To Professor Farndon, but if you read this through, this does not mean the surgeons go there and they do the operation. The surgeon and their staff go there and see what the people in the GOS do, which to a certain extent is the same that happened when Mr Dhasmana and some other member of the surgical team went to Birmingham.

'Q. All right, take it slowly. To whom did you communicate this suggestion?

'A. I think to Professor Farndon, but quite honestly, I do not know if I did.

'Q. You did not do it in writing, did you?

'A. No.

'Q. You did not communicate it to Mr Wisheart?

'A. No.

'Q. Mr Dhasmana?

'A. No.

'Q. Dr Roylance?

'A. No. I did not see any point in sending patients to the GOS with everybody going in and observing. Quite honestly, I do not think that would have helped Bristol in any way whatsoever.

'Q. But is it not the case that going to observe a centre that is a recognised centre of excellence can assist a surgeon to –

'A. Yes, that is correct.

'Q. – to retrain. For example Mr de Leval and the "Cluster of failures" and the Arterial Switch operation?

'A. Yes, but also what we say in surgery is "Watch, do it and teach it". Watching on its own is not a solution to the problem. You can take your registrar and ask him to help you on a million cases. The first time he does it, there will not be much difference if he helps you on a million cases or 100,000 cases. Therefore, what I am reading in this letter is that although they were prepared to take this patient in the interests of the children, they were not going to do anything to really retrain the people because they could not retrain the people.

'Q. So you had no faith in the ability of Great Ormond Street or anyone else to retrain the Bristol surgeons?

'A. No, I did not say that. To retrain people, you have to take these people, not just to watch. Training means you are standing on the side of the assistants and the trainee does the operation. That to me is training. Otherwise just watching by itself is not what I regard as training. That is part of the training, but it cannot be the whole training, if you are not allowed to do things at the first operating surgeon.

'Q. You took it upon yourself to sweep Mr Stark's offer under the carpet?

'A. I do not know what you mean.

'Q. You did not tell anybody about it?

'A. Fine. I made a mistake.

'Q. You accept that was a mistake?

'A. Absolutely.

'Q. Because did you consider Great Ormond Street to be a better centre than Bristol for paediatric cardiac surgery?

'A. Yes, absolutely, but I also considered that Birmingham was a much better centre, particularly for the Switch, than the GOS.

'Q. Later on we will see that you were suggesting, at the time of the Loveday operation, that if it was truly urgent, the case might be sent to Mr Brawn in Birmingham, for example?

'A. That is correct.

'Q. Is that right?

'A. Yes.

'Q. Might there not have been patients between your visit to Mr Stark in November 1993 and Joshua Loveday's operation in January 1995, who, in your opinion, would have benefited from being operated on elsewhere?

'A. Absolutely.

'Q. And Mr Stark's offer would have provided for that?

'A. Yes.

'Q. Would it not?

'A. Yes. Why did not I refer the offer? Very simple: because my main concern was to stop the surgery from taking place in Bristol, because in Bristol we were no good at this kind of surgery; therefore it should not have been carried out. I do not think that I was in any position to influence anybody's decision for these children to be sent to another institution because in fact, as demonstrated, even in the last Switch case, nobody gave a toss about what I was saying. Therefore, they were not listening.

'I accept with you that I should have related this particular information that Mr Stark had given to me to the surgeon and to the cardiologists, and it was a mistake on my part not having done so.

'Q. This is not a case of not listening, this is a case of not hearing because you were not telling them?

'A. In this case, that is correct.'[58]

56 On 16 November 1993 Dr Bolsin went, by appointment, to see Professor Vann Jones who had become the first Clinical Director of the newly created Directorate of Cardiac Services in the preceding month.[59] Professor Vann Jones described his meeting with Dr Bolsin as follows:

'Dr Bolsin came to my office on 16th November 1993 … He showed me results from four different types of operations carried out on children [in the BRI]. They were four specific operations and the point that he was trying to make was that the performance [at the BRI] was well below the national average for these conditions. One of these conditions was ventricular septal defect which is a relatively simple congenital defect and, because of my background ten years earlier in paediatric cardiology, I could tell that the data for that particular operation must have been flawed. A very high mortality was reported for a very low risk procedure and it just could not have been possible that these data were true. I expressed my concern about this to Dr Bolsin and asked him to go away and check his figures. Obviously, this led me to doubt the validity of the data on the other three operations. Dr Bolsin did not seem to me to be particularly concerned and the data were presented in a very matter of fact way. However, because I was convinced, at least, one set of data was flawed I expected him to go away, check the figures and to return. He never did return.'[60]

58 T61 p. 78–82 Professor Angelini
59 WIT 0115 0002; Professor Vann Jones stated that he regarded himself as responsible for an adult, rather than a paediatric, service
60 WIT 0115 0019 Professor Vann Jones. See Chapter 3 for an explanation of clinical terms

57 Professor Vann Jones was asked about his reaction to the results:

> 'We have to envisage the situation in which I found myself. At that stage I had 12 years of very good service from Mr Wisheart, and from Mr Dhasmana, although not so many years. For many years these chaps operated on some extremely sick patients of mine, and the patients survived, the patients did well and were very grateful, and so was I. In front of me was a set of figures which said three operations were worse than the national average, one was not significantly different, and one I could see was blatantly flawed, so I actually wanted some further clarification of this information … .'[61]

58 Professor Vann Jones was asked further about the meeting with Dr Bolsin in the following exchange:

> 'A. It was a totally amicable meeting. It is absolutely right that people should express concerns about the management of cases. That is what they are all there for. Our job is to look after patients in the best possible way. So it was a perfectly amicable meeting. I was somewhat worried about the Tetralogy of Fallot figures. I was hoping he was a bit worried about the VSD figures, but I have to say, it was only four operations, one was not significantly different. Three were and one set of results was obviously quite wrong. I most definitely mentioned that to him, but just how strongly or what message he got from it, I do not know. I think if you are taking sets of figures around and someone actually questions the validity, and it is a very, very important issue you are raising – I mean, we all know how important it is now – I think the least you should do is go and make sure you have your facts right. And I did expect him to come back and he did not.
>
> 'Q. What did Dr Bolsin ask you to do, if anything?
>
> 'A. He asked me to do absolutely nothing. He purely and simply said "Look at these tables, John. I think this is worrying." That was it.
>
> 'Q. Did he suggest that any particular action needed to be taken on those figures?
>
> 'A. No.
>
> 'Q. Because again, his account is that he explained to you that this was as thorough and as complete an audit as he could carry out, and that he believed that there needed to be a full investigation into the paediatric cardiac surgery service on the basis of the figures that you were given?
>
> 'A. Well, I have no recall of him being anything like as positive as that.

[61] T59 p. 107 Professor Vann Jones

'Q. What was his manner to you, as you recollect it?

'A. As I have already indicated, it was a very bland, no sense of urgency type meeting that we had that morning. He presented those very sheets of A4, we talked around them for an hour, but there was no question of "This is a national tragedy brewing, John", absolutely nothing of that. There was a concern about some of these operations and it was expressed at that sort of level, no emotions involved, no tears, such as has happened subsequently.

'Q. Does it need emotions or tears to translate the sort of figures that you are being given into the proposition that children's lives were being unnecessarily endangered?

'A. No, it does not, but you have to remember that if you are talking about 4 per cent of the paediatric cardiac programme, and we are talking about a very small percentage of the cases, then I would want to have seen the whole picture. If the whole picture was one of uniform, you know, worse performance, then that obviously would have been a very, very major cause for concern, but I have not the slightest doubt that had people taken my angioplasty results for 1985, let us say, and compared them with elsewhere, I may well have looked worse than Southampton and I may well have been worse for two vessel disease than for single vessel disease. We all have runs of procedures where we get to the stage where we think we cannot do them any more, and have bad runs. In paediatric cardiology, in particular, the investigations are very complicated.'[62]

59 Dr Bolsin in his written evidence to the Inquiry described the meeting as follows:

'Professor Vann Jones did not ask me to return having checked the figures. I explained that this was as thorough and complete an audit as we could carry out and that I believed there needed to be a full investigation into the paediatric cardiac surgery service on the basis of the figures I gave to him that morning.'[63]

60 Dr Bolsin stated that he had approached Professor Vann Jones in his capacity as Director of Cardiac Services:

'I approached Prof Vann Jones as the new Director of Cardiac Services. I assumed that he had some control over the events in the Associate Directorate of cardiac surgery.'[64]

62 T59 p. 115–18 Professor Vann Jones. See Chapter 3 for an explanation of clinical terms
63 WIT 0115 0025 Dr Bolsin
64 WIT 0115 0025 Dr Bolsin

61 Professor Vann Jones stated:

> 'It was obvious from my conversation with Dr Bolsin … that he had shown these figures to a number of other more relevant people.'[65]

62 When asked why, in his view, Dr Bolsin came to see him, Professor Vann Jones said that he:

> '… would have expected to have been well down the pecking order of people that [Dr Bolsin] should have been reporting his concerns to … That may well have been erroneous … but why he should elect to come to an adult cardiologist who had been Clinical Director of a non-existent directorate for three weeks and regard me as an important player in this … .'[66]

63 He went on that he:

> 'Would have expected [Dr Bolsin] to at least have gone to his Chairman of Division of Anaesthesia.'[67]

64 Professor Vann Jones said that it was his understanding that Dr Bolsin had not approached the surgeons concerned, Mr Wisheart and Mr Dhasmana, with his data:

> 'I think [Dr Bolsin] owed the two surgeons a courtesy to say he had concerns about their performance. … I think you are obliged to go and discuss with people how they were performing … I would have thought if one consultant was really concerned with the performance of another two consultants, that he should go and say "I have serious concerns about this and I must go and raise the subject with the relevant parties". I think it would have been courtesy. Then we would not have people running about with different sets of figures and we could perhaps have sat down and got the whole thing clarified.'[68]

65 In his written evidence to the Inquiry, Professor Vann Jones stated that a day or two after Dr Bolsin went to see him, Mr Wisheart also came to visit him:

> 'He had quite a different set of figures and certainly as far as ventricular septal defects were concerned the figures he presented were much more what I would have expected.'[69]

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65 WIT 0115 0019 Professor Vann Jones
66 T59 p. 119 Professor Vann Jones
67 T59 p. 122 Professor Vann Jones
68 T59 p. 122–3 Professor Vann Jones
69 WIT 0115 0020 Professor Vann Jones

66 Mr Wisheart set out the reasons for his visit to Professor Vann Jones:

> 'A short time prior to my visit to Prof. Vann Jones, Prof. Dieppe[70] had come to see me in my office. Dr Bolsin had just been to see him and had expressed concerns about paediatric cardiac surgery which he [Professor Dieppe] came to discuss with me. I do not remember whether or not Prof. Dieppe mentioned any specific operations. He did not have, or mention to me, any actual figures, or give me any indication that audit figures existed …
>
> 'On reflection, I considered that if Dr Bolsin was expressing concerns to people in the Trust and the University, that Prof. Vann Jones, Clinical Director of Cardiac Services in which Directorate I did most of my work, should know and have the accurate results of paediatric cardiac surgery. Therefore I went to see him. I did not know that Dr Bolsin had already been to see him.
>
> 'Prof. Vann Jones did tell me that Dr Bolsin had been to see him but did not tell me about, or show me, any figures or audit. I continued in ignorance of the existence of Dr Bolsin's audit.'[71]

67 Professor Vann Jones expressed the view, after speaking to Mr Wisheart, that:

> 'At the end of the day, something as important as this should have been a matter that the Chief Executive should have attended to. I do not mean personally, but certainly he should have set in place some form of investigation.'[72]

Discussions with the Department of Health (DoH)

68 Dr Jane Ashwell, a Senior Medical Officer (SMO) at the DoH from 1991 to 1995, described in her written evidence to the Inquiry the contact she had with clinicians at the BRI:

> 'I then met Dr Bolsin at the Royal College of Anaesthetists, in what I believe was about December, 1993, although I have no record of that date. After the College meeting, he approached me on the steps of the College and asked me if he could discuss something privately. I have no written record of what was said and what follows is to the best of my recollection.
>
> 'He was concerned about the outcomes of cardiac surgery in a number of children at the BRI. He had anaesthetised some of them and he continued to have responsibility for future cases. I understood that he was talking to me as a professional colleague and one who had practised as an anaesthetist and would understand the difficult position he felt he was in, but also might have useful advice on what practical and procedural steps he could take.

70 Dean, Faculty of Medicine, University of Bristol
71 WIT 0115 0026 – 0027 Mr Wisheart
72 T59 p. 136–7 Professor Vann Jones

'Such approaches are not unusual for officials in the DoH. Any approach has to be considered and a judgement made about handling. In this case, I understood Dr Bolsin's enquiry to be confidential in the sense that I would not normally divulge what he said to others without his explicit agreement.

'This was the only occasion on which he sought advice on his concerns about paediatric cardiac surgery at the BRI.

'On the basis of what he told me, and with his agreement, I raised the issue with Professor Farndon, in his capacity as a Clinical Director in the BRI. I expressed my concern that issues over the quality of cardiac surgery had been raised with me and indicated that I thought that it should be addressed locally. I expected that the matter would then be investigated further.

'I confirmed in a letter to Dr Bolsin dated 13th December 1993 that I had spoken to Professor Farndon and had raised the issue, although I had not mentioned Dr Bolsin by name. I also enclosed what relevant Departmental guidance I found.

'Dr Bolsin replied on 10th February 1994, thanking me for what I had done and indicating that he thought there would be little benefit from further Departmental intervention. He said he was convinced that I had assisted in the resolution of the matter.

'Dr Bolsin did not speak to me again on this matter.'[73]

69 Dr Bolsin in his written evidence to the Inquiry stated that in his contact with Dr Ashwell he:

'… explained my concerns about the paediatric cardiac surgical unit at the Bristol Royal Infirmary and provided her [Dr Ashwell] with my provisional figures for the Bolsin/Black data collection and analysis. She agreed to review the data and then provide me with some advice in due course.

'I subsequently received a letter from Dr Jane Ashwell referring me to the GMC guidelines and the "three wise men" procedure. This letter confirmed that Dr Ashwell had been contacted the next day by Professor Farndon, who had expressed to her exactly the same concerns as I had expressed to her.'[74]

70 In her letter to Dr Bolsin dated 13 December 1993, Dr Ashwell wrote:

73 WIT 0338 0004 – 0005 Dr Ashwell
74 WIT 0080 0116 Dr Bolsin

> 'You spoke to me in confidence last Thursday. By complete coincidence John Farndon spoke of the same matter to me on Friday. I did not mention you. This letter includes what I expect you would receive, were you to write to the Chief Medical Officer.'[75]

71 In December 1993 Professor Farndon attended a meeting at which Dr Ashwell was also present, as an observer from the DoH. He stated:

> 'She approached me after the meeting to see if I could spare some time to talk to her … she raised with me a concern which had been expressed to her about performance in the paediatric cardiac surgery unit. At this stage, both Dr Ashwell and I were aware that statistics were being prepared by Dr Bolsin. I cannot remember the specifics of the conversation. In general terms we discussed the concerns that some people[76] had about paediatric cardiac surgery. Something was discussed about the mechanisms by which those concerns had arisen, and about the ways forward, to either substantiate or refute the concerns.'
>
> 'I took the meeting to be an informal one, in that we left one place and she wished to talk to me in confidence out of the venue of the previous meeting about some other concerns. I did not interpret this as an "official" Department of Health approach to me about any concerns in Bristol.'[77]

72 Professor Farndon was asked whether it was his recollection that he raised outcomes in paediatric cardiac surgery with Dr Ashwell or whether she raised the issue with him. Professor Farndon said:

> 'My recollection was that she raised it with me and invited me to walk around to another office block of the Elephant and Castle[78] to talk to me.'[79]

73 Professor Farndon told the Inquiry:

> 'I just found it strange and almost unreal that here was someone from the Department of Health, knowing about issues and talking to me after a meeting was complete when other business was being done, and I suppose one had to think, "Is the Department of Health knowing about this formally [or] informally? Is this a formal approach to me to do something about this? Am I still part of a process of trying to help this situation?"'[80]

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75 UBHT 0061 0265. The paper which Dr Ashwell enclosed with the letter was HC(90)9 *'Disciplinary Procedures for Hospital and Community Medical and Dental Staff'*, which can be found at WIT 0037 0079

76 Professor Farndon, when asked in the oral hearings to whom he was referring in this sentence, stated: 'People such as Professor Angelini. I am not sure, again, at what stage others spoke to me, whether people like Sheila Willatts or Cedric Prys-Roberts spoke to me around that time.' Counsel to the Inquiry suggested that Dr Bolsin might also be included in this list. Professor Farndon agreed. T69 p. 124

77 WIT 0087 0008 Professor Farndon

78 Department of Health, Hannibal House, Elephant and Castle, London

79 T69 p. 130 Professor Farndon

80 T69 p. 126 Professor Farndon

74 He went on:

> '… if there were a clear instruction that she had a concern, it was in her domain to have responsibility for clinical performance and that she knew, for example, that there was a problem in Bristol, if she wanted me to be part of that, and a clear signal had come to me from her that this was a responsibility she wanted me to take, I would take it very seriously.
>
> 'But as I say, this was admixed with a chat about other anaesthetic colleagues that she knew and I knew.'[81]

75 Professor Farndon was asked whether he thought it was his responsibility to take the matter forward in any way:

> '… every one of us is so burdened with our own responsibilities in our own domain, one hopes that one does not have to assume responsibilities from areas where there may be no area of expertise, no professional interaction whatsoever. And I felt up to that point that I had given advice as well as I could.'[82]

76 Professor Farndon explained that he had said:

> 'To Dr Bolsin and to Professor Angelini and to others who have said to me about the situation: "Talk together. Is there a problem? Is there not a problem?"'[83]

77 Professor Farndon also stated that he did not know what Dr Ashwell's role, as an SMO at the DoH, would have been in the resolution of any problem in paediatric cardiac surgery at the BRI.[84]

Late 1993

78 On 23 December 1993 Professor Angelini and Professor Farndon went to see Mr Wisheart. Professor Angelini told the Inquiry:

> '… the focus of the meeting was about the desirability of a new appointment of a consultant paediatric cardiac surgeon?'[85]

79 Professor Angelini later in his evidence said:

> '… The purpose of the meeting was first of all to express our concern; second, the appointment of the paediatric surgeon was the resolution to the concern. It was not the other way around.'[86]

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81 T69 p. 129 Professor Farndon
82 T69 p. 127 Professor Farndon
83 T69 p. 128 Professor Farndon
84 T69 p. 128 Professor Farndon
85 T61 p. 85 Professor Angelini
86 T61 p. 90 Professor Angelini

80 Professor Angelini was asked by Counsel to the Inquiry:

> 'Q. Was the data that you had seen from Dr Bolsin actually presented and discussed at that meeting?
>
> 'A. The data was sitting on the table between myself and Professor Farndon who were on one side facing Mr Wisheart. We did not go through in detail with the data … .'[87]

81 Professor Farndon described the subject matter of the meeting as: 'about the appointment of a paediatric cardiac surgeon.'[88] He was asked:

> 'Q. Was there any data from Dr Bolsin, or anyone else, about the outcomes of paediatric cardiac surgery at that meeting?
>
> 'A. Not that I remember.
>
> 'Q. Do you remember any discussion of any data?
>
> 'A. I do not. I remember that our meeting was amicable and proceeded well and it concerned the appointment of a paediatric cardiac surgeon.'[89]

82 In a comment on Professor Angelini's evidence, Mr Wisheart stated:

> 'This meeting took place on 23rd December 1993 for a short time at lunch time.
>
> 'The point of the meeting, as I recall it, was that Prof Angelini wished to create an appointment of a consultant paediatric cardiac surgeon and to do so as a Consultant Senior Lecturer within his department. Although I too, wished to appoint a new paediatric cardiac surgeon, and we did so during the next year, I did not feel that this was the best way to go about it.
>
> 'There was no reference to any specific figure or to Dr Bolsin's audit; there was no presentation of any figures.'[90]

83 Professor Angelini, when asked about Mr Wisheart's comment, indicated that he 'stood by' his description of the meeting. [91]

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87 T61 p. 85 Professor Angelini
88 T69 p. 148 Professor Farndon
89 T69 p. 150 Professor Farndon
90 WIT 0073 0104 Mr Wisheart
91 T61 p. 92 Professor Angelini

84 Professor Peter Keen, Dean of the Faculty of Medicine from 1993 to 1995, in his written evidence to the Inquiry, stated:

> '… in late 1993 Professor Angelini expressed his serious concerns about the standards of paediatric cardiac surgery … we agreed that while this was a matter of concern it would not be appropriate for me as Dean to become involved and that Professor Angelini would take the matter forward.'[92]

85 Dr Sheila Willatts stated in her written evidence to the Inquiry that she had 'prolonged discussions'[93] with Dr Bolsin in 1993 and in 1994. She stated that she advised:

> 'the issue was principally an audit one, namely that the results needed to be scrutinised, validated and agreed. During 1993 and 1994 I spoke to Professor Prys-Roberts, Professor Farndon and Chris Monk expressing my concerns that the data needed to be verified … Professor Farndon volunteered his services as a potential chairman for such a meeting as he was not a cardiac surgeon.'[94]

Report of the performance of the PCS Service in 1993

86 No Annual Report or figures were produced by the Unit in 1993. The Unit's return to the UK Cardiac Surgical Register (UKCSR) showed figures for open-heart surgery:[95]

Operations – Over-1s	Operations – Under-1s
94 (3)	53 (8)

87 There was no record of the Unit having received or considered the 1992/93 figures from the UKCSR, but when the figures for 1993/94 were available (in mid to late 1994) they showed overall mortality in the under-1 group as being 10.5%, and that for the over-1s as being 5.4%.[96] The figures were available from the UKCSR for 1992/93. These record that, for the year 1992, mortality in the UK in the under-1 age group was 14%, and in the over-1 age group was 5.4%.[97]

92 WIT 0413 0001 Professor Keen
93 WIT 0343 0002 Dr Willatts
94 WIT 0343 0002 Dr Willatts
95 Figures taken from UBHT 0055 0221; report to the UK Cardiac Surgical Register for 1992–1993; figures in parentheses are for deaths
96 Figures taken from UBHT 0055 0377; Unit return to the UK Cardiac Surgical Register 1993
97 Figures taken from UBHT 0055 0377; Unit return to the UK Cardiac Surgical Register 1993

Chapter 29 – Concerns 1994

Concerns

January

1 During the latter part of 1993, Dr Alison Hayes, a consultant paediatric cardiologist at Bristol Royal Hospital for Sick Children (BRHSC) from October 1993, had been asked by those in the paediatric cardiac mortality meeting to collate the figures for the Arterial Switch operation. Dr Stephen Pryn, a consultant in anaesthesia and intensive care at the BRI from August 1993, was also asked, by his Clinical Director,[1] to prepare figures on paediatric cardiac outcome data, which he did for the chronological year ending 31 December 1993.[2]

2 It was planned that Dr Alison Hayes would present the data, and that Mr Dhasmana would speak about them, at a meeting on 20 January 1994. At the meeting were a number of anaesthetists: Dr Davies, Dr Pryn, Dr Underwood, Dr Masey, Dr Bolsin and Dr Monk; surgeons: Mr Wisheart, Mr Bryan, and Mr Hutter; and cardiologists: Dr Hayes and Dr Martin.[3] The meeting was held in the seminar room of the Department of Cardiac Surgery on Level 7 of the BRI. In the event, Mr Dhasmana did not attend the meeting,[4] Dr Hayes did not produce data, Dr Pryn presented some figures and Mr Wisheart presented from memory figures for the previous year.[5]

3 Various witnesses described the meeting. Dr Monk, in his oral evidence to the Inquiry, stated that the meeting arose:

> ' … because Professor Angelini and I were discussing how we would create a forum for the issues and problems of data to be discussed … I suspect that the actual timing and venue of the meeting came from the Professor's office … that … would have been ... because Professor Angelini felt that the issues that they talked about in bringing forward the figures on the paediatric cardiac service had not achieved what he wanted, he, and I, may have said, "Then we must try a different route and we will have a meeting in Level 7 of all the cardiologists, surgeons and anaesthetists, and get the figures presented". So it may have been that the January meeting was a direct consequence of Professor Angelini's feelings that enough had not been achieved between the meeting of these three surgeons [Mr Wisheart, Professor Farndon and Professor Angelini].'[6]

1 Dr Monk
2 WIT 0341 0041 Dr Pryn
3 It is not clear whether Dr Joffe attended
4 Mr Dhasmana was operating at the time
5 T92 p. 6 Mr Wisheart
6 T73 p. 127–9 Dr Monk

4 Dr Monk described the meeting further in the following exchange:

> 'A. There was no agenda produced and, as I noted, there was no Chair of the meeting … I realise that was one of the reasons that the meeting was not as effective as it should have been. … If [Mr Dhasmana] had been there, he would have chaired the meeting … My understanding of the meeting was that it would give an opportunity for the surgeons to present their paediatric data and an opportunity for Dr Bolsin to raise his data and that afterwards we could try and find a way forward to get these two groups, or parties, together and that we could resolve the differences that occurred. … The issue that I thought was going to be addressed was the overall performance …
>
> 'Q. So is it your view, having been at the meeting, that the cardiac surgeons had some idea as to why they were there?
>
> 'A. I would have that view, yes.
>
> 'Q. Why do you think Mr Wisheart thought that he was there?
>
> 'A. I think because Mr Wisheart expected that he was going to present his data and he duly did.
>
> 'Q. Your perception from the time, please: why would it be that he should think he was being called upon as an unusual step in this ad hoc specially convened meeting to present his data?
>
> 'A. Because of the concerns that had been raised about the performance of the Unit. …
>
> 'Q. … from where would [Mr Wisheart] have understood … the impetus for the meeting to have come?
>
> 'A. I would think that because Professor Angelini had discussed the meeting; it may well have come from him that he was activating the surgical group and I was bringing in the anaesthetic group.
>
> 'Q. So this may well be a case … of the cardiac surgeon knowing that the anaesthetists were raising concerns about the performance of cardiac surgery?
>
> 'A. It could be an instance or circumstance, yes.'[7]

[7] T73 p. 129–32 Dr Monk

5 Dr Monk was questioned further about the meeting in the following exchange:

'Q. When you spoke … to the anaesthetists to get them there … did you tell them what was on the agenda?

'A. There was no agenda. But I think we would have discussed the fact that this was an opportunity to discuss the data, or the lack of agreed data. But we were still, at that time, trying to produce an environment where people could talk about the differences of data and we could find a way forward. To do that, it had to be presented.

'Q. This would have been a perfect opportunity, one suspects, for Dr Bolsin, had he thought his data presentable, to present his data.

'A. The whole point of the meeting was for the data to be presented. It seemed to me to be a time at which it could be presented, yes.

'Q. And for Dr Pryn to present the results of the work that he had been doing at your request up until then?

'A. I think that Dr Pryn … may not have had adequate time to produce the data in a form that was useful. I think his data was lost to discussion … because it did not match the format of the data that Mr Wisheart presented on a blackboard from memory. …

'Q. And somehow Mr Wisheart begins the discussion, does he, by putting the figures on the board?

'A. Within that meeting, James Wisheart presented his data from memory, or the Unit's data from memory, on the blackboard. If I recall correctly, he had expected that Mr Dhasmana would be there because Mr Dhasmana had been collating data. So what you have are a number of threads which are all happening simultaneously, that we had hoped, or I had hoped, would come together at that meeting. … There was some discussion [about Mr Wisheart's data], but the point of the meeting was to hear another side and to look at it in a constructive way. From that point of view, the meeting did not succeed.

'Q. Why?

'A. Because there was not a Chair of the meeting and there was not an agenda. … it was done in a way which was not as clear as I would like to have done it if I did it tomorrow, then the meeting was already flawed. … Dr Bolsin … did not present his data. … Dr Bolsin played a very minor role, if any at all.

'Q. Dr Pryn raised, did he, some of the figures that he had collated, and then fell into an argument as to whether he should have divided it between particular age groups?

'A. One of the issues that is very hard to deal with when you are looking at retrospective data, particularly in this field, is that the definition of the operation, the diagnosis of the operation, what epoch or age group you define them in, varies. Indeed, it even varies from the point whether you do it from January 1st, December 31st or whether you do it for a financial year. Whereas it seemed sensible for me to do it for a calendar year, in fact the data given centrally is for a financial year. In fact Dr Pryn discovered, to the cost of his data, that the way in which he presented it did not quite accord with the way other people were thinking and therefore, rightly or wrongly, it was dismissed as being inaccurate. But that was the atmosphere at that time, which was difficult, and his data was not in the correct format and he was unable to get his message across.

'Q. So the atmosphere was difficult?

'A. The atmosphere, as people have discussed, is where people were aware of criticisms, so it was a difficult meeting.'[8]

6 Dr Monk continued in the following exchange:

'Dr Pryn was not successful in putting forward his data.

'Q. And Mr Wisheart's was therefore the only data effectively presented to the meeting?

'A. Yes.

'Q. Did that show an acceptable picture of paediatric cardiac surgery in Bristol at the time?

'A. The determination of "acceptable" is very difficult, because we did not have a standard to say "that is acceptable" or "that is not acceptable". If we had a standard that was UK-wide and it said "you can accept this level of mortality or this level of morbidity" and you cross it, you can say it is unacceptable. You are talking about a judgment that is being made in the middle of the experience. So that is one of the cruxes of the whole problem.

8 T73 p. 132–6 Dr Monk

'Q. Let me approach it this way: was there any challenge to the accuracy of the data that he produced, leave aside their interpretation?

'A. Mr Wisheart's data was not challenged from the floor. … You recall from these meetings the impact and what your actions were going to be afterwards, and I had great frustration because what I had hoped to achieve was that other data was presented and then you could say "We need to go forward and have an audit that looks at our work …" When you have got that, we can sit down and talk about it and we can truly analyse the problem. We needed to try and bring everyone together.

'Q. Do you think, looking back on it, that perhaps part of the problem was that there had been insufficient time for preparation before the meeting, for those who might have presented rival data to get their tackle in order to present it?

'A. There are many things that should have been in place before that meeting, one of which was a joint opinion of the cardiac anaesthetists so we could say "This is what we as a group say". It would have been helpful if we had put an agenda on the table with a Chair to run the meeting, but we had not done it. The meeting happened in a very Latin way, as it were, in that Professor Angelini and I still recognised there was a problem and we had an idea, and we thought "Let us go and do it". It developed an impetus of its own. Yes, looking back, I should have, somebody should have, been more structured in the meeting, and because it was not structured the point you are making was not achieved.[9]

7 Dr Pryn, in his written evidence to the Inquiry, described the meeting as a regular audit meeting. He stated:

'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

9 T73 p. 139–41 Dr Monk

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.'[10]

8 Later, Dr Pryn told the Inquiry that:

'… it probably was not a regular meeting, because Sally Masey[11] would not have been there if it was a regular audit meeting.'[12]

9 Dr Pryn described further his understanding and recollection of the meeting in the following exchange:

'A. I thought we were going to talk about the recent results.

'Q. Dr Bolsin's data was not presented to that meeting?

'A. No. … It would have been a good opportunity to present it. It would have been a good opportunity to present my data, but I did not know the meeting was called for that purpose and my data was not ready. If I had been told a few days before, I might have been able to get it ready.

'Q. So what warning did you have of the meeting?

'A. It cannot have been that much, otherwise I would have made a big attempt to complete my data. …

'Q. You do say your data was not comparable because it covered a calendar year, whereas the other one, Mr Wisheart's, was covering a financial year?

'A. His would not have been as up-to-date as mine, because basically I had cases on my list who were still in the intensive care ward; they had only just been operated on, so there were some outcomes we did not know yet.'[13]

10 Dr Pryn's oral evidence to the Inquiry included this:

'Q. He [Dr Monk][14] says at the meeting there was no effective Chair. What is your comment on that?

'A. I think that is true. I think somebody at the back said "James, can you present your data?" and he got up and presented it, but nobody was questioning him on that data and nobody was chairing the meeting to bring in other people's comments and discussions.'[15]

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10 WIT 0341 0041 Dr Pryn. See Chapter 3 for an explanation of clinical terms
11 Consultant anaesthetist
12 T72 p. 144 Dr Pryn
13 T72 p. 145–6 Dr Pryn
14 WIT 0105 0022 Dr Monk
15 T72 p. 146–7 Dr Pryn

11 Dr Pryn expressed the following view about Mr Dhasmana's absence from the meeting:

> 'I would have thought it was really important for him to play a part …'[16]

12 The pattern of the meeting, as seen by Dr Pryn, emerged from the following exchange:

> 'Q. It says here that the main data presented was presented by Mr Wisheart on a blackboard, or a whiteboard, and then it suggests there was something from you: some of the most recent data available on the 1993 operations. Does that overstate the nature of your contribution?
>
> 'A. I think it does, a little bit. Whilst Mr Wisheart was presenting his data, I was looking down through my very rough workings and was trying to count in my mind. I particularly chose the AV canals, because I think Mr Wisheart had said, "Here are the realities for the AV canals; they are not good but they are tolerable", and I wanted to cross-check that with my data. So I was counting the AV canals and I got a little confused between children who were aged over 1 and under 1, and at the end I made some comment about, I do not know, mortality in children with an AV canal over 1, and both Mr Wisheart and Alison Hayes, the cardiologist, actually said to me, "Your data must be rubbish because we do not do AV canals in the over 1s". So that was it. So I sat down again: basically, I had not prepared for a presentation. I was not in a state to do it. So I got what was coming [to] me.
>
> 'Q. Can you remember whether Mr Wisheart's figures covered the range of operations and procedures within the BRI, or whether it was related to one or two procedures only?
>
> 'A. No, I believe that he covered the entire range, which is what impressed me, because it all came off from memory and he could write down all these figures, even for tiny groups. He must have known the figures particularly well to do that.
>
> 'Q. If we go on back to [Dr Monk's] statement: "The meeting resolved little as there was not a frank discussion on outcome, and I believe it did more to consolidate difficulties and differences than start a process to address the problems". What do you have to say about that commentary?
>
> 'A. I think there you come down to the problem that I think Mr Bryan highlighted, where difficulties were often explained away by poor cases such that when Mr Wisheart presented his data, it was all in small subsets of procedures or diagnoses, and it was difficult to see the overall picture of the Unit performing poorly for small children. So the conclusion that Mr Wisheart drew and that we all came away from the meeting with was that "Bristol is not brilliant, but some things

[16] T72 p. 147 Dr Pryn

are quite good; other things are okay; some things are pretty poor, but you know, that is the way all units are and we are no worse than any other unit".

'Q. Which things were pretty poor?

'A. I cannot remember the specifics, but I would have imagined he may well have drawn AV canals, saying they are not good, because that is why I was looking through AV canals.

'Q. Would the Switch operation have featured in discussion?

'A. It may well have done, but I am not sure whether he presented it as a Switch or just mixed the Switches up with Atrial Switches and just had them in diagnostic categories as opposed to operative categories. I cannot remember how he presented his data. In fact, there was no hard copy for us to take away from that meeting.'[17]

13 Dr Bolsin gave his account of the meeting in the following exchange:

'Q. … At that meeting, Mr Dhasmana is supposed to present the results of the Unit but he is operating so he does not?

'A. Yes.

'Q. And the meeting is there. Everyone goes to Level 7. That is unusual, is it?

'A. Yes.

'Q. So there was particular interest in the results?

'A. Yes.

'Q. Particular interest by you, because you had been carrying out your work with Dr Black and you had shown that to some of your anaesthetic colleagues?

'A. Yes. …

'Q. So here was Mr Wisheart coming forward, presenting the results of [the] Fontan operation?

'A. Yes. … I can remember a few figures being put up on what I think was a whiteboard, but I am not sure there was an enormous amount of discussion.

[17] T72 p. 147–50 Dr Pryn. See Chapter 3 for an explanation of clinical terms

'Q. And open to you, had you wished, to say, "Look, we, the anaesthetists, have a bit of concern about the overall outcomes. Can we have a fuller review? We were going to review the figures here today. We have not had them because Mr Dhasmana is elsewhere, can we be circulated because we are concerned from individual experiences that something may need to be improved"?

'A. Yes. … I specifically did not have any concerns about the Fontan procedure, because we had audited the Fontan procedure.

'Q. But the purpose of the meeting would be to look at the results generally?

'A. Yes.

'Q. If you had a general concern, which you say you did … why not raise it at that meeting in some appropriate terms?

'A. I think I was still expecting concerns about results to be raised directly with the surgeons by those people who were empowered to do so, and that was really the Clinical Director and possibly Professor Angelini. …

'Q. … is it right that you understood at the time of this meeting, 20th January 1994, that Chris Monk was calling you and your activities "trouble"?

'A. I think probably for me to say that definitely at this time that had been said may not be true, but certainly, I was aware of a groundswell within the department or possibly the organisation that this was seen as troublesome activity. …

'Q. … if you had felt free in 1991 to raise the issue, after the 1990 events, to raise the vigilance of the anaesthetists and drawing attention to the mortality figures and so on, put your head above the parapet, as it were, then why did you not do it at this meeting here in January? …

'A. … There were also two very different meetings. I think the meeting in 1991, at which I had been prepared to say that the "vigilance of the anaesthetists" was something sitting in an armchair, much more informal. I think in a formal meeting, such as the one on Level 7, I was much less prepared to raise formal criticisms of the paediatric cardiac surgery mortality … Saying this indicated the vigilance of the anaesthetists in keeping their morbidity and mortality data is not the same as raising a service problem of mortality in that unit in a formal setting. …

'Q. So you had a feeling, at this stage, that if you had pushed the issue — let us suppose that you had said something at the meeting of 20th January 1994 … to the effect, "This data is disturbing, we must do something about it and I propose X and Y"? …

'A. I am not sure I would not have had support. I would have been worried about the consequences from other people.

'Q. Both Dr Pryn and Dr Monk seem to recollect that at this meeting, 20th January 1994, it was not just the Fontan results which were presented, that in fact the results for the Unit were presented, even though they might not have been presented as Mr Dhasmana might have wished. Are they right or are they wrong about that?

'A. As I remember the Fontan results, I do not remember the whole results of the Unit.

'Q. Might they have been presented?

'A. It is possible, but I just remember Mr Wisheart standing and writing figures down, and I think it would have been almost impossible for him to have written down all the results of the Unit.

'Q. Had you wished, and had you not felt vulnerable as a result of the influences you told us of, you could, I take it, have presented the data?

'A. Yes, I could if I had wished.

'Q. And if you had done, you would have urged the meeting to carry out a full and thorough review?

'A. Yes. I think my hope was that this meeting was going to be the full and thorough review that we had been aiming at for a long time, so to a certain extent, although it had taken a long time and we had had our data for about two years, my hope was that by going around the various routes that we had gone to, we had actually now achieved the full and open review that certainly I, and I think Andy [Black] working with me, had always wanted. So I expected at this meeting on 20th January, it was actually the goal, the destination that our data was the signpost towards.

'Q. Did you contribute to the meeting at all?

'A. No, I was very disappointed that we were not at this destination.

'Q. So you have a very disappointing meeting on 20th January?

'A. Yes, in terms of data, yes.'[18]

[18] T82 p. 158–72 Dr Bolsin. See Chapter 3 for an explanation of clinical terms

14 Mr Dhasmana gave his view of the meeting in the following exchange:

> 'Q. … it had been intended that you would present the results, the annual results?
>
> 'A. No, that is wrong. That [meeting of 20 January 1994] was an extraordinary meeting, a paediatric cardiac club meeting, not an audit meeting of the department, because I had already presented my yearly audit figure in December 1993, but this was called because I had stopped my neonatal Switch in October 1993. Dr Alison Hayes was asked to have the data prepared …'[19]

15 Mr Dhasmana's evidence also included this:

> 'Q. … The meeting … was a meeting for you to present results, particularly in relation to Switch, you say?
>
> 'A. It was not just for me, really. It was for Dr Alison Hayes to present her figures on Arterial Switches and of course, I would be there in a way to present whatever I could really say on my behalf, but I was told "You are too much involved with this thing, let somebody else do the audit and you be there to answer whatever questions are there". So that is how it was. …
>
> 'Q. As it happens, you were not able to go because you had commitments elsewhere?
>
> 'A. Well, I was operating. I got held up so I started getting worried and I made enquiries, what is going to happen? I was quite shocked to find out Dr Alison Hayes had already presented that data during the first week of January in the Children's Hospital, one of these Monday morning meetings, and I was at that time on holiday to India. I returned only 15th/16th January, and she had presented just after the Christmas break. So that was already presented.
>
> 'Q. That would be to the cardiologists, would it?
>
> 'A. That would be the cardiologists, the cardiac surgeons, and I was told Dr Masey and Dr Underwood also …
>
> 'Q. Were you worried about the Arterial Switch?
>
> 'A. I stopped. That is why I stopped the neonatal Switch programme. …
>
> 'Q. So you had made your decision about that, so that was it?
>
> 'A. In a way I was not going to, but Dr Joffe said "Let Alison Hayes analyse this and find out if we learn anything more". She came back to almost the same type of

[19] T86 p. 145 Mr Dhasmana

answer which I already knew, that there was a higher percentage of coronary abnormality in the series and of course, you know — I think that is what I remember. I think she may have mentioned one or two other things, I am not sure.

'Q. But in any event, nothing in that to make you reconsider your decision?

'A. No …

'Q. … knowing that Alison Hayes had presented data to the cardiologists and surgeons earlier in January, knowing that Mr Wisheart had presented data to the meeting of 20th January … what need did you see to present any further data to the Unit?

'A. I did not.'[20]

16 Mr Dhasmana told the Inquiry that he had subsequently learned that:

'A. … Mr Wisheart presented what he had on last year's figures, and because he saw me preparing, I always thought that he knows and by that time, I would have thought that he also had a copy of my Unit's figures which I had already sent to the register [UKCSR[21]]. So he would have had the data for 1992/93, but I was quite surprised why he should be doing that, because I have already presented that, but this was a different forum. … I asked him what did they talk about, Arterial Switches and various things? Then he said that "The Arterial Switches were already discussed before as you know, but it was mentioned again in the meeting, and I presented what I could remember from your figure".'[22]

17 The overall effect of the meeting was explored by the Inquiry Chairman with Dr Pryn:

'Q. (The Chairman): … this is a meeting called by your Clinical Director. He said here in front of us that he believed it did more to consolidate difficulties than to start a process. I was just wondering about your reflection on whether that is particularly surprising. If you did not know about the meeting until just before it was called, you were not in a position to present proper data, not everybody who should have been there could have been there, and so on and so forth, no one is in the chair. If this is a meeting called to address what is deemed by some to be a serious matter, what was your view, did the meeting as it proceeded achieve anything like the objectives claimed for it?

'A. I did not know the objectives at the time, but in retrospect, it did not address the issue of whether there was a serious problem going on in Bristol at the time.

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20 T86 p. 149–53 Mr Dhasmana
21 UK Cardiac Surgical Register
22 T86 p. 150–1 Mr Dhasmana

'Q. (The Chairman): What does that tell you about organising meetings?

'A. Organising meetings with clinicians is phenomenally difficult, because we all have other commitments. It is very difficult during working hours. We often end up organising meetings in our free time in the evenings. That is just about the only way we can all get together. …'[23]

18 Dr Pryn went on in the following exchange with Counsel to the Inquiry:

'Q. So did anyone suggest that the results were not good enough, or needed dramatic or substantial improvement?

'A. I cannot recall it, unless Chris Monk spoke from the back and said "Mr Wisheart, there have been some concerns, can you tell us the most recent data that you have?". He may have done it like that.

'Q. But once Mr Wisheart presented the data, there was no comeback and argument with that, or conclusions?

'A. I think there might have been a discussion about some of the diagnostic groups, for instance, the Fallots, who had had some particularly poor outcomes in the years preceding, but I think the surgeons had changed their operative techniques and the results were a lot better. So there may have been some discussion about that sort of improvement, but not as a Unit as a whole.

'Q. Dr Monk talks about consolidation of difficulties and differences. What was the overall "temper" of the meeting?

'A. It is hard to tell that because I did not know what the objectives were at the time. It was amiable and professional. I felt somewhat humiliated because I had not prepared properly. It was a professional meeting.

'Q. Did Dr Bolsin speak at any point?

'A. Not that I recall.

'Q. If we go back to your statement, page 41,[24] you say there that after this meeting your audit was effectively abandoned?

'A. Yes, I put it to one side. I did not think it would be that useful, because I thought it would be very difficult to actually categorise the children and I realised that the surgeons were actually collecting this data anyway and were in a much better

[23] T72 p. 150–1 Dr Pryn
[24] WIT 0341 0041 Dr Pryn. See Chapter 3 for an explanation of clinical terms

position to do it, and I thought they were also presenting it regularly. So I did not think that my efforts would be particularly useful.'[25]

19 When asked by Counsel to the Inquiry about the approach that Dr Bolsin might have adopted, Dr Pryn said:

'I think he [Dr Bolsin] should, first of all, have presented it [his audit] to us, to the cardiac anaesthetists at a cardiac anaesthetic meeting, and we would all then have got an appreciation of its strengths and its weaknesses, and its meaning, and then, depending on the relative balance of strengths and weaknesses, I think we should have presented it at a joint audit meeting, and the one in January 1994 would have been a prime example when he could have done that.'[26]

February

20 Dr Bolsin replied to Dr Ashwell's, Senior Medical Officer, DoH, letter of 13 December 1993 on 10 February 1994.[27] He wrote:

'Thank you very much indeed for the letter you sent me immediately after the Audit Meeting at the Royal College of Anaesthetists last year. Professor Farndon, Professor Angelini and myself have made considerable progress with the matters of concern that we discussed. There is now in place a programme for the appointment of a new paediatric cardiac surgeon and a commitment from the highest levels of the Trust to improve and maintain performance. There would seem to be little benefit from any further investigation from your end at this stage although this should not be ruled out if words are not converted speedily into actions.

'I am most grateful to you for your intervention in this matter and I am convinced that you have significantly helped in the resolution of what was an unacceptable clinical practice.'[28]

21 Professor Angelini told the Inquiry that he began to raise concerns with Dr Roylance at about that time:

'Q. How many meetings did you have with Dr Roylance?

'A. I cannot recollect, but I guess at least two from the end of 1993 to March 1994 — at least two.

25 T72 p. 151–2 Dr Pryn
26 T72 p. 125 Dr Pryn
27 See Chapter 28
28 UBHT 0061 0270; letter dated 10 February 1994

'Q. Who was present at those?

'A. At the first one there was nobody except myself and Dr Roylance. At the second one there was Dr Monk and after that, there were several other meetings, but with many other people present, like all the cardiac surgeons; or another one, we had a meeting towards the August of 1994 with Mr McKinlay[29] in his office, Professor Farndon and myself, and Mr McKinlay called Dr Roylance in. So there were several meetings, but always with lots of other people involved.

'Q. Let us look at the period in the early months of 1994, shall we, before the letter that you and Professor Farndon wrote to Mr Durie?[30] Can we confine ourselves to the meeting between —

'A. I think there were definitely two meetings, one on my own and one in the presence of Dr Monk.

'Q. I think you told the GMC [General Medical Council] that you had at least two meetings on your own?

'A. I cannot remember. It may have been one or two. I do not have any evidence to support one or the other.

'Q. There is no written material evidencing what was discussed at any of these meetings; is that right?

'A. Correct.

'Q. No contemporaneous correspondence either from you or Dr Roylance?

'A. No… In fact the first letter I wrote on this matter was when Peter Durie asked me. Then I became very [aware] of the need to write a letter and I wished I had written twice as many.'[31]

March

22 On 3 March 1994 Dr Peter Wilde, a consultant cardiac radiologist at the BRI from 1982, distributed a discussion document, *'Echocardiography on The Cardiac Unit'*,[32] to Professor Angelini, Mr Wisheart, Mr Dhasmana, Mr Bryan, Mr Hutter, Dr Murphy, Dr Jones, Dr Monk and Dr Martin. In a covering letter he said:

'The system is certainly unsatisfactory at present and could potentially be very much better if we had an organised strategy. I feel sure that a high

29 Chairman, UBHT from July 1994 to November 1996
30 Mr Peter Durie was Chairman of the UBHT from April 1991–June 1994
31 T61 p. 97–8 Professor Angelini
32 UBHT 0146 0051 *'Echocardiography on The Cardiac Unit'*

quality supporting echo service would undoubtedly lead to improvements in cardiac outcomes.'[33]

23 In March 1994 Professor Angelini and Dr Monk had a meeting with Dr Roylance. Professor Angelini described the meeting in the following exchange:

'Q. Did you yourself ever actually tell Dr Roylance what data was available?

'A. Yes. He knew that Dr Bolsin had done this data collection.

'Q. Did you yourself —

'A. I said that. I am sure I said that.

'Q. Did you yourself ever tell Dr Roylance that there was data floating about from Dr Bolsin, or did you simply assume that he must have seen it?

'A. I honestly cannot say. If I say yes, I may be lying; if I say no, I may be lying too. I cannot recollect it.

'Q. You cannot confirm that you told Dr Roylance about this data from Dr Bolsin?

'A. No, I cannot, although the data was in my hands in Dr Roylance's office. I cannot remember the specific terms of the conversation.

'Q. So this was another meeting where the data was actually there?

'A. No, this was the meeting with Dr Monk. We both had the data.

'Q. But it was not shown specifically to Mr Roylance?

'A. No.

'Q. A bit like the meeting with Mr Wisheart earlier?

'A. Yes.'[34]

April

24 On 5 April 1994 Dr Monk, Mr Wisheart, Dr Bolsin and Professor Angelini went to dinner at Bistro 21, a restaurant in Bristol.

33 UBHT 0146 0050; letter from Dr Wilde dated 3 March 1994
34 T61 p. 108 Professor Angelini

25 Dr Monk in his written evidence to the Inquiry explained the background to the Bistro 21 dinner:

> 'In an attempt to depersonalise the continued differences in opinion over the P.C.S. [paediatric cardiac surgery] outcomes I spoke individually with JDW, SB [James Wisheart, Stephen Bolsin] and Professor G. Angelini (GA), I chose these colleagues because it was JDW under criticism, SB had performed the audit and GA supported both SB and the need for change. I spoke with each to explain that the aim was for an informal discussion on the different opinions and that I had arranged a meal at a restaurant (13.4.94) to obtain a non-confrontational atmosphere. Although I directly asked the question whether there were any concerns regarding P.C.S. neither SB nor GA replied. In conversation shortly after with JDW I formed the impression from him that if the concerns were not worthy of discussion at the meal then the concerns could not be major.'[35]

26 Dr Bolsin set out his view of the meeting in his written evidence to the Inquiry:

> 'In 1993 [*sic*] Professor Angelini, Dr Monk, Mr Wisheart and myself attended a meeting that was arranged in a restaurant near the hospital, Bistro 21. We were booked in the upstairs room, which was deserted. The meeting proceeded over supper with peripheral discussion of the performance of the unit. There were no direct requests for figures from Mr Wisheart, which led me to believe that he was aware of the results that Andy and I had produced. Certainly my information from both Gianni and Chris Monk was that they had shown the results to the surgeons involved. It was also my understanding that the Chief Executive had been informed of the results and must have discussed them with his Medical Director. It came as no surprise to me that a request for data was not forthcoming at this meeting because as far as I was concerned everybody at the meeting had the results that I, and others, had generated. There was little consequence to the meeting but the issue of poor performance had been raised and I expected a full and open review to ensue as the Medical director of the Trust was aware of the concerns of:–
>
> '1) A Clinical Director of the Trust [*sic*]
>
> '2) The Professor of Cardiac Surgery
>
> '3) An adult cardiac surgery auditor of National Reputation.'[36]

27 Mr Wisheart responded to Dr Bolsin's statement to the Inquiry:

> 'I had become aware that Dr Bolsin, with Professor Angelini, were expressing criticisms about paediatric cardiac surgery. Why they were doing this and on what basis was unknown to me. As rumours continued and progressed I expressed the view to Dr Monk that the only satisfactory course was to speak directly with

35 WIT 0105 0023 Dr Monk
36 WIT 0080 0118 Dr Bolsin

Dr Bolsin and ask him what his concerns were. He agreed and the dinner was set up by Dr Monk and myself for this purpose. I asked the question to Dr Bolsin and Professor Angelini "What are your concerns?" but I did not receive an answer at the dinner party or subsequently.

'Dr Bolsin says that there was no request for figures and of course that is true because I did not know that figures existed. Dr Bolsin, therefore, was mistaken to conclude that I was aware of the figures.

'Neither Professor Angelini or Dr Monk showed me the results, or told me that an audit had been carried out, or that figures existed.'[37]

28 Dr Bolsin discussed the meeting further in the following exchange with Counsel to the Inquiry:

'Q. What was the purpose of going to the meeting? …

'A. I think Chris Monk invited me to attend the meeting. I think it was at relatively short notice, and my understanding was that we were going to address some of the issues in cardiac surgery and probably paediatric cardiac surgery.

'Q. Why the four of you?

'A. To be quite honest with you, I have not thought about that. I assume it was because we all had an interest in paediatric cardiac surgery.

'Q. Was it perhaps because Dr Monk is the Director of Anaesthesia, Mr Wisheart is the Medical Director and has obviously an input into cardiac surgery, was, had been the Associate Director of Cardiac Surgery?

'A. Yes.

'Q. Professor Angelini had been a surgeon whom you had talked to about your concerns and because you were known to be expressing or promoting concerns?

'A. It is certainly possible that those are the reasons, yes.

'Q. If that is possible, did you know, at this stage, whether Mr Wisheart had seen your data?

'A. No. I assumed he had, because when I had given it to Dr Monk, he had said, "Right, I will take this on", and Professor Angelini had said, "I will show the appropriate people this data".

37 WIT 0080 0332 Mr Wisheart

'Q. So your understanding was, "Mr Wisheart has a copy of my data and knows it has come from me"?

'A. Yes. He may well have known that it came from myself and Andy Black, yes.

'Q. So there you are, at the meeting, at the dinner: called to discuss your data and the conclusions to be drawn? The way forward? What?

'A. I am not sure. I think it was paediatric cardiac surgery and adult cardiac surgery.

'Q. Did you in fact discuss it?

'A. It was a very unusual meeting because if the agenda or the purpose of the meeting was as you suggest it, the first two courses were spent in small-talk, talking about nothing really to do with cardiac surgery at the BRI, and only latterly did we get into any conversation about cardiac surgery at the BRI at all.

'Q. Is that a reflection of awkwardness in grappling with the subject, bearing in mind that there may be different perspectives on it?

'A. Yes, I think it was the taboo nature of the subject.

'Q. So there you are circling around the issue in the first two courses?

'A. Yes.

'Q. Talk being whatever it was, Manchester United [Football Club] and so on. When did you get to grips with the subject? Did you ever?

'A. I did not want to raise it, and I do not think I did raise the subject.

'Q. Why not?

'A. Because I felt very uncomfortable raising this subject with that company. I would raise it with —

'Q. That is what you were there for, was it not?

'A. I was not sure that the purpose of the meeting was for me to raise the subject in front of that company. I had already raised the subject with Dr Monk and I had already raised the subject with Professor Angelini, and I would have been happy to contribute to a debate if they raised the subject and it impacted on the data that I had collected or the views that I held.

'Q. So you thought you were there to contribute to a discussion, but not to begin it?

'A. Yes, very much so. I was not prepared to initiate a discussion on the basis of what had happened up until this meeting.

'Q. So if someone had said, "Do you have any concerns about paediatric cardiac surgery?" looking at you or Professor Angelini, you might have responded to it?

'A. If the issue of concerns about paediatric cardiac surgery would have been raised, I would have expected either Professor Angelini or Dr Monk to have taken the lead and said, "Well, actually now you come to mention it, we do have a problem and I do not know, Steve, whether you would like to come in on this one and tell us about your data collection?"

'Q. What Dr Monk has suggested to us he said – because he told us you were getting frustrated that by the end of the evening nobody had grappled with the subject which he had arranged the meeting for –

'A. It was a very difficult subject to grapple with.

'Q. His recollection is that although he does not recall the exact words, he said words to the effect of: "Do you have any difficulties with the paediatric cardiac services?" May I tell you that in comments he has given us, Mr Wisheart says he said words to the same effect, "Do you have a problem with paediatric cardiac services?" Did one, or the other, or both say that to you and Professor Angelini, or you or Professor Angelini?

'A. I think the question, if it arose, would have arisen to the table, so that one person would have been speaking to three others, and I would not have responded to that; I would have contributed to it, but I would not have responded to that —

'Q. Can I take it in stages. Was the question asked?

'A. Possibly.

'Q. If it was asked, why did you not respond?

'A. I would have contributed. I did not want to raise the issue of me being the prime mover in concerns about paediatric cardiac surgery. That was why I was going through every other route possible to press alarm bells to get somebody to come and deal with the issue of paediatric cardiac surgery.

'Q. So Professor Angelini, someone you were on friendly terms with, shared your concerns?

'A. Yes.

'Q. After the dinner, did you say to him, "Gianni, for goodness sake, why did you not respond to that question? It was not for me, I am a junior consultant, but you are a Professor, why did you not say something?"?

'A. Yes.

'Q. Did you say that to him?

'A. No, I thought in a sense the question in my mind was redundant, in that, at that stage, I believed that both Chris Monk and Professor Angelini had raised the issue with Mr Wisheart so that the issue of concerns was one that was current within this group, within that group; it was not really a question of saying, "Is there a problem?", it is a question of what we are going to do about the problem.

'Q. … The meeting, you are going to tell me, I know, ended without any discussion actually taking place?

'A. Yes.

'Q. If a question were asked, as it is suggested to us and you cannot deny was asked, like "Are there any difficulties?" and so on, "What is the problem?", why did it not lead to a discussion there and then?

'A. I am not sure, because Dr Monk was aware of my concerns and Professor Angelini was aware of my concerns. I was aware of my concerns. I thought that Mr Wisheart was aware of the data, and I would have expected a meeting like this to have been dealing much more with solutions than with whether or not there was a problem. As far as I could see, the data coming from the Unit already recognised that there was a problem. My data confirmed the data that recognised that there was already a problem. We should not have been talking about whether there was a problem, "Do you have any concerns?"; we should have been talking about, "What are the solutions to the problems we know exist within this Unit?" and the director should have been very much aware of that.

'Q. The solution you had in mind was the need for an immediate, thorough investigation and review?

'A. Which we had been promised in January when Mr Dhasmana was due to present the data and he did not …

'Q. Would not this meeting have been an ideal opportunity, bearing in mind your concern for little children in the Unit, to press the case for just such a review?

'A. Yes.'[38]

[38] T82 p. 178–85 Dr Bolsin

29 At a later stage in his evidence to the Inquiry, Dr Bolsin had the following exchange with Counsel to the Inquiry:

'A. Could I add one other thing about the Bistro 21 dinner. … The other possibility and I think this was a very real possibility, was that this was a sort of "bonding" exercise in the Trust, and I think that given the sort of management culture that was overtaking the NHS at this time, those kinds of exercises were seen as quite useful, and I think it is quite possible that I believed that I was going to a bonding, you know, touchy-feely-fuzzy-warm meeting at which we were going to get together, rather than necessarily a meeting at which we were going to address a specific issue of paediatric cardiac surgical mortality. I do not know if that helps?

'Q. I am not sure it does. For what reason do you think, looking back on it, the Bistro 21 meeting may have been a touchy-feely-fuzzy-warm bonding session, as opposed to a dinner intended to sort out differences, if there were differences, as to the performance of cardiac surgery and the interpretation of any figures there were?

'A. I think firstly the venue, holding a meeting in a restaurant, is not a venue for where you will sort something out; it is more a venue where you will have a warm convivial meeting, and I think if we were going to sort out paediatric cardiac surgery, it would have been better to have done it in an office in the University department, or something.

'Q. Yesterday you were telling us that – these are your words "I think Chris Monk invited me to attend the meeting. I think it was at relatively short notice"?

'A. Yes.

'Q. "My understanding was that we were going to address some of the issues of cardiac surgery, and probably paediatric cardiac surgery."

'A. Yes, but I think it could have been in a "How can we move this forward together?" kind of atmosphere.

'Q. Again, to try and get what you are saying right, are you saying that you go along to address the issues, not with the object of being confrontational, but with the object of producing a resolution?

'A. Yes.

'Q. So what you would have been looking to achieve from your own point of view from the meeting, was a consensus that matters needed to be moved forward and a plan of action?

'A. That kind of thing, yes.

'Q. And as it happened, as we know, nothing transpired?

'A. I think if we had been intending to do that in a Bistro 21 atmosphere, it would have been formal and not informal, and the formality was not there.'[39]

30 Professor Angelini gave his view of the Bistro 21 meeting in the following exchange:

'A. That dinner was organised by Dr Monk and the idea of that dinner was to have Mr Wisheart and [Dr] Bolsin together to try to reconcile some of their differences. I was invited, I guess, I do not know, as a sort of honest broker, or outside — I do not know what to call it, but the dinner was organised by Dr Monk.

'Q. Was the dinner the place where Mr Wisheart asked Dr Bolsin and yourself if you would share your concerns with him and Dr Monk about the paediatric cardiac surgery?

'A. No.

'Q. It is right, is it not, that Dr Bolsin did not take any data to that dinner?

'A. Correct.

'Q. You did not take any data?

'A. No, I was just the guest at a meeting organised by somebody else.

'Q. No data was produced, if I can put it like this, from Mr Wisheart's side?

'A. No.

'Q. So it must follow that presumably if Dr Monk did not bring any data there was no data discussed at the dinner?

'A. Again, the purpose of this meeting, everybody seems to emphasise the need to have these pieces of paper in front of you with the data. The fact of the matter was that we were at a stage where we were trying to get across the message that some of us in the Unit were not happy with what was going on in paediatric cardiac surgery. On the other side, there were people like Mr Wisheart who were not prepared to accept that there was a problem. So effectively, any conversation was almost dead before it started, because we could only agree to disagree. Therefore, there was never the opportunity to expand and go into details of "Let us look at the VSD, whether a mistake has been made; let us look at the AV canal"[40], because there were two opposite views. One view was what was going on was acceptable surgical practice; the other view was that what was going on was not acceptable

39 T83 p. 52–4 Dr Bolsin
40 T61 p. 114–22 Professor Angelini. See Chapter 3 for an explanation of clinical terms

surgical practice. These two things were impossible to reconcile. As a result of this, there was never any proper conversation which could try to analyse the problem or, if so, how to resolve it.[41]

'Q. Dr Monk had accompanied you to the meeting with Dr Roylance?

'A. Yes, just a few days or weeks before.

'Q. He was also at this dinner with you and Dr Bolsin and Mr Wisheart?

'A. Yes.

'Q. Did he try to bridge the gap between Mr Wisheart on the one side and Dr Bolsin on the other?

'A. I think Dr Monk was concerned about all of this because of his position, and also because he was genuinely concerned, but again, as it had happened for other people, it was very difficult for him to get the message across.

'Q. Across to whom?

'A. To Mr Wisheart. I mean, everybody, even the Professor of Surgery who was in a much more senior position, was always finding himself almost embarrassed in having to say to a colleague, a friend, somebody very senior, that his results were not up to scratch. It was always the sort of psychological barrier, if you want to call it, where people could not just get the message across. One reason was that there was apprehension, because as I said, Mr Wisheart was a very influential individual within the Trust. But there was also —

'Q. So does that mean that there was the fear that there would be repercussions?

'A. I do not know if "fear" is the right word, but let us say apprehension.

'Q. Apprehension of what?

'A. Yes, even apprehension of what it would be, your future career.

'Q. What was going to happen?

'A. I do not know. Perhaps your career, internal promotion, would have been curtailed down, really.

[41] See Chapter 3 for an explanation of clinical terms

'Q. How would that come about?

'A. How would that happen? At the end of the day the people who were running the hospital can have a profound effect in the way your practice or your individual practice is run. They may not be so sympathetic when you go and ask for something like, you know, you want to go and improve something in the service, or even on personal grounds.

'Q. Was Mr Wisheart, so far as you are concerned in the spring of 1994, one of the people who was, as you put it, running the hospital?

'A. More or less, yes. I do not know if he was running the hospital, but as the Medical Director he was [on] the Trust Board. Maybe he was not the Chairman of the Hospital Medical Committee at that stage. Before that stage he had been Chairman of everything that moved in [the] hospital, the Division of Surgery, cardiac surgery, everything. We had an Associate Director of Cardiac Surgery, Mr Dhasmana, who could never take a decision. He never ever took a decision because whatever decision he took was going to be turned down or changed by Mr Wisheart.

'Q. So were you scared of Mr Wisheart?

'A. Not particularly, no.

'Q. Not particularly?

'A. No.

'Q. A little bit?

'A. No. And I can tell you why.

'Q. So not at all?

'A. I would say not at all, yes, but despite of the fact I was not scared, I was feeling very uncomfortable all the time, because it is not very pleasant to confront a colleague who happened to be senior to – I mean, Mr Wisheart could have been – he is the same age of the person who trained me. He could have been my trainer. And now I was there, confronting him, trying to tell him, "Look, your results are not good". This is very uncomfortable.

'Q. But you did not confront him, because paediatric cardiac surgery was never mentioned at the dinner?

'A. But many times before. That dinner was not organised by me, I was simply there as an observer. I did not organise the meeting, I was not responsible for the talking of anything. I had spoken to Mr Wisheart about the results of paediatric cardiac surgery in a very polite fashion many, many times.

'Q. I think you said, possibly at the GMC, that you discussed the arts, you discussed Manchester United?

'A. Everything. Football, Italy, all sorts of things. One of the difficulties people have to talk to Mr Wisheart, not only because he is a very senior person and is a very authoritative person, but also, he is very fluent. You start a conversation on a subject, you end up with something totally different, you do not know how you got there. He has a very good ability of discussing in the fashion he wishes, and therefore wriggles out if he does not like the kind of conversation that is taking place.

'Q. If that is the perception that you had of Mr Wisheart, does that not make it all the more odd that you should not have made full use of the meeting that you had with Dr Roylance in March when Dr Monk was with you, when there was a chance, with somebody who was higher up the management tree even than Mr Wisheart, indeed, at the top, and you and Dr Monk pulled your punches with Dr Roylance?

'A. I think you British say "You need two to tango". If the other one is not prepared to listen, as I said, short of pinning him down on a chair, I do not know what else I could have done, and so with Dr Monk. Dr Roylance was not interested whatsoever in this kind of conversation. It was like listening to a tape-recorder: "This is not a matter for me. This is a matter for the clinician." This was the message over and over and over. Even when I went to see Dr Roylance, before I spoke to him, before and after the last operation, even after the last operation, this was the same recorded message.

'Q. But it was a matter for the clinicians, was it not?

'A. You are asking me?

'Q. The Chief Executive cannot force people to talk about a subject over dinner if they do not want to talk about it?

'A. No, but the Chief Executive can call all the involved parties in a room around the table, which should have happened, and said, "Right, concern has been expressed in the hospital by various sides. I would like first of all to see, if I have not seen it, the data of Dr Bolsin that everybody is talking about"; second, I would have

instructed the two surgeons, Mr Wisheart and Mr Dhasmana, to produce their data to be confronted with the one of Mr Wisheart [*sic*] and then, once the facts were concerned, all the people, not just the surgeons, the anaesthetists and everybody else, discuss this matter, then we decide if we have a problem. If we have a problem, we decide how we are going to solve it. If we do not have a problem, the people who said we had a problem will have to apologise. This never took place.'

31 Dr Monk gave his view of the dinner at Bistro 21 in the following exchange:

'A. The venue was chosen because I had recently organised a large meal there. I had asked the restaurateur to use the upstairs room, which would be private and quiet. It would enable me to produce an environment outside the hospital and to be non-confrontational. I had James Wisheart, who was aware of the concerns but did not have any details. I had Dr Bolsin, who had produced an audit and was asking me to act upon it but was not willing to present this audit to people who could help me form a corpus of opinion and take it forward. And I had Professor Angelini, who was aware of Dr Bolsin's audit and was willing to support it. I therefore produced an environment in which I thought we could, with the least amount of conflict possible, bring together these divergent opinions. To get Dr Bolsin and Mr Wisheart to sit around a table, I would have had to go through a number of conversations in order for them to understand why we are going there. I do not think that Dr Bolsin and Mr Wisheart would just wish to go for a meal to chat about football.

'Q. In fact, did you end up talking about football?

'A. We did indeed. I am a keen Manchester United supporter, having lived there for many years. Professor Angelini had helped me organise a holiday in Italy. Therefore much of the meal was spent, as these meetings are, I presume, talking about generalities before we start to get down to the meat of the conversation.

'Q. What you have said already suggests that you had spoken to Mr Wisheart because – you arranged the meeting, you had spoken to Mr Wisheart, Professor Angelini and Dr Bolsin?

'A. Correct.

'Q. And your purpose was to get them talking?

'A. That is correct.

'Q. Did each of them know that that was your purpose?

'A. I believe so, yes.

'Q. … What was he [Mr Wisheart] given by you to understand he should expect to deal with at the meeting?

'A. I believe he knew Steve Bolsin had raised criticisms and he would want to know from Steve Bolsin what those criticisms were.

'Q. What would Dr Bolsin have understood from you?

'A. He and I had numerous conversations about the form of his audit: that, in my opinion, it had been performed in a clandestine manner and therefore its value was lost because it was not owned by people, it was not open; it had not been verified and therefore could be criticised; and that it would be appropriate in this non-threatening environment, supported by me as the Clinical Director and also Professor Angelini, to put forward his data. The danger that I had in having this data and putting it forward to James is that I may not be able to support it from criticism, because my knowledge of it is literally what you have in front of you.

'Q. So at this stage Mr Wisheart would have understood your role to be effectively that of the United Nations, trying to bring peace between the rival views?

'A. I think that is a little excessive in a description. What we had were people with different views upon outcome, and the views were that it was —

'Q. What I am asking is whether he appreciated the role that you sought to fulfil?

'A. Who appreciated?

'Q. Mr Wisheart?

'A. I believe so. I may be mistaken about that, but I would have thought that he understood it.

'Q. Was the meeting, the meal, relatively amicable or not?

'A. It was a difficult meeting because people were there with an agenda, and therefore it is difficult to be amicable in those terms where you were there just for a social meal for the pleasure of your colleagues.

'Q. … At any stage, did the conversation at the meal turn to the issue that had brought everyone together?

'A. It was raised in a very peripheral way on a number of occasions. I felt it was important that we did discuss the issue. Towards the very end, my personal frustrations in not succeeding led me to ask a direct question. I cannot recall the

exact words that I used, but I did say, "Do you have any difficulties with the paediatric cardiac service?"

'Q. You were addressing whom?

'A. I was looking across the table at Dr Bolsin and next to him was sat Gianni Angelini. It was a table for four, obviously. There was no reply. There was no denial; there was no assertion that there was; there was no answer. At that point my frustration rose to a very high level because I realised that my intent in bringing these people together to discuss the issue … had failed.

'Q. Did you consider going further and saying, "Look, Steve, you have raised concerns with me. Do you now want to raise them with James?", or anything to that effect?

'A. After asking the direct question and receiving no response my frustration was such that I did not ask those questions. To my recollection, the meal, the meeting, whatever, just disintegrated and we all left.

'Q. And no attempt was made by Professor Angelini on the one hand, Dr Bolsin on the other, or for that matter Mr Wisheart, to raise and grapple with the issue which had in fact brought them to Bistro 21?

'A. All four of us failed to achieve that. An option would have been for me to have put the data on the table and say, "What about that?". I did not do that.

'Q. Did anyone have the data with them?

'A. I certainly did not. James could not because he had not got the data. Whether Professor Angelini or Dr Bolsin had the data, I do not know.

'Q. Did James Wisheart know something of the nature of what had been going on, that there had been a collection of data which showed paediatric cardiac services in a bad light?

'A. I cannot answer for his knowledge base at that time —

'Q. Had he been told in front of you, in your hearing?

'A. I did not tell him that I had in my possession an audit of this form ...

'Q. There may have been suggestions in other forums — you did not give evidence at the GMC, did you?

'A. I was not asked to give evidence by any of the people involved.

'Q. But there may have been a suggestion that there were two camps at this restaurant: you and Mr Wisheart on the one side and Professor Angelini and Dr Bolsin on the other. Would there be any truth in that or not?

'A. I did not see my role as being in any "camp". I was the Clinical Director of Anaesthesia, and therefore I had a management role, but I had worked closely with Dr Bolsin for many years, and I had discussed our concerns. He and I had spoken beforehand, and I had taken it to a non-threatening environment. Had we had this meeting in the Medical Director's office, within the Trust headquarters, then I think that could be a reasonable supposition. But it was not, it was held outside of the Trust.

'Q. You had had the view before this meeting that the concerns which Dr Bolsin had, which you tended to share because you tended to be towards his wing, as it were, of the spectrum of anaesthetist opinion, were major concerns?

'A. They were concerns — I had such concerns that I was willing to work hard to try and resolve the issue.

'Q. After this meal — can we look at your statement[42] that describes Mr Wisheart's reaction to the meal. He was effectively saying to you, "Well, if you are not prepared to raise it to my face", or something along those lines, "then there cannot be much in it". Was that the flavour of it or not?

'A. I think it was an impression that I gained from him that if we had gone to the effort to sit at the table, it was an opportunity that was of such low impact as regards to the Trust management situation, because he was probably the Medical Director at this stage, if they cannot raise it then, when he is at his most open, then what were these concerns? I do not know what JDW actually thought at that time, but I felt – maybe it represents also some of my frustrations – that that was a reasonable summary.[43]

32 Dr Monk was asked by Counsel to the Inquiry about his view of Mr Wisheart's capacity to listen to criticism:

'Q. You valued your relationship with Mr Wisheart, did you?

'A. I value all my relationships with my colleagues. It is an important way of working.

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42 'In conversation shortly after with JDW I formed the impression from him that if the concerns were not worthy of discussion at the meal then the concerns could not be major'; WIT 0105 0023 Dr Monk

43 T73 p. 148–54 Dr Monk

'Q. You had been prepared to suggest and, as it were, host a meeting of Bistro 21 at one stage in order to reconcile what you saw as opposing views?

'A. At that stage the Bolsin data, the audit, had not been presented to Mr Wisheart. There were concerns raised by Dr Bolsin and these had been discussed between many people.

'Q. The point I am driving at is, was it your view throughout the 1990s that Mr Wisheart was someone who was amenable to conciliation, someone who regularly took the bigger picture and would not necessarily hold it too strongly against someone that he was the object of their criticism?

'A. I think everyone finds personal criticism difficult to accept, particularly when you are a senior person, but we would not have got Mr Wisheart to the dining table with Dr Bolsin unless Mr Wisheart was willing to listen to the criticisms.

'Q. So it is your view that he was someone who was willing to listen to criticisms, even though they were personal?

'A. The function of that meal was to achieve that.

'Q. No, I am asking for your view of Mr Wisheart and the extent to which he would be prepared to listen to and accept eventually criticisms which were to an extent personal?

'A. I think Mr Wisheart was very proud of his performance. He was towards the end of his career. To criticise his performance would be very difficult for him to accept, but we did discuss on occasions the concerns over the paediatric service, and he accepted that, with the appointment of a new surgeon, he would give up paediatric practice. He had looked to appoint a paediatric professor of cardiac surgery, and, therefore, he obviously realised that the service would improve by bringing in new blood. So in a way he accepted the criticisms that the service was not as good as it may well have been.'[44]

33 Mr Dhasmana was asked about his views of the Bistro 21 meeting in the following exchange:

'Q. … Mr Wisheart, Dr Monk, Professor Angelini and Dr Bolsin went out for an evening to a restaurant, Bistro 21 in Bristol. You know that now.

'A. I did not know that until really the GMC proceeding, that they went to some dinner or something like that. And the reason, and purpose that I heard, I felt were quite ...

[44] T73 p. 36–8 Dr Monk

'Q. Part of the reasoning appears to have been a view that they all four shared that there was a need to discuss matters of concern, if they were of concern, so as to, I suppose, create a harmonious way forward. Did you have any sense, in early 1994, that those with whom you worked were unhappy with any aspect of the Unit's performance?

'A. No.

'Q. (The Chairman): Mr Dhasmana … when you were talking about the dinner, you said "and the reason for it and the purpose, I felt were quite...", and you did not finish the sentence. I was intrigued to discover what you felt?

'A. I do not know what would have come out in the flow at that time, but I felt no real — I mean that, to my mind, was not the way to discuss the problem in a dinner meeting at the Bistro club.

'Q. (Counsel): What would have been the way to discuss the problem?

'A. Well, if the problem is in the paediatric cardiac surgery, if there is a concern, whether it was relating to me or not, I would have thought that being 1993 [*sic*] must have related to my neonatal Switch, why did not any of those gentlemen talk to me and I could have also gone to same dinner and probably would have raised the question, or there should have been a meeting of all concerned parties, and an open airing; it should have been aired openly.

'Q. Did you still share an office with Mr Wisheart?

'A. No, I did not. I moved out from the office I think in 1992.

'Q. Did you still see him regularly?

'A. Yes.

'Q. Did you discuss matters of interest to the Unit in 1994?

'A. I had almost a monthly consultants' meeting arranged during part of my Associate Director job, or post, or appointment, and of course Mr Wisheart I would be meeting quite often in the ITU and other areas, yes.

'Q. Mr Wisheart never mentioned, did he, the fact that he went to a dinner meeting with a view to whatever it was, ironing out concerns that there might be?

'A. Not until after, you know, when it was known to almost everybody else.

'Q. Did you have the sense later on then that you were almost the last to know?

'A. That is a difficult question to answer. I cannot answer that.

'Q. (The Chairman): If we can just press on that question a little bit more, you were, after all, doing the surgery. Did you think it was odd that you were not there at the meeting?

'A. I think that was the word I was really looking for at that time, "odd" to have gone to that dinner meeting. So odd, yes.

'Q. Not odd that others would go, but odd that you were not invited, was what my question was.

'A. Odd that I was not even told.'[45]

34 Dr Joffe told the Inquiry of Mr Wisheart's account to him of the Bistro 21 dinner:

'A. He [Mr Wisheart] mentioned that they had had this dinner together and that he was anticipating that this would give Professor Angelini and Dr Bolsin an opportunity to comment, if they had criticisms which appeared to be the case, so he said, for them to state those criticisms and raise the whole question of data or what they felt was amiss with the performance of cardiac surgery – in this case paediatric cardiac surgery – but somehow the evening went by and this did not happen. … That is the sum total of my information that I gleaned from that discussion.'[46]

35 Mr Wisheart described to the Inquiry a number of approaches to him, including the Bistro 21 dinner, over doubts about performance figures as indirect and 'incomplete':

'Q. The indirect approach you had had in respect of doubts over performance figures … ?

'A. That would have been the matter of Professor Dieppe [Dean, Faculty of Medicine], talking with me, which we have discussed, the subsequent discussion which I initiated with Professor Vann Jones [Clinical Director of Cardiac Services], and those of course were the main issues that led up to the Bistro 21 dinner when I made inquiries. So those were the approaches which were indirect and in retrospect quite incomplete approaches, yes.'[47]

45 T86 p. 153–6 Mr Dhasmana
46 T91 p. 156–8 Dr Joffe
47 T94 p. 136–7 Mr Wisheart

36 Mr Wisheart told the Inquiry that he had not pursued matters raised by Dr Bolsin after the Bistro 21 dinner:

> 'Q. You regret as well, in your statements, not having pursued Dr Bolsin in early 1994, when you appreciated that he was said to have concerns but had not discovered what those concerns were?
>
> 'A. Well, I had discovered that he was expressing the viewpoint. I am not sure if you are using the word "concern" in the manner defined by this Inquiry. If you are, then I did not know that. I knew that he was expressing criticisms to other people, for a variety of reasons, and I did ask him to tell me what those concerns were in April 1994.
>
> 'Q. But you say in your statement – I assume it is right – that you regretted not pursuing him?
>
> 'A. After that.
>
> 'Q. And you give us the reason why you did not?
>
> 'A. Yes. I allowed myself to be deflected.'[48]

37 Three days after the Bistro 21 dinner, a report on the activities of the Cardiac Surgery Department was presented by Mr Wisheart, as Medical Director, to the Trust Board. It included the following:

> 'The work of the department has been of a high standard and includes a larger proportion of high risk cases than in some other centres … In recent years the results of the work with children has [*sic*] been excellent, and in infants similar to that reported elsewhere …'[49]

38 On 18 April 1994 Dr Bolsin went, by appointment, to see Janet Maher, then General Manager of the Directorate of Surgery at the UBHT. Mrs Maher stated that she was unsure why Dr Bolsin, a consultant from another directorate, wanted to see her:

> 'Dr Bolsin told me that he had been doing some work which had produced data, which he had collected in the form of an audit. I do not recall a time period that this information related to, but it concerned the outcomes following paediatric cardiac surgery. I remember that early on in our conversation Dr Bolsin made reference to the Department of Health. My understanding was that he was on a committee or working party at the Department of Health in relation to other issues. His position on this committee had, however, placed him in a position where he had access to data, and this data was the source of concern which had brought him to me on 18 April 1994. Dr Bolsin said that he had data from other paediatric

48 T92 p. 24–5 Mr Wisheart
49 UBHT 0020 0015. The results reported in Bristol and elsewhere in respect of 1993 are summarised at the end of this chapter

cardiac surgery centres and the comparisons made with BRI data showed that the results of the Bristol Paediatric Cardiac Unit were not as good, in comparison with other units.'[50]

39 Mrs Maher stated further:

'Dr Bolsin repeatedly referred to the data upon which he based his concerns. At no stage during that meeting did Dr Bolsin explain what that data was, or show me the data.'[51]

40 Mrs Maher continued:

'The potential seriousness of what Dr Bolsin was saying made me feel extremely uncomfortable. I asked Dr Bolsin if he had shared this information with paediatric cardiac surgeons, or if he had shared the information with anybody else. I could not get a clear response from Dr Bolsin on this point. He intimated that he had talked to colleagues in his own anaesthetic department, although he did not identify who they were. He implied having spoken to other cardiac surgeons, but again did not say who they were. He had already by this stage made reference to the Department of Health and discussing it with someone there, although again this person was unnamed. Dr Bolsin's response was extremely unclear and he left me feeling increasingly uncomfortable that he had not actually spoken to the clinicians involved in the work. He appeared to have spoken to some people, but they did not seem to be the people who were directly concerned with paediatric cardiac surgery. I was very concerned that if he did have data, that it ought to be shared and on the table for everybody to have a look at. I remained unsure as to what the data was. I got the distinct impression that he had not discussed his concerns openly with the clinicians in question and I felt this was wrong.

'I said to Dr Bolsin that I felt he should go through the appropriate channels. I told him that I did not know what data he was referring to and that it was inappropriate for me to get involved. I advised him to talk to his Clinical Director, who at that time was Dr Chris Monk. I also advised him to go back and talk to the paediatric cardiac surgeons, Mr Wisheart and Mr Dhasmana. I felt that that was the correct way forward. From our conversation, given that Dr Bolsin had referred to other conversations he had had with other people (again not named), I was not sure just how widely he had discussed it with anybody and I felt that the people directly involved needed to know. I also suggested to Dr Bolsin that he ought to discuss his concerns and whatever data he had available to him in an open audit between the surgeons, cardiologists and the anaesthetists involved in paediatric cardiac surgery.

50 WIT 0153 0019 Mrs Maher
51 WIT 0153 0020 Mrs Maher

'I was extremely concerned that Dr Bolsin should deal with his concerns in an appropriate way, talking to the right people. He was implying that Bristol results were not as good as elsewhere and I had no idea what the data was, whether it was accurate and whether this was a real basis for concern. In terms of raising it as an issue, given what Dr Bolsin had told me, it could not just be "left" because it could involve serious accusations concerning patient safety and the competence of the paediatric cardiac surgeons. Any comment that Bristol was not doing as well as elsewhere would have concerned me, but particularly where the person telling me appeared not to have talked it through with colleagues who were involved. I was not sure what Dr Bolsin expected me to do in response to his approach in April 1994 and the somewhat vague information he had given me. He did not ask me to do anything in particular.'[52]

41 Mrs Maher stated that she was concerned as to the action she should take:

'Following the meeting with Dr Bolsin I felt it was inappropriate to simply react to Dr Bolsin's concerns by making wide-reaching enquiries. Because Dr Bolsin had been extremely vague about who he had spoken to, I had no idea whether the matter had already been discussed and addressed elsewhere. For all I knew, if it had been, it may well have been resolved already. I felt it prudent to "sound out" key personnel to see if they were aware of Dr Bolsin's concerns. I felt that the three key people I needed to contact were Dr Chris Monk as Dr Bolsin's Clinical Director, Dr John Roylance as Chief Executive of the Trust, and Mr James Wisheart. Within approximately 1 week of Dr Bolsin meeting me, I had spoken to all three. I do not now recall in which order I spoke to Dr Monk and Dr Roylance. I do specifically remember that I spoke to Mr James Wisheart last of the three, given the possible seriousness of Dr Bolsin's allegations for him personally.

'I spoke with Dr Chris Monk and repeated to him what Dr Bolsin had said to me. I told Dr Monk that it seemed to be about an audit, but that I was unaware of the issues involved. I told him I felt I was not qualified to comment upon what these issues might be. When I spoke to Dr Monk, I recall from my GMC evidence that I was aware at the time that Dr Monk probably knew something of Dr Bolsin's concerns, but that he had not seen any information or data. I do not now recall the details of Dr Monk's response to what I told him, although I believe he was keen to bring whatever Dr Bolsin's data and concerns were out into the open in order that open discussions could take place. I left the meeting believing that Dr Monk would make every effort to open up this discussion and bring whatever issues Dr Bolsin had into an open forum so that they could be resolved.

'In the same week that I spoke with Dr Monk I also spoke with Dr John Roylance, the Chief Executive, in his office. I do not recall which of the two I spoke to first. I repeated what Dr Bolsin had said to me. I got the impression that Dr Roylance may have been in a similar position to Dr Monk, that is someone who was starting

52 WIT 0153 0020 – 0021 Mrs Maher

to get to know that there was something being raised as a concern, but that the detail of that concern was still very unclear. I would not have expected Dr Roylance to indicate to me how he planned to deal with this information and, quite rightly, I believed he needed time to assess the best approach. My understanding was that Dr Roylance intended to take time and talk to the key people involved, probably including Dr Chris Monk and also Mr James Wisheart. I did not know if he would go directly to Dr Bolsin or not. I cannot remember any other details of my meeting with Dr Roylance.

'Having spoken to Dr Roylance and Dr Monk, I also spoke to James Wisheart. To put this in context, my position as General Manager for the Directorate of Surgery was such that I regularly liaised with all three colleagues, particularly in relation to the proposed move of paediatric cardiac services to the Children's Hospital, on an almost weekly basis. A combination of my level of concern, and the regularity with which I saw these three individuals meant that within about a week of Dr Bolsin's meeting with me I had raised the matter with each of them.

'When I met with James Wisheart, I repeated the substance of my meeting with Dr Bolsin in the same way that I had explained to Dr Monk and Dr Roylance. Mr Wisheart was very concerned, both in terms of not understanding which data Dr Bolsin was referring to, and also that nobody had directly raised any concern with James Wisheart himself. The lasting impression I have about these discussions was that there was a lack of clarity about which data was the basis for the concern, and that it certainly did not seem to have been imparted to the cardiac surgeons involved. When James Wisheart expressed his concern about the basis for Dr Bolsin's comments, I told him that I thought the best person to talk to was Dr Bolsin himself and also to Dr Chris Monk. I remember that Mr Wisheart's main concern was that he did not have access to whatever this data was, or that there was some other data around that he had not seen. I am reminded by my GMC transcript that at the time I gave evidence to the effect that Mr Wisheart had found Dr Bolsin's comments about data confusing, as it did not tie in with Mr Wisheart's own data. I could not recall his exact words at that time and I certainly am unable to recall them now.'[53]

42 Dr Monk described his response to Dr Bolsin's meeting with Mrs Maher in the following exchange:

'Q. In any event, very shortly after that meeting I think Dr Bolsin reports that he went to speak to Janet Maher, and that the following day, he suggests, you came to him and said in effect that it was the wrong approach to go to the manager of the surgical department in order to take his concerns further. What do you say about that?

'A. Yes, I believe I did tell him that.

[53] WIT 0153 0023 – 0025 Mrs Maher

'Q. So the way in which it worked was, what? Janet Maher had had a word with you and said one of your anaesthetists had come to [her] with this concern, and you then went to Steve Bolsin and said that is not quite the way to do it?

'A. The culture of the Trust at that stage was that the managers at that level had very little input into clinical management and decision-taking.

'Q. I do not want to press you on that, as to why you said it, but just the fact that you did?

'A. I just felt that an explanation of why I said it would be quite appropriate. The person that Dr Bolsin needed to give his data to were the surgeons or the cardiac anaesthetists, not a manager who had no obvious way in which she could influence that problem.'[54]

43 Professor Vann Jones was asked by Lesley Salmon, General Manager of Cardiac Services from October 1993 to October 1994, to convene a meeting of the non-medical staff: the perfusionists, the physiotherapists and the nurses. The meeting, held in April 1994, was, according to Professor Vann Jones, 'to inform or to reassure the departmental staff in a situation where there were many rumours flying around.' [55]

44 Professor Vann Jones said that he:

'… told them at that meeting that I still had reservations about some of the data because [Dr Bolsin] had not come back about the information on VSDs. I was not certain by any means about the statistics and that the matter was being looked into. I said "in the meantime, we have to carry on business as usual".'[56]

45 He went on:

'I told the non-medical staff of the meeting on November 16th [with Dr Bolsin when] I had been presented with some data that had caused some concern and I had been presented with some that was basically wrong, I thought incorrect, and we waited for their [Dr Bolsin's and Dr Black's] clarification of that.

'Q. The reference to the data that was wrong and incorrect was meant to be a reference to Dr Bolsin's figures on VSD, was it?

'A. That is right.

54 T73 p. 154–5 Dr Monk
55 T59 p. 155 Professor Vann Jones
56 T59 p. 148 Professor Vann Jones. See Chapter 3 for an explanation of clinical terms

'Q. Was it fair to characterise what you said to the meeting as "an attempt to discredit the Bolsin/Black data"?

'A. Absolutely not. The whole point of the meeting, as I recall, was to try and keep our team figure [*sic*] — inform people as to what might be happening, and as I say, there were moves afoot to appoint a new surgeon and move to the Children's Hospital, so it was an information-providing meeting. There was absolutely no way I was attempting to discredit Steve Bolsin and Andrew Black.

'Q. After that, Dr Bolsin goes on to say[57] you received a letter from Dr Black asking you to retract your criticism of the Dr Black/Dr Bolsin data, which you did by letter. Do you have any recollection of that account of events?

'A. That is also inaccurate. What actually happened was that within about half an hour of the end of that meeting – and it was a very efficient grapevine – within half an hour of the end of that meeting Andy Black was in my office, all fire and brimstone, and not very pleasant. However, I told him to calm down and tell me what the problem was. He accused me of casting aspersions on his statistics, his statistical ability. That is quite a bit different to the data. So we agreed that we had actually not disagreed at the end of the day and there was no, as far as I recall, exchange of letters, but it was certainly a very entertaining half-hour with Andy Black in my office.'[58]

May

46 In May 1994 Professor Angelini was visited by Mr Durie, Chairman, UBHT, and Mrs Maisey, Director of Operations and Nurse Advisor. Professor Angelini told the Inquiry about the meeting in the following exchange:

' … at short notice, my secretary said that Mr Durie's secretary had phoned and he wanted to see me to discuss the expansion plan for the Academic Department on Level 7. I said, "Fine, tell him to come along". He came along, to my surprise, with Margaret Maisey. Quite honestly, I do not know what she was there for in terms of discussing the academic plans.

'Q. Who was Margaret Maisey?

'A. I think she was Head of Nursing, I do not know how you call it within the UBHT. She was an executive member of the UBHT and Director of Nursing.

57 At WIT 0132 0072 Dr Bolsin says 'Professor Vann Jones received a letter from Dr Black asking him to retract his criticism of our data which Professor Vann Jones did by letter'

58 T59 p. 158–9 Professor Vann Jones

'Q. She worked closely with Dr Roylance?

'A. I have no idea. It probably was the first time I met the woman. … They came into my office. I did not organise the meeting. They came to me. The conversation on the academic department expansion lasted about 30 seconds. I must say, I was not expecting him to raise the issue of paediatric. What he said was that he was very concerned about what he had heard and he had an impression or an opinion or whatever you want to call it that the paediatric service was sub-standard.

'Q. What did he say he had heard and from whom?

'A. I think he just said "The service is not good". I cannot recollect the precise words, but the message or gist of it was "I am very unhappy at what I have heard that the paediatric service is not up to scratch". What his exact words were, I do not know. I cannot recollect.

'Q. What did you say?

'A. I said then, I share his sympathy in full. He asked me whether I had any solution and I said then in my view, the solution was to try to appoint a new paediatric cardiac surgeon.

'Q. What did he say to that?

'A. He said would I be kind enough to put this in writing and could I be kind enough to go and see Professor Vann Jones to discuss this with him, and make sure that he was in agreement with this concept and send him a letter, and he would have done something if he could.

'Q. Why did he tell you to go and see Professor Vann Jones do you think?

'A. Because Professor Vann Jones was the Director of Cardiac Services. Presumably he was trying to suggest to me to go through the established channel of command.'[59]

47 Professor Vann Jones stated in his written evidence to the Inquiry that, after talking to Professor Angelini independently of the meeting between Mr Durie and Professor Angelini:

'Together we wrote to Mr Drury [Durie], Chairman of the Trust, hoping to fund the appointment of a new paediatric cardiac surgeon. This letter was sent in April 1994 which was the earliest opportunity at which I could possibly make such an offer as it was only in April 1994 that the Directorate of Cardiac Services finally came into being with its own budget.'[60]

59 T61 p. 127–9 Professor Angelini
60 WIT 0115 0021 Professor Vann Jones

48 The letter, dated 12 May 1994, stated:

> 'Gianni has come up with the novel idea of appointing a senior lecturer under his auspices for two years and for then the NHS to take over this chap assuming he has done what we would want him to do and that is turn the service around. I am strongly in favour of this and I think the time has come to make a decision because if we do not get ahead with it paediatric cardiac surgery in Bristol is going to fold and shortly after that paediatric cardiology will go with it.'[61]

49 Also on 12 May the Cardiac Expansion Working Party of the UBHT met. A draft of their report stated, at one point:

> 'There is a perception that the quality of paediatric cardiac services in UBHT does not match the standards of the Trust's major competitors and it is imperative that the Trust demonstrates continued commitment to improved quality in waiting times and outcomes which have an impact on mortality and morbidity in specialist areas.'

50 It went on:

> 'If the BRCH [*sic*] is to regain and build upon its reputation, the appointment of a consultant paediatric cardiac surgeon is required to undertake and oversee this service. It has proved impossible to attract a suitable candidate under the current split site arrangements.'[62]

June

51 Kay Armstrong, Sister in Cardiac Theatres at the BRI, stated that she had been reassured by the expected movement of children's services to the BRHSC and the appointment of a paediatric cardiac surgeon:

> '… the reassurance began to wain [*sic*] when the prospect of a paediatric cardiac surgeon being recruited seemed further away after Professor Angelini came instead of a paediatric cardiac surgeon. The move to the Bristol Children's Hospital also seemed quite distant. As time passed, theatre staff felt that something more positive had to be done to address the concerns about the service. As a result, in the middle of 1994, myself and other theatre nurse colleagues stopped scrubbing for complex paediatric cardiac surgery cases. Out of approximately 9 members of staff, only 2 nurses, Alison Reed and Onyx Berwin, would scrub for children's cardiac theatre.'[63]

61 UBHT 0061 0246; letter dated 12 May 1994
62 UBHT 0275 0139; draft report *'Options for Development of Adult and Paediatric Cardiac Services in UBHT'* dated May 1994
63 WIT 0132 0057 Ms Armstrong

52 On 21 June 1994 a letter was signed by six anaesthetists at the UBHT expressing concern about the Arterial Switch programme being undertaken at the BRI. Dr Davies, consultant anaesthetist at the BRI from 1993, stated in his written evidence to the Inquiry:

> 'In mid-1994 Dr Bolsin drafted a letter addressed to Dr Monk, the Clinical Director,[64] and had asked a number of the anaesthetists to sign it. … The letter went through a number of drafts.'[65]

The first draft of the letter was addressed to Dr John Roylance.[66]

53 In the first draft of the letter, Dr Monk had been a co-signatory. In its final form, he became the addressee. Dr Monk told the Inquiry how this came about in the following exchange:

> 'If I had signed the letter, it was difficult to take forward and to discuss it, so it was felt, and supported by some of the others, that it should be addressed to me; that I should not sign it and I could then take it forward. I agreed to that. It may have been better if I had signed the letter and posted it.
>
> 'Q. What did you mean by "taking it forward"?
>
> 'A. My intent was to approach the Chief Executive with this letter and use it to explain that we, as consultant anaesthetists, had concerns about the Switch programme, and, in addition, the paediatric cardiac surgical programme. It says quite clearly that there should be a confidential review and that it should take place amongst the entire multi-factorial process and the clinicians involved to look at what the figures were.
>
> 'Q. So, having got this letter, what was it intended you should do with it?
>
> 'A. My intent was to visit the Chief Executive with the letter. Whether they had other intents for it, I am not aware.'[67]

54 Dr Masey told the Inquiry that it had initially been thought that the letter would be addressed to Dr Roylance, and would be signed by Dr Monk, in addition to others.[68]

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64 Clinical Director of Anaesthesia from January 1993 to December 1995
65 WIT 0455 0003 Dr Davies
66 No copy of this draft was produced to the Inquiry
67 T73 p. 158–9 Dr Monk
68 T74 p. 122 Dr Masey

55 Dr Underwood told the Inquiry of her understanding of the use to which the letter would be put:

> 'I was aware only that we were sending it initially to Dr Monk, with the understanding that he would then be able to use it.'[69]

56 The letter in its final form was signed by six anaesthetists and had the approval of the person to whom it was addressed, Dr Monk. It raised concerns about the Arterial Switch programme currently being undertaken, expressed the view that mortality for that operation was apparently high, referred to the recent death of a 14-month-old child following an Arterial Switch procedure, and sought a review of the results achieved thus far. The letter referred to the Arterial Switch programme without drawing any distinction between neonates and older children, although it referred to results being particularly bad in the neonatal period.

57 The first of the drafts in which the letter was addressed to Dr Monk, rather than signed by him, began:

> 'We wish to express our [increasing] concern about the Arterial Switch programme currently being undertaken in this hospital.
>
> 'The mortality for this operation is apparently [unacceptably] high, particularly for those operations undertaken in the neonatal period, but the recent death of a 14-month-old child following the Arterial Switch procedure must now lead to an open and thorough review of the results so far. It is our belief that this review should be confidential and take place between all the cardiac anaesthetists, all the cardiac surgeons, all the paediatric cardiologists and the Director of Cardiac Services. This responsible approach to (our)[70] [what is obviously an unacceptable] clinical practice would defuse many of the criticisms of this programme in this institution expressed privately and publicly.' [71]

58 The words set out in square brackets in the letter quoted above appeared in this draft but were removed following further discussion. Four anaesthetists had been prepared to sign the letter in its original draft form.[72] Dr Masey, however, stated in her written evidence to the Inquiry:

> 'I was happy to co-sign this letter, as I felt that this was the first time that Dr Bolsin had involved his cardiac anaesthetic colleagues. I viewed this as an open and transparent approach to the voicing of concerns. I asked Dr Bolsin to make a minor change in the letter before I was willing to sign it, changing the phrase "unacceptable results" in Switch procedures to "apparently unacceptable results",

69 T75 p. 151 Dr Underwood
70 The word 'our' appeared in the later drafts when the words in square brackets were removed
71 GMC 0004 0064; letter from Dr Underwood, Dr Davies, Dr Pryn, Dr Masey, Dr Bolsin and Dr Baskett to Dr Monk dated 21 June 1994
72 UBHT 0061 0006; letter of 21 June 1994 signed by Dr Davies, Dr Pryn, Dr Bolsin and Dr Baksett, but not by Dr Underwood or Dr Masey

as I did not believe that at that time we had accurate enough figures for the results of this procedure in older children to make this statement.'[73]

59 In her oral evidence to the Inquiry, Dr Masey said that it was:

'… not the word "apparently" that I wished to have added but the word "unacceptably" that I wished to have removed'.

She had been unable to agree to the emphasis of the first letter.[74]

60 Dr Underwood saw the letter as amended. The letter with the words in square brackets removed became the final version. The signatories were Dr Davies, Dr Baskett, Dr Pryn, Dr Bolsin, Dr Masey and Dr Underwood. No single copy of the letter had all six signatories, although the signatures of all six appeared on one or other copy of the final version of the letter.

61 Dr Underwood stated in her written evidence to the Inquiry that by the winter of 1993 there was growing concern amongst cardiologists, cardiac surgeons and anaesthetists over the mortality of the neonatal patients undergoing the Switch operation.[75] She told the Inquiry that she signed the letter because she believed that the mortality for the operation of neonatal Switch was 'apparently high' and:

'… in order to get the group working as a team, to have an open review, I felt that this was a suitable letter to sign. We did refer to a thorough and open review of the results so far, and I felt that that was the key issue in this letter.'[76]

62 Dr Masey told the Inquiry that she agreed with the terms in which the letter was sent.[77] Its purpose, she said, was:

'… to actually make this into a much more open and transparent mechanism for looking at any criticisms and trying to gain more information to see whether there was any basis in these criticisms'.[78]

63 Dr Monk told the Inquiry that the letter reflected 'the strong feeling that Drs Davies, Pryn, Bolsin and myself had already expressed about the Arterial Switch programme'.[79]

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73 WIT 0270 0015 – 0016 Dr Masey
74 T74 p. 120 Dr Masey
75 WIT 0318 0011 Dr Underwood
76 T75 p. 150 Dr Underwood
77 T74 p. 118–19 Dr Masey
78 T74 p. 123 Dr Masey
79 T73 p. 157 Dr Monk

64 On 30 June, nine days after signing the letter, Dr Underwood anaesthetised a non-neonatal patient undergoing a Switch operation. She told the Inquiry:

> 'I did not think this letter prevented me from continuing with that routine work, and indeed, my experience from my own records was that the cases of older children having Switches, which I had done with Mr Dhasmana, had generally survived.'[80]

65 On 29 June 1994 Mr Dhasmana wrote to Dr Martin. In his letter he stated that he had seen a patient named Joshua Loveday along with his parents earlier that day at his clinic. Joshua was then 12 months old. He stated that:

> 'I have recommended Arterial Switch repair with coronary transfer and patch repair for VSD. The nature and risk of this operation has been explained to his parents to which they have agreed. I hope to operate on him within the next four to six months.'[81]

July

66 Dr Monk stated in his written evidence to the Inquiry that he spoke to Dr Roylance on a one-to-one basis, and gave two dates in July 1994 when he might have done so in relation to the letter signed by the anaesthetists: 1 July and 12 July. He stated that he informed Dr Roylance that there was a problem in paediatric cardiac surgery regarding outcomes, which he was unable to solve as Clinical Director of Anaesthesia. He went on:

> '… his response remained unchanging in his assertion that he was the Chief Executive and therefore a manager, that the difficulty lay within clinical practice and therefore it was for the clinicians and clinical directors to solve. He did not accept that the flat management structure of the Trust had failed because it was the Medical Director and the Clinical Director of Cardiac Surgery being criticised. He did not accept the role as a final arbitrator and continued to refer the problem back to the clinicians. … In spite of discussing the letter's content, the reason for requesting an audit and my concerns JR [John Roylance] again used the logic that, if there was a problem, it was in the clinical area and it was the clinician's responsibility to address. He declined to organise a formal audit, did not accept the existence of a problem and refused a copy of the letter as it was addressed to me and did not require his action. I did not subsequently take the letter to JDW [Mr Wisheart] but assumed that JR would speak to the Medical Director [Mr Wisheart] regarding the content of the letter.'[82]

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80 T75 p. 152 Dr Underwood. This was the last such Switch before the operation on Joshua Loveday on 12 January 1995, which is described in Chapter 30

81 MR 0164 0033 Joshua Loveday's medical records. See Chapter 3 for an explanation of clinical terms

82 WIT 0105 0028 – 0029 Dr Monk

67 Dr Monk added in his oral evidence to the Inquiry:

> 'I think he was saying "no" to the fact that it was him that should implement the review; that it was a clinician's problem to go and deal with. But I was saying that I could not deal with that problem and I had come to him as one of his Clinical Directors.' [83]

68 Dr Roylance stated in his written evidence to the Inquiry:

> '… I am certain that Dr Monk did not show me the letter. It would be an unusual letter for me to see and I do not believe it is possible that I could have forgotten it. … I do not believe that Dr Monk discussed with me the existence of this letter or its contents and I am sure that he did not ask me to become involved in organising a review of any paediatric cardiac surgery.'[84]

69 In his oral evidence to the Inquiry, Dr Roylance said that if he had been shown the letter he would have been astonished and would have reacted very quickly and very strongly.[85] He said that a letter such as this was unique and that he found it 'astonishing', and the fact that it was signed demonstrated that there was an 'astonishing degree of concern being felt by the signatories which they thought was not being addressed one way or another'.[86]

70 The following exchange took place between Counsel to the Inquiry and Dr Roylance:

> 'Q. How often did you see Dr Monk?
>
> 'A. Once a week, twice a week, sometimes more.
>
> 'Q. He told us that he took the letter to you?
>
> 'A. I am surprised he said that. This is not the sort of letter that I could conceivably forget.
>
> 'Q. He maintained, although pressed on the point, that he gave the letter to you?[87]
>
> 'A. No.

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83 T73 p. 164 Dr Monk
84 WIT 0108 0128 Dr Roylance
85 T88 p. 148 Dr Roylance
86 T88 p. 149 Dr Roylance
87 In fact, Dr Monk's evidence was that he offered Dr Roylance a copy of the letter but that Dr Roylance refused to accept it; T73 p. 165–6 and WIT 0105 0029

'Q. And you pointed out, as is the case, that it was not addressed to you and therefore handed it back to him?

'A. That is nonsense, all he had to do was write on the bottom "copy to Dr Roylance" and I was stuck with it; I do not find that remotely feasible, I am sorry.

'Q. He tells us that when he took the letter to you, as he says he did, he told you about the concerns in it and that he supported them?

'A. He is mistaken. I do not think I ought to speculate as to how that mistake comes about but I have absolutely no doubt that I did not see this letter until after I had retired.

'Q. I asked him "What was the response when you (that is Dr Monk) showed him (that is you, Dr Roylance) the letter?". His answer was "The response was that it remained a clinical problem, but he was the Chief Executive of the Trust and it was for the clinicians to solve".

'A. If you believe that, you would believe anything. I mean, the suggestion — please, the suggestion that I would see a letter like this, astonishing as it is, inexplicable as it is and say "I do not want it, nothing to do with me" I find offensive.'[88]

71 Dr Underwood, when asked about the effect that the letter had, said:

'A. I do not think that it led to an open and thorough review of the results. In that sense it was disappointing.

'Q. Did you ever discuss it with Mr Dhasmana?

'A. … I do not remember doing so.

'Q. Or why no open or thorough review had been taking place in response to it?

'A. No. I do not think I did.'[89]

72 Dr Masey told the Inquiry that she could not recall ever asking Dr Monk: 'Look here Chris. What has happened to the open and thorough review we asked for?'.[90] Dr Monk told the Inquiry that he was:

'… greatly frustrated by my [his] failure to achieve the goals, and there were a number of issues or actions that I thought I could take. It would have been appropriate to write to him and give him a copy of that letter. I did not believe it

88 T88 p. 152–3 Dr Roylance
89 T75 p. 151–2 Dr Underwood
90 T74 p. 125 Dr Masey

would make any difference at all in the process that we were now in and I did not do so.'[91]

73 In July 1994 the anaesthetists' concerns about the Arterial Switch programme were brought to Mr Dhasmana's attention. Mr Dhasmana told the Inquiry:

> ' … Dr Monk told me that that is what the anaesthetists have decided: that in a way if you are really arranging any more Switch operations, you must discuss with us.'[92]

74 Mr Dhasmana explained that for him this meant:

> ' … the neonatal Switch was stopped and for older Switches I agreed with them that if I arranged any I would talk to them [the anaesthetists].'[93]

75 On 19 July 1994 Dr Peter Doyle, a Senior Medical Officer at the Department of Health (DoH), attended a meeting in Bristol concerning the audit system of the Association of Cardiothoracic Anaesthetists of Great Britain and Ireland (ACTA). In his written evidence to the Inquiry Dr Doyle stated:

> 'Once the formal business was completed, Dr Bolsin asked if he could accompany me back to the station. During the trip he explained that he was very concerned about the results of an audit he had conducted into neonatal and infant cardiac surgery at Bristol Royal Infirmary. His primary concern at that time was to seek my advice about how to get those responsible in the Trust to address his concerns.'[94]

76 In his written evidence to the Inquiry, Dr Bolsin stated:

> 'During this meeting Professor Angelini mentioned the problems of paediatric cardiac surgery at the Bristol Royal Infirmary. Due to pressure of time it was not possible for me to discuss in detail these problems with Mr [*sic*] Doyle but in the taxi on the way to Temple Mead station I provided the background information and the figures that were available to me at that time. These included the results of the Bolsin/Black data analysis/collection; the Arterial Switch mortality rates (provisional); the recent AV canal data for Mr Wisheart. The discussion on the journey centred on the most appropriate way to deal with [the] problem.'[95]

77 Dr Bolsin told the Inquiry his reason for accompanying Dr Doyle to the station:

> ' … I had already been to Dr Ashwell at the Department of Health and been referred to the GMC guidelines which had been deemed inappropriate and I was still concerned about the continued activity in some paediatric cardiac surgical

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91 T73 p. 165 Dr Monk
92 T87 p. 38–9 Mr Dhasmana
93 T87 p. 40 Mr Dhasmana
94 WIT 0337 0002 Dr Doyle
95 WIT 0080 0119 Dr Bolsin. See Chapter 3 for an explanation of these clinical terms

operations in Bristol which I believed were exposing children to risk and I thought that I was now justified in involving another senior medical officer at the Department of Health to try and find out if there was a problem and whether we should be doing something about it.'[96]

78 In the course of his oral evidence, Dr Doyle said:

' … He [Dr Bolsin] actually handed me an envelope which he said contained the audit results. He did not go on to be particularly specific about what those results showed or when the audit was conducted. He just said, "I have done an audit".'[97]

79 When asked what advice he gave to Dr Bolsin, Dr Doyle stated:

'I explained if there were questions … it was a matter for the Trust and there were well recognised mechanisms. He said he had tried to bring the results to the attention of people in the Trust, so far without success, so I went on to explain in greater detail about HC(90)9 … .'[98]

80 Dr Doyle went on:

'… the argument over those figures, over the significance of those figures, is an inter-professional dispute. Ipso facto, if the two sides cannot agree as to the meaning of those figures and the importance of those figures, then management has on its hands an inter-professional dispute. That inter-professional dispute requires to be resolved. You cannot allow clinicians in the departments to carry on disputes for many years. It damages the effectiveness of the unit. So management has a requirement to bring in outside independent people who have the skills to look at that, to peer review in effect what is going on and to make recommendations.'[99]

81 Dr Doyle explained why he directed Dr Bolsin to HC(90)9:

' … One thing I was clear about is that he was one side of an inter-professional disagreement or dispute of some sort. Whether right was on his side at that stage, I had no way of judging adequately.

'There was clearly a mechanism laid out, one which I was fairly familiar with, for resolving these disputes, so the first initial concern on my part was to make sure

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96 T83 p. 98 Dr Bolsin
97 T67 p. 26 Dr Doyle
98 T67 p. 27 Dr Doyle. DoH Health Circular HC(90)9 set out the terms and conditions of service for hospital medical and dental staff and doctors in community medicine and community health service. It was introduced on 18 April 1990 and set out two new procedures: one for disciplinary action short of dismissal; and the other for review of the conduct of consultants alleged to have failed repeatedly to honour their contractual commitments
99 T67 p. 56 Dr Doyle

that the appropriate mechanism was used, was expedited to get on with resolving this dispute.

'The question was, I have asked myself this many times, whether I could nudge the process forward and ensure that the Trust took action fairly speedily to resolve the dispute and to get to the bottom of the argument as to whether there was or was not a case to answer.'[100]

82 Dr Bolsin told the Inquiry that he discussed three options with Dr Doyle.[101] The first and second options (which were, respectively, to go to the Secretary of State, or to the Royal Colleges) were discounted. They would, in all likelihood, mean the cessation of all operations within the Unit and Dr Bolsin said that he felt that there were still beneficial operations taking place within the Unit.[102] Dr Bolsin went on:

'The third course of action was that Mr [*sic*] Doyle would write to Professor Angelini who was aware of the problems and I had reported to Mr [*sic*] Doyle that Gianni was aware of the problems and he would then report back to Peter Doyle with the authority of having been contacted by the Department of Health about a perceived problem. It was the third course of action we agreed upon because that preserved operating within the Unit, it would lead to the open review, it would reduce the high-risk operations and the solution would be found, we hoped.'[103]

83 Dr Doyle explained that, because there was an appropriate mechanism for dealing with disputes of the nature Dr Bolsin had outlined to him, he at no time looked at the contents of the envelope that Dr Bolsin had given him.[104] On his return to the DoH Dr Doyle filed the envelope in his personal filing cabinet with the other papers which he had collected whilst at Bristol.[105]

84 On 21 July 1994 Dr Doyle wrote to Professor Angelini. In his letter, Dr Doyle stated that concerns over mortality rates in neonatal and infant cardiac surgery at the BRI had been brought to his attention. Dr Doyle wrote:

'I am sure you agree that this is a matter for very great concern. If the position proves to be as reported to me, the excess deaths are in themselves a tragedy. If the problem has been recognised and adequate remedial steps have not been taken, it becomes an unacceptable tragedy.'[106]

100 T67 p. 34 Dr Doyle
101 T83 p. 99 Dr Bolsin
102 T83 p. 99–100 Dr Bolsin
103 T83 p. 100 Dr Bolsin
104 T67 p. 36 Dr Doyle
105 T67 p. 40 Dr Doyle
106 UBHT 0052 0287 Dr Doyle; letter dated 21 July 1994

85 Dr Doyle added:

> 'If there is a problem and, for any reason, you are not able to reassure me that it has been resolved, the circumstances are such that I would be obliged to seek the help of colleagues in the Performance Management Directorate who would doubtless raise the matter formally with the Trust. It is highly likely that some sort of formal enquiry would follow.'[107]

He continued:

> 'I recognise that this letter may put you in a very difficult position personally. If there is anything I can do to help, please do not hesitate to get in touch.'[108]

August

86 Professor Angelini replied to Dr Doyle's letter on 19 August 1994:

> 'Thank you for your letter of the 21st July to which I am a bit late in replying since I have been abroad.
>
> 'I appreciate your frankness and concern about some of our paediatric cardiac surgery work. I have to admit that indeed there have been audits carried out which have shown a greater mortality than perhaps could be expected in a particular surgical procedure. This has been a matter of concern for us all and we have tried very hard in the last few months to implement changes aimed at improving our results.
>
> 'In line with the expansion which is taking place in our department, we have been able to advertise a new position for a full-time consultant paediatric cardiac surgeon. I am glad to say that we have had a good response to our advert and an interview is now being held on the 20th September. I can assure you that we will do our best to appoint a suitable candidate – it is our desire to find somebody familiar with the surgical procedure for which our results have been least satisfactory. Of course, it all depends on the quality of the applicants but I can tell you that from the interest this position has generated, we will certainly have at least one, or possibly two, very experienced candidates.
>
> 'In order to achieve an excellent paediatric service, however, it is also necessary to provide a better environment in which such surgery can be conducted. The view of all the medics involved in this work, anaesthetists, surgeons and cardiologists, is that the present facilities should be moved from the Bristol Royal Infirmary into the Bristol Royal Hospital for Sick Children and it is my understanding that the Trust has been looking in this direction. The appointment of a full-time paediatric surgeon and the move [of] the activity to the "Children's Hospital" would greatly strengthen

[107] UBHT 0052 0287 Dr Doyle; letter dated 21 July 1994
[108] UBHT 0052 0288 Dr Doyle; letter dated 21 July 1994

our unit and address the shortcomings pointed out in your letter. I can assure you that everything will be done to appoint a suitably experienced person and I can also assure you that it is the wish of all the medics to move the paediatric surgery to the "Children's Hospital". Ultimately, however, the decision to move the unit is not in my hands but in the hands of the UBHT Trust so I am not in the position to comment any further on this particular issue.

'I am very grateful for the interest you have expressed in our unit. There is no doubt in my mind that the problem we have been experiencing is something which we can address. I am sure that in the next six months I will be able to write to you again and present you with evidence that the changes have taken place, as desired by you and indeed by everybody else concerned here in Bristol. I will keep you informed all the way along. May I thank you again for the opportunity you have given us to put our house in order.'[109]

87 Dr Doyle replied to this letter on 30 August 1994. He wrote:

'I am very pleased to hear that the difficulties I referred to in my last letter have been recognised and action is being taken to remedy matters. I look forward in due course to hearing that a new appointment has been made and that the results from Bristol are at least as good as those from other major centres undertaking paediatric cardiac surgery.'[110]

September

88 Following Dr Doyle's reply to Professor Angelini, Dr Roylance wrote to Dr Doyle. Dr Roylance had been made aware of the correspondence that had passed between Dr Doyle and Professor Angelini as Professor Angelini had copied Dr Roylance in to his letter to Dr Doyle.[111] Further, Mr Wisheart had written to Dr Roylance on 4 September commenting on Professor Angelini's letter of 19 August. Mr Wisheart referred in the letter to the 'limited nature of the problem'.[112]

89 In his letter to Dr Doyle dated 12 September 1994, Dr Roylance stated that:

'I felt I should write to confirm the Trust Board's awareness of this problem, for which reason we are seeking to appoint another full-time Consultant Paediatric

109 DOH 0001 0012 – 0013; letter dated 19 August 1994
110 UBHT 0052 0284; letter dated 30 August 1994
111 UBHT 0061 0273 – 0274; letter from Professor Angelini to Dr Doyle dated 19 August 1994
112 UBHT 0061 0276; letter from Mr Wisheart to Dr Roylance dated 4 September 1994. In June 1996, Mr Wisheart was to report in his *'Statement to the Clinical Directors of UBHT'* that: 'Paediatric cardiac surgery had disappointing results in about 2% of its work for reasons which have not been clearly identified. However, paediatric cardiac surgery was not a disaster area and ironically in the years '92 to '95 the results were the best we had ever achieved. Audit was active, healthy and was used. True information was given to parents and consent was informed. Decisions to operate were deliberate and not cavalier.' UBHT 0054 0007

Cardiac Surgeon, and the Appointments Committee is due to meet on the 20th September.

'The decision has already been taken by the Trust Board, and plans are in hand, to move Paediatric Cardiac Surgery into the Children's Hospital. I have every confidence this move, and the appointment of the new surgeon, will resolve the situation for the future.'[113]

90 Dr Roylance was asked by Counsel to the Inquiry:

'Q. When you say you write to confirm the Trust Board's awareness, did you tell the Trust Board at this time of this correspondence?

'A. I do not know. I do not know. I may well not have done … .'[114]

91 Mrs Maisey, in her written evidence to the Inquiry, made this comment on the letter:

'As an executive board member, I should like to confirm and clarify that I was not aware of such matters at that time. My recollection is supported by the Board minutes which show that the first time that concerns surrounding paediatric cardiac surgery were drawn to the attention of the Board was at a meeting on 24 February 1995, following the de Leval and Hunter visit.'[115]

92 As to the 'problem' referred to, there was the following exchange with Dr Roylance in the course of his giving evidence to the Inquiry:

'Q. When you … write in the second paragraph that you felt you should write to confirm the Trust Board's awareness of this problem, … you did not know what the problem was that the Department of Health had in mind?

'A. I thought I did. I mean, I thought there was no doubt. If you read Gianni's letter, he says there is a particular treatment with which they have had very poor results. That could only have meant, in my belief at the time, the neonatal Switch procedure, which had stopped. That is what Gianni Angelini said. There was one problem, as I remember – I cannot remember his exact words, but there was one problem of treatment, which was being addressed – something like that. I knew, because we were at that time, as it says, seeking a paediatric cardiac surgeon to reinstitute neonatal Switches.

113 UBHT 0061 0278; letter dated 12 September 1994
114 T89 p. 48 Dr Roylance. No minute indicating that the Trust Board was made aware of the particular problem raised by Professor Angelini was produced to the Inquiry
115 WIT 0337 0062 Mrs Maisey. See Chapter 30

'Q. The words he used were "a greater mortality than perhaps could be expected in any particular surgical procedure"?

'A. In "a particular surgical procedure", yes. I knew a particular surgical procedure was neonatal Switches. It was part of the work-up to the appointment of a paediatric cardiac surgeon. So I thought I was entirely aware of what the conversation was about.

'Q. Did you know that the neonatal Switch had in fact ceased the previous October?

'A. Yes.

'Q. A year before this, almost?

'A. Yes.'[116]

93 In his letter to Dr Doyle, Dr Roylance wrote in the final paragraph:

'I will continue to monitor the situation with Gianni Angelini, and I see that he has promised to keep you informed.'[117]

94 Dr Roylance was asked:

'Q. … you continued to monitor the situation with Gianni Angelini. What were you monitoring?

'A. The arrival of the new surgeon and the move up the hill. I am sorry to say the Health Service has a long track record of not achieving its firm decisions, and that was what I was monitoring.

'Q. So we read "continue to monitor the situation" as meaning to ensure that these two promises are kept?

'A. Yes.'[118]

95 The letter from Dr Roylance led to a reply from Dr Doyle in which he said:

'I was very relieved to hear from Gianni Angelini that a change in the service had been planned. Under the circumstances I think it best to leave the Trust to effect the proposed changes as quickly as possible.'[119]

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116 T89 p. 47–8 Dr Roylance
117 UBHT 0061 0278; letter dated 12 September 1994
118 T89 p. 48–9 Dr Roylance
119 UBHT 0052 0283; letter from Dr Doyle to Dr Roylance dated 20 September 1994

96 Dr Roylance wrote back to Dr Doyle on 22 September 1994 to inform Dr Doyle that Mr Ashwinikumar Pawade had been appointed as a consultant paediatric cardiothoracic surgeon and to state that:

> ' … [UBHT] is progressing the move of paediatric cardiac surgery to the Bristol Royal Hospital for Sick Children.
>
> 'The Trust is confident that these changes will assist with the continued progress of paediatric cardiac surgery.'[120]

97 Dr Doyle replied thanking Dr Roylance for keeping him up to date.[121]

98 Professor Farndon, in his written evidence to the Inquiry, stated that it was also in September 1994 that:

> 'As the possible appointment of a new cardiac surgeon became more imminent I certainly did meet with Mr McKinlay, the then Chairman of the Trust. I may have mentioned concerns at that meeting, although I cannot remember having done so. This meeting was held between myself, Mr McKinlay and Professor Angelini. By that time it had been resolved that we would look for an appointment in paediatric cardiac surgery and we knew of the possible candidacy of Mr Ash Pawade. Professor Angelini and I wanted to ensure that there would be no administrative problems in the possible appointment of Mr Pawade associated with his move from Australia … .'[122]

99 Professor Angelini and Mr McKinlay stated that there was a discussion about the poor performance of the paediatric cardiac surgery service at this meeting.[123] Professor Farndon told the Inquiry that he could not recall this. According to Mr McKinlay, both Professor Farndon's and Professor Angelini's concern:

> '… was centred on the poor performance of the Switch operation and the controversy over the time taken by Mr Wisheart on some procedures. The Switch operation had been suspended and the position would be resolved by the appointment of a new full time paediatric cardiac surgeon.'[124]

100 Professor Farndon's recollection was that:

> ' … some smaller part of that meeting was concerned with paediatric cardiac surgical outcome and performance.'[125]

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120 UBHT 0061 0280; letter from Dr Roylance to Dr Doyle dated 22 September 1994
121 UBHT 0061 0281; letter from Dr Doyle to Dr Roylance dated 3 October 1994
122 WIT 0087 0009 Professor Farndon
123 WIT 0073 0055 Professor Angelini, WIT 0073 0016 Professor Angelini
124 WIT 0102 0028 Mr McKinlay
125 T69 p. 165 Professor Farndon

October

101 It was in October, according to Mr McKinlay, Chairman of the Trust Board, that he began to hear for the first time from Dr Roylance the names 'Bolsin' and 'Peter Doyle' and talked to Dr Roylance about them.[126]

November

102 Mr Alan Bryan, consultant cardiac surgeon, told the Inquiry about a consultants' meeting, attended by Mr Dhasmana, Mr Hutter, Mr Bryan and Professor Angelini,[127] immediately after the monthly audit meeting of 10 November 1994:

> 'Professor Angelini asked Mr Dhasmana whether the paediatric service could be rationalised prior to the arrival of Mr Pawade … Mr Dhasmana was very offended by the Professor's apparent interference. ... He accused the Professor of criticising the paediatric cardiac surgery service outside Bristol … Professor Angelini had sought advice and help … from [Mr Stark] … Mr Dhasmana unfortunately appeared to interpret this action as unwelcome and unfair interference from others outside the running of the service. This meeting degenerated into an unpleasant argument … the Professor asking for the rationalisation of the service and Mr Dhasmana rejecting outside interference in the service. Mr Hutter and I participated very little in the argument which ended in an acrimonious impasse.[128]
>
> ' … I can fully understand why Mr Dhasmana would view this … action as unsolicited and unfair interference by Professor Angelini …[129]
>
> 'Q. … Did Mr Dhasmana … perceive Professor Angelini as being one of the outsiders interfering with the service?
>
> 'A. Yes … I think that is specifically what I mean.'[130]

103 Mr Dhasmana told the Inquiry about the meeting:

> 'The whole meeting related to raising concerns about my surgical work outside Bristol without first discussing them with me.'[131]
>
> 'It started friendly. … It became … acrimonious … It was not — more an argument in the end, it became almost a one-sided, a Latin burst. … I was angry but I am not very good with my words so I became dumb when I heard somebody [Professor Angelini] really saying "kiss my feet". … After that I became totally dumb because I thought "if I respond now I am angry I may say something and I will regret it".

126 T76 p. 45 Mr McKinlay
127 T63 p. 67 Mr Bryan
128 WIT 0081 0026 – 0027 Mr Bryan
129 T63 p. 74 Mr Bryan
130 T63 p. 79 Mr Bryan
131 WIT 0081 0039 Mr Dhasmana

Obviously he himself felt a bit bad having uttered those words so he was trying to explain and it became … one-sided. He really said "well, I tried to save your bacon, the Department of Health was going to close the Unit and I really fought your corner, I really told them your results are very good, we do not need to stop the Unit, it is just we really need to look at a few things." But I am sorry at that time I was in no mood to reciprocate or communicate any further and I just kept listening …

'Q. … there had been concern expressed to the Department of Health about the results in paediatric cardiac surgery and that he … had suggested that the Unit was solving the problems by appointing a new cardiac surgeon so that the work would go on taking place …

'A. At that time I did not understand that that is what he was saying, but when I read further information on that I think it became more clear. I do not think it was that clearly mentioned at that time. What upset me … we were meeting almost every other day or every week in the Unit, we were working on a common purpose, to get a paediatric cardiac surgeon and he never mentioned that there was this talk with Dr Doyle or the Department of Health … I was very pleased that he was with me on this one to get [Mr Ash Pawade]. … He talked to other people, why could not he really just tell me at the same time? … If you are told by somebody "kiss my feet", would you take any further part in the conversation?

'Q. (The Chairman): Mr Dhasmana, what did you understand was meant by that? …

'A. Very humiliating.'[132]

104 Mr Dhasmana told the Inquiry about the effects of the meeting:

'I thought I had good relations with all the gentlemen who had been here and saying something totally different than what they said before.

'Q. And Professor Angelini?

'A. I have changed my mind after the November 1994 meeting.'[133]

105 On 17 November Professor Farndon discussed the concerns being expressed about paediatric cardiac surgery with one of the surgeons involved, Mr Wisheart:

'I met with James Wisheart on 17 November 1994. At that meeting I made a note … The meeting took place in James' office on Ward 5, which is the cardiac ward. I made the note on the night of the meeting but did not provide a copy to James. The fact that I made a note was a measure of the degree of importance I attached to

132 T87 p. 27–30 Mr Dhasmana
133 T86 p. 160 Mr Dhasmana

the meeting. Until that occasion the writing of notes would *never* have been something I would have done.'[134]

106 Professor Farndon told the Inquiry about his reasons for calling the meeting:

'I think I had heard a volume of continued disquiet, noise, and it was almost an exasperation that no resolution had occurred. It still was not within any of my remit, strictly speaking, to be concerned with the results of cardiac surgery, but people kept talking and no evidence was ever handed to me that everybody had agreed upon, identifying that there is a problem or there is not a problem. So there was a feeling of exasperation that the thing had not been resolved.'[135]

107 Professor Farndon, in his written evidence to the Inquiry, stated that:

' … as a friend and colleague of James, I could not tolerate hearing oblique criticisms (without objective evidence) of a colleague's work or performance. I felt a duty, first, to be sure that James was aware of these criticisms, and, secondly, to see if I could help in the resolution of any particular problems that might exist.'[136]

108 Professor Farndon went on:

' … James agreed that the outcomes of some paediatric cardiac procedures were not good but I do not remember discussing any specific procedures. I think I would have made a note if we had. I also remember that we discussed case complexity and risk factors and how these played upon outcome.'[137]

109 He concluded:

' … at the end of the meeting we had resolved the issues and we had seen a potential way forward. It was agreed that there would be a tabulation of results, and an agreement between the relevant surgeons as to their authenticity and accuracy. Then, there would be an open meeting with the cardiologists and anaesthetists to discuss that data. This was in respect of all the cases, adult and paediatric … .'[138]

134 WIT 0087 0009 Professor Farndon (emphasis in original)
135 T69 p. 170 Professor Farndon
136 WIT 0087 0010 Professor Farndon
137 WIT 0087 0010 Professor Farndon
138 WIT 0087 0011 Professor Farndon

110 Professor Farndon's note of the meeting recorded the outcome as follows:

> ' … *That it is resolved that*: the 5 cardiac surgeons will tabulate results, agree them as authentic and accurate and that the 5 surgeons will then meet openly with cardiologists and cardiac anaesthetists to discuss results.
>
> 'Agreed that
>
> '(i) cardiac surgeons will meet & agree figures for all cases
>
> '(ii) hold an open meeting for *all* to examine results …
>
> '(iii) that I ring Chris Monk and advise him of these things
>
> '(iv) that JW [Mr Wisheart] recognises that he gets more difficult cases … .'[139]

111 On the following day, Professor Farndon wrote to Mr Wisheart, with a copy to Dr Monk:

> 'I really do believe that the best way forward is for an internal discussion to begin initially with the five cardiac surgeons. Work should be done fairly quickly to agree the data and this should then be openly discussed with colleagues from cardiology and cardiac anaesthesiology.'[140]

112 Professor Farndon stated:

> 'I wanted the matter to be resolved quickly. I was getting impatient with colleagues talking in corridors without objective evidence. I wished to see the situation resolved. I indicated to both James and Dr Monk that if the group wished me to play any further part I would be pleased to do so. My aim was to be an objective and honest broker, or chair, if that were to be desired. I hoped that the things we had agreed would happen.[141]

113 Professor Farndon noted:

> 'No one ever returned to me to ask for my further services.'[142]

December

114 On the evening of 8 December 1994 a scheduled meeting of the Paediatric Heart Club took place at Dr Joffe's home.[143] Mr Dhasmana told the Inquiry that Dr Martin and he had discussed the proposed Switch operation on Joshua Loveday after Joshua

139 WIT 0087 0025 – 0026; transcript of Professor Farndon's handwritten note of the meeting on 17 November 1994 (emphasis in original)
140 WIT 0087 0028; letter from Professor Farndon to Mr Wisheart dated 18 November 1994
141 WIT 0087 0012 Professor Farndon
142 WIT 0087 0012 Professor Farndon
143 T87 p. 41 Mr Dhasmana

had been seen in Gloucester in November 1994.[144] Mr Dhasmana and Dr Martin decided, and Dr Joffe agreed, that the meeting of the Paediatric Heart Club was a suitable occasion on which to discuss the issue of Mr Dhasmana's performing non-neonatal Switch operations. After the decision had been taken to dedicate the meeting to a discussion of the non-neonatal Switch series, Mr Dhasmana told the Inquiry that he:

> '… made personal telephone calls and communicated to everybody that I would be grateful if they attended this meeting, all of them.'[145]

115 Mr Dhasmana said that he asked Dr Bolsin to attend:

> '… when I talked to him he looked in his diary, he said "Sorry, I am busy at that time somewhere else but I will see what I can do". In the end he did not turn up.'[146]

116 Mr Dhasmana was asked about the meeting in the following exchange:

> 'Q. So the meeting then took place. What discussion was there about the Joshua Loveday operation? Was it about the operation or was it about the Switch programme itself?
>
> 'A. It was about the older Switch programme. It is just I intimated to them that: "I have got a patient on my list to be operated on".
>
> 'Q. So no specific conversation about that particular patient, just about the Switch programme?
>
> 'A. Yes.
>
> 'Q. Were there any figures discussed at that meeting?
>
> 'A. I took my hand notes because I was not going to that meeting without any information with me. So in my hand I had written down all the Switches which I had done right from number 1 in 1988 – I am talking of all older Switches – until the last one.'[147]

117 Mr Wisheart, in his written evidence to the Inquiry, stated:

> '… there was a long and detailed discussion as to whether it was appropriate for Mr Dhasmana to continue to do the Arterial Switch operation in older children. For the purposes of the discussion, all sides of the debate were examined and data

144 T87 p. 41 Mr Dhasmana
145 T87 p. 41 Mr Dhasmana
146 T87 p. 41 Mr Dhasmana
147 T87 p. 42 Mr Dhasmana

was provided to that meeting. The meeting concluded that Mr Dhasmana should continue to do the Arterial Switch operation in older children.'[148]

118 Mr Wisheart stated that Dr Joffe, Dr Martin, Dr Hayes, Dr Masey, Dr Underwood, Dr Pryn, Dr Wilde, Mr Dhasmana and he were present at the meeting. Mr Wisheart stated that Dr Bolsin was not present.[149]

119 When Dr Masey was asked about the meeting, she said that she had 'very little recollection of the subject matter' of the meeting.[150] As regards the discussion of the non-neonatal Switch series, she said:

'My recollection was that the results in the older Switches were acceptable, yes, were within acceptable … were acceptable, yes.'[151]

120 Dr Pryn and Dr Underwood both had a very poor recollection of the meeting and what was said at it.[152]

121 No minutes were made of the meeting.

122 On 15 December Professor Vann Jones, having received some further data from Mr Wisheart, wrote to Mr Wisheart acknowledging receipt of the data:

'I looked through the figures with interest and certainly as far as I can see all the groups to which statistics could be sensibly applied equal or better the national average. As you know there are many small groups some better, some worse than the national average but where one single event totally distorts the picture. I personally feel very re-assured about the figures and would stoutly defend them if they ever become the subject of further debate.'[153]

123 Subsequently, in his oral evidence to the Inquiry, Professor Vann Jones said that he had:

' … made assumptions that that must be validated data. I did not know until later on, for instance, that the whole thing was anonymised and lumped together … I had no idea in those days, it was just people sending forms in and the whole thing was lumped together, so therefore any particular centre that was not performing was just lost in the overall … .'[154]

148 WIT 0120 0455 Mr Wisheart
149 WIT 0120 0455 Mr Wisheart
150 T74 p. 129 Dr Masey
151 T74 p. 131 Dr Masey
152 T75 p. 155 Dr Underwood; T72 p. 161 Dr Pryn
153 JDW 0005 0180; letter from Professor Vann Jones to Mr Wisheart dated 15 December 1994
154 T59 p. 129 Professor Vann Jones

124 Dr Bolsin stated in a report in October 1995 that at some point in December 1994 he contacted Dr Doyle at the DoH in the light of the proposed operation on Joshua Loveday:

> 'When it became apparent that the operation was very likely to proceed, and after consultations with Mr Bill Brawn (Consultant paediatric cardiac surgeon, Birmingham Children's Hospital) and Mr John Parker,[155] I contacted Dr Doyle and told him of my grave concerns over the safety of the patient. Professor Angelini also contacted Dr Doyle for the same reasons.'[156]

125 Mr McKinlay, in his written evidence to the Inquiry, stated:

> 'By Christmas 1994 I had reached the point where I told Dr Roylance that I wanted an independent inquiry and he agreed … it is my recollection that he or Mr Wisheart had started to explore with the Royal College of Surgeons the identification of experts who might conduct the inquiry.'[157]

126 Mr McKinlay was asked about this part of his statement when he gave oral evidence:

> ' … I can remember going away for the Christmas break and saying, "John [Dr Roylance], I think we need to have an inquiry."
>
> 'Q. That would have been into what, precisely?
>
> 'A. Into whether or not there was a problem …
>
> 'Q. Dealing only with the neonatal Switch operation … ?
>
> 'A. No, I think at that time the concerns must have been broader; they really had to cover the behaviour of the Unit as a whole. At that time I thought that the centre of [the] problem was the neonatal Switch, but it really should be a wider inquiry.' [158]

127 Mr McKinlay's evidence included the following exchange:

> 'Q. If you and Dr Roylance had agreed that by Christmas, why was one not set up by Christmas, or early in January?
>
> 'A. I thought that Dr Roylance agreed with me, but he had to go off and think about it. I thought that in January he started the mechanism for setting up an inquiry, to find the people to actually do the job.

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155 The then President of the British Cardiac Society

156 UBHT 0052 0175; Dr Bolsin's report: *'An account of the events occurring in the Bristol Royal Infirmary & United Bristol Healthcare Trust Department of Paediatric Cardiac Surgery 1989–1995'*, dated October 1995

157 WIT 0102 0028 – 0029 Mr McKinlay

158 T76 p. 49 Mr McKinlay

'Q. Before any question of the Joshua Loveday operation?[159]

'A. I thought so, but … I cannot pin that down.' [160]

128 According to Dr Roylance, the decision to hold an inquiry was made rather later:

' … I decided to have an inquiry when I was told that the child [Joshua Loveday] had died.'[161]

129 Mr Graham Nix stated that he could not recall precisely when he first became aware of an inquiry involving independent experts to report on paediatric cardiac surgery although:

'… it was probably in very late 1994 or early 1995. I understood that independent experts were to be called in, to advise Dr Roylance by providing an outside view of the problems in the paediatric cardiac service.'[162]

130 As regards the proposed operation on Joshua Loveday, sometime in December 1994 or early January 1995, Professor Angelini made a telephone call to Dr Martin, consultant paediatric cardiologist, who was at a peripheral clinic outside Bristol. Professor Angelini said of the telephone call:

'I questioned to him the wisdom of doing this case in the BRI. I also told him that this was not an urgent case and there was no need to do this operation and if he felt that the child needed an operation, we could have him sent to Birmingham, to Bill Brawn, who was perhaps the best surgeon in the land, to do this operation safely.'[163]

131 Professor Angelini's evidence continued:

'Q. Did Dr Martin agree that the operation was urgent or not? Or did he agree it was not urgent?

'A. He agreed it was not urgent.

'Q. So what did you understand his justification being for carrying out the operation?

'A. His justification was since this child was not a neonate, the results on the non-neonate were much better than the results on the neonate, therefore he was justified to go ahead with the operation.'[164]

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159 The operation took place on 12 January 1995. See also Chapter 30
160 T76 p. 49 Mr McKinlay
161 WIT 0108 0130 Dr Roylance; Joshua Loveday died on 12 January 1995, the day of his operation
162 WIT 0106 0070 Mr Nix
163 T61 p. 183 Professor Angelini

132 Professor Angelini told the Inquiry that he asked Dr Martin why Joshua Loveday, who had been waiting for his operation for some time already, could not wait until Mr Pawade took up his position.[165] Professor Angelini said that Dr Martin had told him:

> '… in his view the competence of the surgeon to do this operation in a child of the age of the child we were dealing with, was adequate. Of course, I totally disagreed with this.'[166]

133 Dr Martin told the Inquiry:

> 'My understanding was that he [Professor Angelini] was questioning whether this operation that was planned as a Switch operation was a neonatal operation and I think I informed him that Joshua was an older child, I may have told him his age, I cannot remember, and I felt he [Professor Angelini] was under the misapprehension that this was a neonatal operation or a younger operation.'[167]

134 Dr Martin told the Inquiry that he did not remember how long the conversation lasted;[168] whether or not the question of transferring Joshua to another hospital was discussed;[169] whether or not the urgency of Joshua 's case was discussed;[170] or whether there was any discussion of why the operation could not wait until Mr Pawade started work.[171]

135 After spending Christmas with relatives, Joshua's parents returned home to find a letter from the BRI advising them that there was a space available in the operating schedule and that, if they wished the operation to go ahead, then Joshua could be admitted to the BRI on 10 January 1995.[172] Joshua's mother stated in her written evidence to the Inquiry that:

> 'Bert and I thought that both this letter and the previous communication from Mr Dhasmana's secretary were very odd. We had, after all, seen Mr Dhasmana in November, only a couple of weeks before his secretary telephoned. At the previous consultations with both Dr Martin and Mr Dhasmana, neither had indicated that the operation was urgent.'[173]

164 T61 p. 183 Professor Angelini
165 Mr Pawade was due to start work in Bristol in May 1995
166 T61 p. 184 Professor Angelini
167 T77 p. 108 Dr Martin
168 T77 p. 108 Dr Martin
169 T77 p. 108 Dr Martin
170 T77 p. 109 Dr Martin
171 T77 p. 109 Dr Martin
172 WIT 0417 0012 Ms Evans
173 WIT 0417 0012 Ms Evans

Report of the performance of the PCS Service in 1994

136 In 1994, the figures for 1993–1994 were produced by the Unit, but not published, as had been the case prior to 1992. Figures were, however, submitted to the UK Cardiac Surgical Register (UKCSR):[174]

Operations – Over-1s	Operations – Under-1s
93 (4)	50 (14)

137 This compared with the figures for 1993–94 from the UKCSR, when produced, which were to the effect that overall mortality in the under-1 operative group was 11%, and that for the over-1s was 5.4%.[175]

174 UBHT 0055 0229; figures in parentheses are for deaths; mortality rates calculated by the Inquiry
175 UBHT 0055 0373; report of the UKCSR 1993/94

Chapter 30 – Concerns 1995 and after

Concerns 1995

January

Joshua Loveday's surgery

1 In late December 1994, it was planned to operate on Joshua Loveday in January 1995.

2 His clinical history was that on 22 June 1993, he was born the second son of Amanda Jayne Evans and Robert Loveday at Gloucester Maternity Hospital.[1] Soon after returning home on 30 June 1993 Joshua's mother noticed that he was having difficulty feeding, and mentioned this to a visiting midwife. The midwife recommended that Joshua should be seen by his GP. It was decided that he needed immediate attention. He was taken to Gloucestershire Royal Hospital, and referred from there to Bristol.

3 Joshua's parents met Mr Dhasmana at the BRI. He explained that Joshua would require an immediate operation, without which he would die, and that later on he would require a 'Switch' operation. The next morning, 1 July 1993, Joshua underwent a 'banding' operation performed by Mr Dhasmana. He recovered slowly, returning after about two weeks to the main recovery ward in the Bristol Royal Hospital for Sick Children (BRHSC),[2] and after about a further month to Gloucestershire Royal Hospital, where he remained for about two weeks before returning home.[3]

4 After his return home Joshua was seen at monthly outpatient clinics at Gloucestershire Royal Hospital. His mother described the clinics in her written statement to the Inquiry:

> '… Joshua was seen once a month, in the local outpatient clinic, by a member of staff from Bristol. Normally, a man called Dr Martin saw him. Dr Martin would usually ask whether Joshua was feeding properly, and he expressed his satisfaction as Joshua got better and put on weight. Dr Martin would do simple diagnostic tests, such as weighing Joshua, and, usually, he would look at his fingers.'[4]

Joshua's mother described his general condition during this time:

> 'Generally, Joshua reached all his milestones, and, although he was small for his age, he grew steadily. He appeared to be a normal, healthy baby. He was never on tablets, and he did not suffer unduly from illness. He was still pink, although he became purple when he was upset.'[5]

1 WIT 0417 0002 Amanda Evans
2 WIT 0417 0008 Amanda Evans
3 WIT 0417 0009 Amanda Evans
4 WIT 0417 0009 Amanda Evans
5 WIT 0417 0009 Amanda Evans

5 In the spring of 1994, Joshua Loveday and his parents were seen again by Mr Dhasmana in Bristol. At this meeting Mr Dhasmana again explained Joshua's condition and drew diagrams of Joshua's heart and a normal heart.[6] He again mentioned that a Switch operation would be needed. Joshua's mother stated that Mr Dhasmana had said to her that there was a success rate of 80–85% in the case of the Switch operation. She stated that Mr Dhasmana did not offer any alternative to the Switch operation, did not mention the possibility of brain damage occurring during the operation, and did not make clear what 'failure' might consist of.[7] Mr Dhasmana, she stated, told her that the operation would occur when Joshua was aged between 3 and 5 years old. Joshua's mother explained that:

> 'Both Bert and I felt generally reassured by this interview'.[8]

6 On 23 May 1994 Joshua had a cardiac catheterisation which showed that the initial diagnosis of double outlet right ventricle with subpulmonary Ventricular Septal Defect (VSD) was correct.[9]

7 On 20 June 1994 Drs Joffe, Martin, Hayes, Wilde and Jones, together with Mr Wisheart and Mr Dhasmana, met at a joint cardiac surgical meeting and discussed Joshua's case.[10] At this meeting the clinicians decided that Joshua looked:

> '… suitable for an arterial switch operation with closure of VSD'.[11]

8 In November, Joshua was taken again to the outpatient clinic. Joshua's mother stated that this meeting confirmed her and Joshua's father's belief that the operation was routine but that it would not take place for some time to come.[12]

9 Dr Martin told the Inquiry that he saw Joshua at the clinic in November:

> '… I spoke to Mr Dhasmana towards the end of November when we were talking about scheduling … We were talking about the fact that I had seen Joshua Loveday in the Outpatients Department and I was concerned about his waiting.'[13]

10 Mr Dhasmana told the Inquiry that he knew Dr Martin had seen Joshua in November because:

> 'I am not exactly certain whether he [Dr Martin] wrote me a letter or sent me a memo or telephoned to say: "Janardan, what is happening with this patient, you

6 WIT 0417 0010 Amanda Evans
7 WIT 0417 0010 Amanda Evans
8 WIT 0417 0010 Amanda Evans
9 MR 0164 0022; Medical Records of Joshua Loveday. See Chapter 3 for an explanation of these terms
10 MR 0164 0034; Medical Records of Joshua Loveday
11 MR 0164 0034; Medical Records of Joshua Loveday
12 WIT 0417 0011 Amanda Evans
13 T77 p. 81 Dr Martin

have promised an operation in 4 to 6 months and it is more than 6 months, I saw him, he is getting quite blue?"'[14]

11 Accordingly, an operation was set for 12 January 1995. Joshua's mother stated that while she and Joshua's father had misgivings about the operation, they felt that it was an appropriate time for Joshua to have his operation as it allowed him time to recover fully before he was to start school. They decided to confirm with the hospital that they would bring Joshua for admission into the BRI on 10 January 1995.[15]

12 Mrs Herborn, a sister in cardiac theatres at the BRI, stated in her written evidence to the Inquiry:

> 'I was horrified when I saw this on the monthly list for January after the Christmas holiday, and immediately pointed it out to Dr Bolsin. He already knew about it and told me not to worry, it would not take place. Between then and the 11 January. I spoke to him again and also to Professor Angelini. I was assured each time that they were dealing with it. I had made up my mind that whatever happened I would not scrub for it, nor would I alter the daily roster when I noticed that Alison Reed had a day off on 12 January. Alison Reed was Mr Dhasmana's favourite scrub nurse. She was very experienced and would have been his first choice. Apart from her there were only Kay Armstrong and myself available … Kay Armstrong agreed with me and was also unwilling to scrub for the case.'[16]

13 Professor Angelini told the Inquiry that he went to see Mr Wisheart on 6 January 1995 to:

> '… persuade him … of how unwise it was to go ahead with this [the Joshua Loveday] operation … .'[17]

14 Mr Wisheart stated that:

> 'On Friday 6th January, six days before the scheduled operation, Professor Angelini came to me in my office on behalf of Dr Bolsin and himself and spoke to me as Medical Director. He indicated that it was the view of Dr Bolsin and himself that this operation should not proceed.'[18]

15 Mr Wisheart continued:

> 'He showed me some figures which were written on a piece of paper in his hand and which I cannot now recall, which purported to be the results of Mr Dhasmana's

14 T87 p. 40 Mr Dhasmana
15 WIT 0417 0013 Amanda Evans
16 WIT 0255 0016 – 0017 Mrs Herborn
17 T61 p. 184 Professor Angelini
18 WIT 0120 0455 Mr Wisheart

surgery for the switch operation. I was familiar with his results for this operation and I did not recognise these figures. I said so.'[19]

16 Immediately after the meeting with Professor Angelini, Mr Wisheart stated that he telephoned Dr Bolsin. Mr Wisheart stated that in the course of this conversation, he and Dr Bolsin agreed on two matters:

> '… (1) that it was extremely foolish to be in a position where we were arguing about verifiable facts [Mr Dhasmana's outcome data] and that Mr Dhasmana and one of the anaesthetists should work together to establish agreed data on the results of the arterial switch operation in all age groups; and (2) that after that data had been urgently gathered there would be a meeting of the whole Paediatric Group to review this decision to operate on Joshua Loveday … . It was not possible to convene the meeting until Wednesday 11 January 1995 because of people's legitimate commitments on the Monday or Tuesday.'[20]

17 Professor Angelini wrote to Mr Wisheart on 10 January 1995. Professor Angelini explained that he wrote the letter:

> '… as the final attempt to see whether by putting my concern in writing this could have somehow convinced them or – I do not know what – but it was literally the final attempt'.[21]

18 In the letter Professor Angelini wrote:

> 'I would like to put into writing my concern with regard to the "switch"operation planned for next Thursday January 12th. Given the circumstances which we all know, and the considerable degree of pressure coming from different quarters, for example the anaesthetists and the nursing personnel, I think it would be better not to proceed with this operation.
>
> 'Sorry to have to write to you in this manner but I feel that I must disassociate myself from the potential consequences if this operation was to proceed as planned.'[22]

19 Professor Angelini told the Inquiry that he had been in contact with many other people before he both went to see and subsequently wrote to Mr Wisheart in his capacity as Medical Director:

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19 WIT 0120 0455 Mr Wisheart
20 WIT 0120 0455 – 0456 Mr Wisheart
21 T61 p. 184 Professor Angelini
22 UBHT 0052 0277; letter dated 10 January 1995

> 'I had spoken with Dr Roylance. I had spoken with Dr Doyle [Peter] at the Department of Health. Dr Sheila Willatts, Professor Farndon, you name it. I did not have anything else I could do except writing this letter, and that is the last thing.'[23]

Counsel to the Inquiry asked Professor Angelini what response he had received from Dr Roylance. He replied:

> 'The usual type [of response], the "recorded message": "This is a matter for the clinical people".'[24]

20 Professor Angelini was asked what response he would have expected Dr Roylance to give:

> 'By that time, there had been no meeting of all the people involved because the meeting took place the night before the operation, so that was after I had spoken with Dr Roylance. But the issue was a more fundamental one here. The people who were trying to take the decision on whether to go ahead or not, not only were making a decision 12 hours before an operation, but somehow they were all emotionally involved in this business of the switch operation. They were not in any position to take any sensible decision.
>
> The reason I went to see Mr Wisheart and then Dr Roylance was simply to say to them, "You are senior people, you are in a position to stop this operation which is not urgent. Why do you not just think about this. Why do we not assess this with a cool head before embarking and doing the surgery which may end catastrophically for the child, and then what we have proved?" So the people who were taking the decision were too much emotionally involved in what was going on. I think that was a wrong decision, and the Chief Executive and the Medical Director should have appreciated that the decision should not have been left to these people.'[25]

21 Joshua's parents took him to the BRI on 10 January 1995. For themselves, they were allocated accommodation in a shared house near the hospital. On 10 January, they were invited to sign a form giving consent for the operation. They were not told that there was to be a meeting on the following day to decide whether or not to proceed with the surgery. Joshua suffered from Taussig-Bing syndrome.[26] They were not told that Mr Dhasmana had operated on only one child suffering from such a syndrome beforehand. That child had died.

22 On 11 January 1995 Joshua was given two surgical baths in preparation for his operation.[27]

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23 T61 p. 185 Professor Angelini
24 T61 p. 186 Professor Angelini
25 T61 p. 186 Professor Angelini
26 See Chapter 3 for an explanation of this term
27 WIT 0417 0014 Amanda Evans

23 Dr Martin did not see Joshua upon admission to the BRI, as indicated in the following exchange:

> 'Q. Apart from seeing him [Joshua] in outpatients in November 1994, did you see Joshua Loveday again before 11 January 1995?
>
> 'A. No, I did not see him on that admission at all.
>
> 'Q. On 11th January 1995, is it right that you had last seen Joshua on 21st November 1994?
>
> 'A. That is correct, yes.'[28]

24 Dr Peter Doyle told the Inquiry in his oral evidence that, on 11 January 1995, he had telephoned Dr Roylance to advise him of the fact that concerns had been expressed to him by Professor Angelini. Dr Doyle noted that Dr Roylance had told him that he would be guided by the Medical Director (Mr Wisheart) and that, at the very time that he and Dr Roylance were speaking, Mr Wisheart was at a meeting to discuss the situation.[29]

25 Dr Doyle stated that Mr Wisheart telephoned him on the next morning (12 January) to inform him that the outcome of the meeting had been to proceed with the planned operation, since the view of the meeting had been that the results of non-neonatal heart surgery were as good as the national average.

26 Dr Christopher Monk spoke to Mr Wisheart during the day on 11 January, expressing the view that the risks of going ahead with the proposed operation exceeded the possible benefit.[30]

27 At 5.30 pm on 11th January, a meeting of clinicians was held in the Catheter Laboratory at the BRHSC. Present were the cardiologists Drs Joffe, Hayes and Martin; the surgeons Mr Dhasmana and Mr Wisheart; and the anaesthetists Drs Masey, Monk, Bolsin and Pryn (who left midway through). Two notes of the meeting were made at or about the time: one by Dr Monk and the other by Dr Martin.

28 Both notes stated that there was a discussion first as to the outcomes at Bristol of Arterial Switch surgery, and second as to whether or not to proceed with the planned surgery on Joshua Loveday. Dr Martin's note described the discussion of outcomes as follows:

> 'The results for neonatal arterial switch for patients with intact ventricular septal were discussed in passing. The overall mortality has been 9/13 (69%). It has

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28 T77 p. 97 Dr Martin
29 T67 p. 86 Dr Doyle
30 UBHT 0054 0011; Dr Monk's minute of the later meeting on 11 January 1995

previously been decided to halt the neonatal arterial switch programme for the moment pending the development of the new unit.

'In total, since February 1988, a total of 28 patients have undergone an arterial switch operation with closure of VSD. This included patients who have undergone coarctation repair and pulmonary artery banding, those with multiple VSDs and those operated on in infancy without prior pulmonary artery banding. Four patients have been operated upon by Mr Wisheart who is no longer undertaking arterial switch operations. This leaves 24 patients operated on by Mr Dhasmana during the period of February 88 to December 94. Overall mortality for this period is 8/24 patients (33%). Mortality was higher in the first 2 years presumably reflecting the learning curve for the operation. Over the period of 1990 to 1994 15 operations were performed with 3 deaths giving an overall mortality of 20%. 8 of these patients were over one year of age with one death (12½% mortality).

'Reviewing the figures it was clear that the mortality at the start of the programme was high but had improved significantly over the latter few years. These mortality rates were compared to published data. From the multi-centre study in the United States, the mortality for transposition with multiple VSDs was 22% and for transposition with single VSD was 16%. Based on the UK registry the mortality for treatment of transposition with VSD (majority would have had an arterial switch operation) was 19.5% in 1990, 17.6% in 1991 and 12% in 1992. There was discussion on these results and it was felt that our more recent results were similar to that for published data and, therefore, acceptable.

'There was a discussion amongst the group on these results and there was general agreement that, based on the mortality figures it was appropriate to continue with an arterial switch programme in children outside of the neonatal period.'[31]

29 Dr Monk's note recorded that:

'Under discussion it was decided that the outcomes of Bristol were within the expected range of mortalities but not in line with the best reports from centres such as Melbourne, Great Ormond Street, Birmingham or Boston. These figures did not support the withdrawal or stopping of the present non-neonatal programme, the question was asked distinctly by CRM [Dr Monk] and all members with the exception of SP [Dr Pryn] (absent) agreed that the programme should continue.'[32]

30 Dr Monk's note, but not Dr Martin's, recorded that:

'General and specific discussion on the risks of performing surgery with a fatal outcome was discussed and the option of delaying for a week or until the arrival of

31 UBHT 0054 0013; Dr Martin's minutes of the meeting
32 UBHT 0054 0011; Dr Monk's minutes of the meeting

the new surgeon was proposed strongly by SNB [Dr Bolsin] as much could be lost by the death of the child.'[33]

31 Mr Wisheart set out his recollections of the meeting in his written evidence to the Inquiry:

'Data was presented and, after adjustment to a detail, was agreed. In as much as one could derive reliable and relevant information from recent publications, the literature was reviewed. My recollection is that it was agreed by all present that Mr Dhasmana's results for the switch operation outside the neonatal period lay within what would be expected from this review of the literature. His results in children over 1 year of age were better. Mr Dhasmana's results were for the period 1990 to 1994.

'I believe that Dr Bolsin also accepted this view of the data, but he put the point that the operation should nevertheless not be done for "institutional reasons"and because of the possible "political consequences". There followed a discussion at the end of which most of us remained quite unclear as to what he meant by these two phrases. Most people felt that the decision should be made on clinical grounds and in the best interests of this individual patient and not for extraneous or political grounds. All those present with the exception of Dr Bolsin confirmed the decision and plan to operate on Joshua Loveday.'[34]

32 In his evidence to the Inquiry, Dr Bolsin explained what he had meant by what he described as an 'institutional reasons', in the following exchanges:

'The focus in 1992 in setting up a data collection was that we were looking at the major factors in which we had intuitively surmised that some of the surgical factors may be important. So we had confined ourselves to the surgeons as opposed to including cardiologists and anaesthetists and other things, so the whole thing had evolved over that period.'[35]

33 Counsel to the Inquiry explored the issue further with Dr Bolsin:

'Q. Again going back to the process of question and answer about being quite rightly self-critical and excluding yourself as a cause of excess mortality because your procedures were exactly the same as others —

'A. Yes.

'Q. — the intuitive approach you have described arose, did it, out of essentially that process, your logbook, your focus on your logbook, your focus upon your own experience with children and in essence was it perhaps a question "It is nothing

33 UBHT 0054 0011; Dr Monk's minutes of the meeting
34 WIT 0120 0456 – 0457 Mr Wisheart
35 T82 p. 105 Dr Bolsin

I am doing, so it must be something the surgeons are doing"? It is a very crude way of putting it, but is that broadly how the intuition arose, do you think?

'A. Yes, I think what we were wondering was whether the surgical techniques and the surgical management of the cases was one of the major causes for serious morbidity and mortality.'[36]

34 In a written account Dr Bolsin described the meeting of 11 January 1995:

'One of the features of the meeting was the production (for the first time) of the mortality figures for all "switch" operations undertaken by both surgeons from 1988–95. These data had been collated by both the surgeons and Dr Underwood and Dr Pryn (Consultant paediatric cardiac anaesthetists involved in the "switch" programme). The fact that the surgeons' figures had to be modified at that meeting to produce the actual results suggested that these figures had only just become available. This was the first time that the results for this operation were reviewed by a multidisciplinary team. The results confirmed that the overall mortality rate for the neonatal arterial "switch" operation was 67%. These figures were worse than my estimates of July 1994.

'I put forward the view that there was an obvious institutional problem with the arterial "switch" operation in Bristol and that, particularly in view of the recent events, to expose a child to unnecessary risk when the Trust was already committed to a new surgeon and a new site was unwise. The meeting was presented with data from the "switch" programme which had been sub-divided by age (over or under 1 year) and year of operation (before or after 1990). The meeting was asked whether, on the information presented for the specific category into which the prospective patient fell, there was enough evidence that the results in Bristol were "significantly worse" than the "national average"? It was apparent that the effect of the precise subdivision of the data was to create a small group, in comparison to which the Bristol results could not be said to be worse. The numbers were small and the "national average" comparator was itself contentious containing an unknown number of non-"switch" operations for transposition of the great vessels. I had to agree that the data, as it was presented, would make it very difficult to demonstrate with any degree of certainty that the Bristol performance for the small subgroup selected was statistically worse. This disregards the context of the unit's long standing poor record with complex operations. The group was asked if the operation should proceed. *I asked for my opposition to be minuted; I was a minority of 1.*'[37]

36 T82 p. 105 Dr Bolsin

37 UBHT 0052 0176 – 0177; *'An account of the events occurring in the Bristol Royal Infirmary and United Bristol Healthcare Trust Department of Paediatric Cardiac Surgery 1989–1995',* Dr Bolsin, October 1995 (emphasis in original)

35 Dr Sally Masey, consultant anaesthetist, stated in her written evidence to the Inquiry that she attended the meeting of 11 January 1995. She stated that she had been part of the group that put together the statistics that were discussed during the meeting:

> 'Prior to this meeting, Dr Pryn, Dr Underwood and myself had made an effort to try and have a list of all the non-neonatal switches performed with their outcomes. Dr Underwood and myself looked at our personal records of cases for which we had anaesthetised and checked through theatre books. Dr Pryn referred to computer-generated information. Dr Pryn took this information to the meeting so it could be cross-referenced with information supplied by Mr Dhasmana.'[38]

36 Dr Masey explained that the conclusion reached at the meeting was:

> '… unanimous agreement, including Dr Bolsin, that there was nothing in the figures to suggest that Mr Dhasmana should not proceed with Joshua's operation the following day.'[39]

37 Dr Stephen Pryn, consultant anaesthetist, stated that he helped Dr Masey and Dr Underwood to prepare the figures which were presented at the meeting on 11 January. He explained in his written evidence to the Inquiry that, notwithstanding that the figures that he had helped to prepare which seemed to show that Mr Dhasmana's results were comparable to those in the rest of the country, he felt 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 the 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.'[40]

38 In his note of the meeting of 11 January 1995, Dr Monk wrote:

> 'SNB [Dr Bolsin] was pressed for an explanation of the reasons behind informing the Department of Health prior to the meeting to discuss whether the programme should proceed the next day. The working relationship between himself [Dr Bolsin], Peter Doyle and the Department of Health funding for his audit programme was so intertwined that SNB felt unable not to tell Peter Doyle of the forthcoming event.'[41]

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38 WIT 0270 0016 Dr Masey
39 WIT 0270 0016 Dr Masey
40 WIT 0341 0045 Dr Pryn
41 UBHT 0054 0011; Dr Monk's minute

39 Dr Martin also prepared a minute of a side-meeting between him, Mr Wisheart and Mr Dhasmana, which took place after the discussions in the meeting:[42]

> 'After this general discussion there was a joint discussion between myself, Mr Dhasmana and Mr Wisheart regarding whether it was clinically appropriate to proceed with Joshua's operation the following day. Joshua is already 18 months old and quite severely blue. We have recently reviewed the clinical and angiographic data and felt that he is suitable for an arterial switch in our unit. With his cyanosis being quite severe it was felt unwise to postpone surgery for a matter of months. Based on the results that we have discussed, we did not feel it was appropriate for referral to another centre. The decision, therefore, was made to proceed with the planned arterial switch operation the following day.'[43]

40 Dr Martin explained his view further in the following exchange:

> 'Q. … is it right that a decision that there is no reason not to do a particular series of operations becomes, in any individual case, a reason to do it?
>
> 'A. I think we felt that there was no reason not to do it. There are many reasons to go ahead and do an operation in that setting that we were faced with there. We had a child already in hospital, prepared for surgery. You had a child that was well at that stage, no intercurrent infections, so there is an opportunity to do it. His parents were, if you like, ready to go ahead, so there are many reasons why you would go ahead in that situation. You do not cancel operations lightly the night before, so there are positive reasons to proceed.'[44]

41 Dr Monk's note also dealt with the side-meeting. Not being present, he could not note what happened at the side-meeting, only its outcome. His note recorded:

> 'The meeting dissolved with the support for the continuation of the programme but with an awareness of the political dangers. Doctors Dhasmana, Wisheart and Martin discussed the need for the child's operation and decided that its clinical condition merited an immediate intervention and considered a delay inappropriate. This was accepted with a greater or lesser degree of happiness and conversation outside of the meeting was held between JDW, SNB and CRM regarding the representation of the Trust by SNB and the inappropriate channels of communication that the Department of Health were using.
>
> 'The meeting decided that immediate action by the Medical Director and John Roylance to contact the Department of Health to submit the figures for the paediatric programme was an absolute priority.'[45]

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42 UBHT 0340 0350; Dr Martin's minute
43 UBHT 0340 0350; Dr Martin's minute
44 T77 p. 138 Dr Martin
45 UBHT 0054 0012; Dr Monk's minute

42 In his written evidence to the Inquiry Mr Wisheart gave his account of the side-meeting:

> '… I then had a conversation with Mr Dhasmana and Dr Martin. I asked Dr Martin what his views on the urgency of the operation were. My recollection is that he said it should be carried out within a week, although his recollection is that he said it should be carried out within a month. I spoke to Mr Dhasmana [*sic*] that the circumstances of the debate and this meeting were such that there would be considerable pressure on him while undertaking the operation. He indicated, without any ambiguity, that he felt he would be able to do the operation and that this extrinsic pressure would not [be] a factor.'[46]

43 Mr Dhasmana told the Inquiry of his view of the side-meeting:

> '… I was myself quite surprised, really. Maybe Mr Wisheart would have another answer, but I was surprised that if this has been discussed in there, then why call outside?'[47]

44 Mr Dhasmana was asked by Counsel to the Inquiry whether the side-meeting may have been called because he was to be Joshua's surgeon and Dr Martin was his cardiologist and so a separate meeting with only him and Dr Martin might have been useful. Mr Dhasmana replied:

> '… there was nothing new which we mentioned there to Mr Wisheart'.[48]

45 Dr Martin told the Inquiry that he thought:

> '… he [Mr Wisheart] was concerned about the potential political repercussions if you like of it going ahead and questioned whether — there was certainly discussion as to whether that might influence Mr Dhasmana's performance in the operation and that was a concern I shared.'[49]

46 Mr Wisheart told the Inquiry of his view of the background to the discussion that took place at the side-meeting. He said:

> 'The meeting took place on a Wednesday, 11th January. Certainly on the Wednesday, possibly on the Tuesday, I had two conversations. One was with Dr Willatts[50] and one was with Dr Monk. What I remember of the two conversations, because they were both quite long and I may not remember everything, but what I do remember was what was similar in them both. What each of them represented to me was the point of view that this present difference of

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46 WIT 0120 0457 Mr Wisheart
47 T87 p. 68 Mr Dhasmana
48 T87 p. 69 Mr Dhasmana
49 T77 p. 132 Dr Martin
50 Dr Sheila Willatts, a consultant in anaesthesia and intensive care medicine at the BRI, and consultant in charge of ICU at the BRI since 1985

opinion created an additional pressure for the people who would be caring for Joshua Loveday. On the one hand I felt the point they were making to me was a relevant and important one. I did not, as has been suggested by some, feel that it constituted a veto to the operation, I felt it was an important consideration.

'On the other hand, as a surgeon I do know that surgeons frequently have to operate under pressure of a whole variety of types. So pressure is not unusual. However, in the light of the importance of the point they had made to me I felt it was very important that I should represent that point to Janardan, to Mr Dhasmana, with Dr Martin. That is why we had the conversation. I know I made the point, and it is certainly possible that in making the point I suggested to them that the operation should be postponed, suggested how that might be done and so forth; that is certainly possible, in trying to put the point to them in a range of different ways so that I was satisfied it had been properly considered.'[51]

47 Counsel to the Inquiry explored the reasons for a possible postponement of the operation with Mr Wisheart:

'Q. If you sought a postponement or proposed that the operation should be postponed in the wording that you used to the Clinical Directors[52] [which referred to pressure on the surgeon and the surgical team], you were using as an argument, matters which had no direct bearing on the clinical needs of the patient, were you?

'A. Well, they had a direct bearing on the clinical ability of the team to provide a service to the patient.

'Q. So you queried —

'A. At least they had a potential direct bearing, excuse me.

'Q. You queried the clinical ability of the team given the circumstances?

'A. I asked the question.

'Q. That is where we come back to the semantic difference possibly between asking the question and proposing postponement.

'A. I did not just want to ask a question, get an answer and go away. I was putting it quite seriously and expecting it to be seriously considered. I think it is clear, although the recollection has escaped me, that I probably put it in a variety of

51 T92 p. 118 Mr Wisheart
52 Mr Wisheart's *'Statement to the Clinical Directors of United Bristol Healthcare Trust'*, 3 June 1996, at UBHT 0054 0004 – 0008

different ways and that this was perceived at any rate, certainly by them, possibly by me at the time, to be a proposal, an attempt to persuade them.

'Q. What did you want to achieve?

'A. I wanted to protect everybody involved from the possibility that an operation would have been carried out by somebody who was not truly fit on that day to do it.'[53]

48 Mr Wisheart continued in the following exchange:

'Q. Did you at the start of this conversation consider that there was a risk to the patient given the ability of the team under the pressure that they were to perform the operation?

'A. I considered there was the possibility.

'Q. Tell me, you go on in your description to the Clinical Directors to describe Dr Martin's advice.[54] How do you now recollect Dr Martin's words?

'A. In the same way.

'Q. So you saw him as saying "This operation should not be postponed for longer than a week"?

'A. Yes.'[55]

49 Mr Wisheart went on:

'… Dr Martin joined with me in putting the question [of extra pressure affecting Mr Dhasmana's ability to work] to Mr Dhasmana once I had articulated it — Mr Dhasmana was positive that the discussion was over, that was past and it would have no impact on his ability to undertake the operation. So the subsequent discussion was pushing him and exploring that, but he remained resolute.'[56]

50 Mr Wisheart stated in his written evidence to the Inquiry:

'He [Mr Dhasmana] indicated, without any ambiguity, that he felt he would be able to do the operation and that this extrinsic pressure would not [be] a factor.'[57]

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53 T92 p. 119 Mr Wisheart

54 UBHT 0054 0007. In his '*Statement to the Clinical Directors of United Bristol Healthcare Trust'* dated 3 June 1996, Mr Wisheart stated: 'Dr Martin advised that the operation should not be postponed for longer than one week on account of the patient's severe cyanosis. When pressed he adamantly insisted that one week was the absolute maximum'

55 T92 p. 120 Mr Wisheart

56 T92 p. 122 Mr Wisheart

57 WIT 0120 0457 Mr Wisheart

51 Dr Martin was asked about the degree of urgency of the operation on Joshua:

> '… I did not personally feel that was in Joshua's best interests [to delay the operation] because any further prolonged delay without any obvious gain to him in the longer run, I did not see that that was in his best interests. You know the question was whether, if you like, the political considerations should take precedence over the clinical considerations for Joshua and being one of the clinicians involved I felt that his clinical status was important.'[58]

52 Mr Wisheart said that, had Dr Martin expressed the view that the operation was urgent in that it had to be carried out within three months:

> 'I think it might have led me to prolong the conversation a little bit but I think that the essential points had been covered in the larger meeting and — I mean this was not a passing conversation, the one we are discussing, this was a 20 to 30 [minute] conversation. The points were seriously and repeatedly put and I did feel that I had received a serious answer and one that I was prepared to accept.'[59]

53 Mr Wisheart was asked whether the question of referring Joshua to a different centre was explored:

> 'It did not really impact as an issue. Had the decision been that the team were not competent to undertake the operation, then whether the operation had been needed within 24 hours or a week or whatever, the patient could have been referred. The issue in my mind was never that the patient could not be referred physically, or because of his immediate clinical need; the issue primarily was, were the team competent to undertake the operation? Then the other considerations were secondary to that.'[60]

54 Dr Martin was also asked whether there was anything which had prevented the referral of Joshua to another centre:

> 'No, I would have been quite happy referring him elsewhere, in fact we referred many patients after this to other centres, but I was basing that assessment in the letter on the group review of the figures and also of Joshua's situation which unanimously suggested it was clinically reasonable to proceed with the planned surgery. There was nothing stopping me referring him away. Mr Dhasmana could have referred him away.'[61]

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58 T77 p. 133 Dr Martin
59 T92 p. 127 Mr Wisheart
60 T92 p. 123 Mr Wisheart
61 T77 p. 136 Dr Martin. In Dr Martin's minute of the meeting he states that referral was discussed but thought to be inappropriate in Joshua's case; UBHT 0054 0013

55 Mr Wisheart was asked about his knowledge of a proposed independent review of the results of paediatric cardiac surgery:

> 'Q. Were you the only person, do you think, at the meeting who had any inkling that Dr Roylance was minded to call for an independent [review] —
>
> 'A.Yes, I think that is probably correct.'[62]

56 Asked why he had not told Mr Dhasmana that a review of results was in all probability imminent, Mr Wisheart replied:

> '… in essence I felt that that would be to add further to the pressure on Mr Dhasmana. I do not know whether that was a right judgement or a wrong judgement, but that was my recollection of what I thought at the time.'[63]

57 Mr Wisheart continued in the following exchange:

> 'Q. Did you know at the time that had he [Mr Dhasmana] known that there was to be a review in the paediatric cardiac surgery generally, he would have chosen not to operate?
>
> 'A. No, I did not know that.
>
> 'Q. That might suggest he was actually quite fragile in his confidence at the time?
>
> 'A. Yes, he has said that.
>
> 'Q. And he is a person, is he, who is perhaps more than most self-critical?
>
> 'A. He is self-critical, but not lacking in determination or concentration.
>
> 'Q. Is determination sufficient, do you think, to avert some of the potential effects of the stresses?
>
> 'A. I do not know whether it is sufficient, but it is certainly necessary. I am sure many things are necessary in order to cope with the stresses but I think determination and mental discipline is certainly one of them and I believe he showed that he had that, at least to the best of my ability to understand him, knowing him.'[64]

58 Mr Wisheart agreed with Counsel's suggestion that perhaps Mr Dhasmana could be so keen to help his patients that he could sometimes be prone to ignore external

62 T92 p. 116 Mr Wisheart
63 T92 p. 127 Mr Wisheart
64 T92 p. 125 Mr Wisheart

pressures and think that once in the operating theatre he would be focused on the operation and nothing else:

> 'I suppose it is because of that possibility that I pursued the matter from a number of different angles with him and extended the conversation to the length it was and so I thought I was exploring that with him.'[65]

59 Counsel to the Inquiry asked Dr Martin for his view on Mr Dhasmana's state of mind:

> 'I guess it is something you are going to have to ask him, exactly what his feelings were, but the impression I gained was that he was not reluctant to proceed. I certainly did not gain that impression. He naturally listened to everyone's concerns and I think he took careful notes of what people said. I presume he was reassured by the fact that as a group we had all sat down and looked at it and felt it was appropriate for him to continue. We specifically, in that separate meeting, did discuss whether we thought, if you like, the political aspects, perhaps the implied criticism there had been, might affect his performance in theatre. That was a concern. But he assured us that that was not the case and I was happy under those circumstances to give my approval, or support him, if you like, in the decision to proceed with the operation. When it comes down to it, it has to be his decision. I cannot make him do an operation. I was concerned that we might be put in a situation where he was going into it, as you put it, reluctantly, but I did not gain the impression that was the case.'[66]

60 Mr Dhasmana described his feelings before and after the meeting, in the following exchange:

> 'Q. There must have been great pressure on you?
>
> 'A. Going into the meeting, but coming out, I felt very good, because people supported, I thought, you know, people supported me. People expressed their trust and belief in me, so I was feeling very much better.'[67]

61 Mr Dhasmana was then asked:

> 'Q. When you came out of the meeting, you knew what you had not known when you went in, that the Department of Health had been contacted; that Mr Wisheart's view was that the operation should be postponed if at all possible?
>
> 'A. It was not his view like that. He was asking the question, whether it can be postponed. I mean, that was the question and he said, you know, "Here we have in a way a loose cannon, and if the patient dies, which is possible with any cardiac

65 T92 p. 129 Mr Wisheart
66 T77 p. 140 Dr Martin
67 T87 p. 70 Mr Dhasmana

patient, this could happen". And we felt that this was a clinical meeting and we should not really be deciding on the basis of political repercussion.'[68]

62 Mr Wisheart was asked by Counsel to the Inquiry whether he had any regrets about the fact that the operation on Joshua Loveday was neither stopped nor referred to a different centre:

'In the light of the outcome of the operation in relation to Joshua and in the light of all the other outcomes of the operation, it is impossible not to regret that decision. Looking back at the actual basis of the decision, I am conscious of this point that you raised about not telling Janardan of the decision to have the outside advice and of course that has been an issue elsewhere as well, but that apart, I feel that the discussion at the meeting — first of all the decision to have the meeting and the discussion at the meeting and the subsequent discussion, all those steps I felt were open and were very clear-cut in their outcome.'[69]

63 Counsel to the Inquiry asked Mr Wisheart what he meant by 'that apart':

'From what you tell me if that information had been made known then Mr Dhasmana — says he would have decided not to do the operation. I can say no more.'[70]

64 Joshua's parents met Mr Dhasmana on the evening of 11 January 1995. Joshua's mother stated that once again Mr Dhasmana drew a diagram for them. She stated that he quoted a success rate of 80–85% for the operation and asked them to sign a consent form. Mr Loveday signed this form. Joshua's mother stated that she was keen that they should see Joshua before he was given his pre-operative medication the next morning. She explained that she had already asked a nurse to call them before Joshua was given the medication and she confirmed with Mr Dhasmana that this would happen.[71]

65 Mr Dhasmana was asked by Counsel to the Inquiry whether he informed Joshua's parents about the meeting of clinicians which had taken place before he met them on the evening of 11 January:

'That is my deepest regret, really. With what happened at the end, I regret that I did not really tell them everything when I met them. I wish I had. But at that time, I just had come out from a long tiring meeting, having heard the supporting ways, and I felt quite confident that there would be no problem and this child would be moving about tomorrow or the day after, and I do believe that I felt, you know, that I would be causing more anxiety by telling them what had happened, which, in

68 T87 p. 70 Mr Dhasmana
69 T92 p. 129 Mr Wisheart
70 T92 p. 130 Mr Wisheart
71 WIT 0417 0015 Amanda Evans

retrospect, I accept is not right. I do regret that very sincerely and I wish I could really have told them what had happened before.'[72]

66 On the morning of 12 January Joshua's parents stayed with him until he went into the operating theatre. At that point they stated that they were advised to go out for the day and then to telephone the hospital at about 4.00 pm.[73]

67 In her written evidence to the Inquiry, Joshua's mother stated that they duly returned to the hospital at around 4.00 pm. Joshua was not out of surgery so a nurse showed them round the Intensive Care Unit (ICU), to acclimatise them to the setting that Joshua would be in on his return from the operating theatre. The nurse who was showing them around telephoned the operating theatre to find out how Joshua was progressing. She returned to tell Joshua's parents that the operation was still going on as there had been some complications. The nurse then showed them where they would be staying whilst Joshua was in the ICU.[74]

68 Joshua's mother stated that, at around 6.00 pm, the nurse who had been looking after them came into the room where they were watching television and told them that Joshua had died. The nurse sat with them both for a short time and told them that there would need to be an autopsy and an inquest.[75]

69 Joshua's mother stated that Mr Dhasmana arrived to speak to them about half an hour later. Joshua's mother described the meeting in this manner:

> 'He [Mr Dhasmana] was still dressed in his surgical green gown, and even had his white cap on; he must have walked straight over from theatre. There was blood spattered all down the front of his gown. He looked remorseful, and said, "I'm really sorry". He kept repeating, "I'm so sorry", all through the subsequent meeting with us. By this time, I could not function, let alone talk to him — I just kept saying "Oh my God, oh my God". Because this was the case, Bert talked to Mr Dhasmana, who explained that the part he had tried to fix was too small. Bert shook his hand, and said, "Thanks, mate, you've tried your best".'[76]

70 Joshua's mother stated in her written evidence to the Inquiry that, on arrival home, they telephoned the hospital and were told that Joshua would be in the Chapel of Rest and that family and friends could visit when they wanted. Joshua's parents decided to go to see Joshua the next day. They met Helen Vegoda, Counsellor in Paediatric Cardiology, who described what the Chapel of Rest would be like. After they had seen Joshua, Joshua's parents went to see Mrs Vegoda again. At this meeting she explained that they could have a meeting with Mr Dhasmana if they wished. Joshua's mother

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72 T87 p. 89 Mr Dhasmana
73 WIT 0417 0016 Amanda Evans
74 WIT 0417 0017 Amanda Evans
75 WIT 0417 0019 Amanda Evans
76 WIT 0417 0019 Amanda Evans

stated that they felt that they had said everything they wished and, therefore, declined the offer.

71 Joshua's mother stated that a few days later she telephoned Mrs Vegoda to enquire when the inquest, which the nurse at the hospital had mentioned, would be taking place. Joshua's mother stated that, in reply, Mrs Vegoda told her that there would not be an inquest and that she and Joshua's father:

> '… had received all the investigative care to which [they] were entitled.'[77]

72 Mrs Vegoda, commenting on this, stated:

> 'I cannot recall such a telephone conversation but it was not uncommon for bereaved parents to see me, as a first point of contact after a bereavement, … I would never have dismissed a parent's query regarding a post mortem or inquest … I most certainly would never have suggested that a family were not entitled to any investigation they felt were [*sic*] appropriate.'[78]

73 A coroner's post-mortem was carried out on Joshua on 13 January 1995.[79] The post-mortem report described Joshua's condition up to the point of his admittance to the BRI on 10 January 1995. The report described how, during the operation on 12 January 1995, the pulmonary banding, which Mr Dhasmana had inserted on 2 July 1993, was removed after heart-lung bypass was established. After this procedure was carried out the repair of the transposition of the arteries was attempted.[80] The post-mortem report stated:

> 'The pulmonary artery was transected just below the band and the two coronary arteries implanted in the pulmonary artery. The right coronary artery appeared rather taut at this stage.'[81]

74 It was later noted in the post-mortem report that:

> 'It was realised that the right coronary artery was very taut … . An attempt was made to mobilise the right coronary artery but this caused injury to the main artery, and it was then decided to re-implant the right internal mammary artery to the right coronary artery at the site of the injury … right ventricular function did not show improvement.'[82]

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77 WIT 0417 0021 Amanda Evans
78 WIT 0417 0027 Mrs Vegoda
79 MR 0164 0021; Medical Records of Joshua Loveday
80 See Chapter 3 for an explanation of these clinical terms
81 MR 0164 0022; Medical Records of Joshua Loveday
82 MR 0164 0022; Medical Records of Joshua Loveday; see Chapter 3 for an explanation of these clinical terms

75 In his letter to Joshua's GP, after Joshua's death, Mr Dhasmana explained:

> 'This was a rather tricky anastomosis as both of these vessels were very small, less than 1mm in diameter.'[83]

76 After examining the body, Dr Michael Ashworth, the consultant paediatric pathologist, stated:

> 'The abnormalities present were complex and the surgery complicated by difficult coronary artery transfer.'[84]

Further events in January

77 On 16 January 1995, Dr Doyle wrote an internal memorandum to Dr Graham Winyard, Deputy Chief Medical Officer, and Dr Gabriel Scally, Director of Public Health, South & West NHS Executive. The memorandum was entitled 'Paediatric Cardiac Surgery: Bristol Royal Infirmary'. In the memorandum Dr Doyle described how Professor Angelini had approached him about concerns over paediatric cardiac surgery at the BRI. Dr Doyle explained that Dr Bolsin contacted him on 11 January 1995 to inform him that a 'Switch' operation had been listed for the following day. Dr Doyle stated that he advised Dr Bolsin to discuss the matter with Professor Angelini and Dr Bolsin's anaesthetic colleagues and, if enough of them agreed that the operation should not take place, to:

> '… make every effort to persuade their colleagues to postpone the operation and/or make arrangements for the operation to be done at another centre.'[85]

78 In the memorandum, Dr Doyle also indicated that the operation had taken place and that Mr Wisheart had telephoned him to inform him of the outcome:

> 'This has been a difficult and traumatic episode for all concerned. There will doubtless be a good deal of heart searching among those involved and a lot of questions have been raised. Perhaps the first question is whether the death was avoidable? We may not know the answer to that question for some time (if ever?). If it was, where does the blame lie? What could/should have been done? Possibly most importantly, how can differences of professional opinion or interpretations of audit data, be resolved without putting patients at risk? It would seem that we need a well recognised and acceptable mechanism for getting independent advice on such difficult questions.'[86]

83 MR 0164 0019; Medical Records of Joshua Loveday
84 MR 0164 0028; Medical Records of Joshua Loveday
85 DOH 0001 0009; memorandum dated 16 January 1995
86 DOH 0001 0010; memorandum dated 16 January 1995

Dr Doyle's memorandum concluded:

> 'I have spoken to Dr Roylance (Trust CE) today who assures me that he is setting up an immediate internal enquiry to establish the facts followed by an independent enquiry using outside experts (cardiothoracic surgeons). I expect to hear the results in due course including any recommendations for the future conduct of paediatric CT [cardiothoracic] service in Bristol. I do not believe any further action is required at present but am happy to be advised by yourself or copyees.
>
> 'One other general point is whether we should consider initiating discussions with the profession about mechanisms for resolving professional differences without putting patients at risk.'[87]

79 Mr Wisheart stated in his written evidence to the Inquiry:

> 'We [he and Dr Roylance] made the decision to seek external advice to help the Trust resolve internal differences of opinion. There is uncertainty as to whether we made that decision before or after the meeting of the 11 [January 1995].'[88]

80 Dr Bolsin stated in his written evidence to the Inquiry:

> 'A meeting took place between at least one senior civil servant from the Department of Health, [Dr] Peter Doyle, Dr Roylance and senior Trust officials in Bristol. My understanding of this meeting was that the Trust was now required to undertake an investigation into paediatric cardiac surgery and abide by the findings and recommendations of the investigators.'[89]

81 Professor Angelini described in his written evidence to the Inquiry what he saw as:

> '… a general unwillingness from any quarter to draw in anybody from outside to give us an honest opinion of what we were doing, and indeed it was only after the death of Joshua Loveday that Dr Roylance sought external advice.'[90]

82 On 16 January 1995 Professor Angelini wrote to Dr Roylance:

> '… it is sad that we have failed to resolve the issue of paediatric cardiac surgery work internally. In view of this, I share your opinion that an enquiry should be held on the paediatric work carried out in the Department of Cardiac Surgery from 1988 to the present day. I think this is the minimum requirement, given the recent circumstances … .'[91]

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87 DOH 0001 0010 – 0011; memorandum dated 16 January 1995
88 WIT 0120 0457 Mr Wisheart
89 WIT 0080 0126 – 0127 Dr Bolsin
90 WIT 0073 0018 Professor Angelini
91 UBHT 0217 0138; letter dated 16 January 1995

83 Professor Angelini was asked by Counsel to the Inquiry in the following exchange whether the letter of 16 January showed that he knew, or thought, that Dr Roylance had by then decided upon an inquiry:

> 'Q. So Dr Roylance had by this stage decided there should be an enquiry, had he not?
>
> 'A. No, he had not.
>
> 'Q. That is what the letter said?
>
> 'A. It was me putting words in his mouth to force his hand, to have the enquiry … This is the reason why I cc'd it to everybody, because I was hoping that now, forcing his hand, he could not wriggle out once more and perhaps we now were going to have a really proper look at the results of paediatric surgery.'[92]

84 In his written evidence to the Inquiry, Mr Alan Bryan, a consultant cardiac surgeon at the BRI, described the decision to commission the inquiry as 'good' but 'belated'. He considered that the decision was 'a response to crisis'.[93]

85 On 19 January Professor Vann Jones, Clinical Director of Cardiac Services, wrote to all the cardiac surgeons, stating:

> 'Dr Roylance has requested that I call a meeting between all the Cardiac Surgeons, myself and himself to discuss the present situation with regard to the "Switch" operations. I would be very grateful if you could make every effort to attend as this is a matter that has to be clarified once and for all.'[94]

86 Professor Vann Jones wrote again to his colleagues on 23 January 1995 stating:

> 'I was dismayed at the meeting of the Cardiac Surgery Associate Directorate last Tuesday to find how divided and acrimonious the atmosphere is in Cardiac Surgery. I was also sorry to hear and indeed to see how our colleagues in less favoured positions in the directorate are being abused. I don't think we should be bandying terms like "disloyalty" or "lack of co-operation" about. I also thought it was distressing to see the Perfusionist so interrupted that he couldn't get a word in edgeways particularly as the person berating him didn't even turn around to face him.
>
> 'I am not trying to single out any individual for particular attention but surely we can take steps to make these meetings more constructive and much less acrimonious. Giant steps have been taken to improve the profile of Bristol Cardiac Services in the past decade and it really is sad to see the way the present situation is

92 T61 p. 193 Professor Angelini
93 WIT 0081 0028 Mr Bryan
94 UBHT 0061 0255; letter dated 19 January 1995

developing. I hope once again we can get the whole thing on amicable terms and if there has to be some straight talking let's not air our views quite so publicly.'[95]

87 In his written evidence to the Inquiry, Dr Doyle stated that he spoke to Dr Roylance and Mr Wisheart after the operation on Joshua Loveday and:

'… advised that an outside independent inquiry into both the immediate case and the wider issue of the overall results of the paediatric cardiac surgical service was now essential.'[96]

88 Dr Doyle wrote a further internal memorandum on 24 January 1995 addressed to Dr Winyard and Dr Scally. In this memorandum he further updated his colleagues on the situation developing in Bristol:

'It is still not clear whether there is a serious problem with cardiac surgery or whether this is a serious breakdown in professional relationships. There is cause for grave concern that the Trust has not taken action to resolve the problem; that children's lives might have been put at risk and that rumour and innuendo have been allowed to spread apparently unchecked.'[97]

The memorandum continued:

'I spoke to Dr Roylance (Chief Executive) this morning and advised him in the strongest possible terms to stop complex neonatal and infant cardiac surgery forthwith and to expedite the proposed Enquiry that we discussed the previous Monday. … I also advised Dr Roylance that yourself and other colleagues in the Department now had to be informed of the situation.

'You will see from this that I have informed Secretary of State's office, Press Office and CA-IU [Corporate Affairs-Intelligence Unit] in case the story leaks to the media. I am not sure whether further action is required at present but am happy to be advised by you or copyees.

'Suggested line to take if required.

'We are aware that concern has been expressed about the neonatal and infant cardiac surgical services at Bristol Royal Infirmary. We do not know at present whether there is any basis for the concerns but have advised the Trust to set up an immediate Enquiry and to cease complex neonatal and infant cardiac surgery until the facts have been established.'[98]

95 UBHT 0082 0083; letter dated 23 January 1995
96 WIT 0337 0003 Dr Doyle
97 DOH 0001 0015; memorandum dated 24 January 1995
98 DOH 0001 0015 – 0016; memorandum dated 24 January 1995

89 On 25 January 1995, Dr Doyle wrote once more to Dr Roylance:

> 'There is clearly a growing belief that childrens' [*sic*] lives may have been put at unnecessary risk. Until such doubts can be resolved, it would be extremely inadvisable to undertake any further neonatal or infant cardiac surgery.
>
> 'I recognise that this is a very difficult situation for all concerned. The doubts raised can only be resolved by an impartial enquiry and I feel sure that everyone would benefit from disinterested and objective advice. I would therefore suggest that you take all reasonable steps to expedite the proposed Enquiry.
>
> 'As you will appreciate, I will have to inform colleagues in the Department about the circumstances as they are currently known to me. I should be grateful if you would let me know as soon as possible of any additional facts that you feel are relevant and what you decide to do. I also expect to be informed, in confidence, of the outcome of the enquiry as soon as they are available.'[99]

90 Dr Roylance replied to Dr Doyle's letter on 26 January 1995.[100] In his letter, Dr Roylance confirmed that the UBHT had ceased to perform complex neonatal and infant cardiac surgery, although he indicated that the UBHT reserved the right to perform such surgery in an emergency if it was in the best interest of the patient to do so. Dr Roylance also confirmed that the Trust was in the process of appointing outside experts to lead an inquiry into its paediatric cardiac surgery service. Dr Roylance indicated that Professor Marc de Leval[101] had already accepted an invitation to be one of the outside experts. Dr Roylance went on to express concern to Dr Doyle over the way in which the matter had come to Dr Doyle's attention:

> '… this matter has developed, apparently on the basis of views or whispers by "staff of the Bristol Royal Infirmary and outside Cardiac Surgeons". We do not know whether any facts are on your table. We have had no opportunity to inform you of the results of our work which we are always ready to do, and which was done annually in the context of being a supra-regional centre between 1984 and 1993. Yet we now find ourselves with no practical alternative to a temporary stoppage of infant work following your letter.'[102]

91 Mr Wisheart described in his written evidence to the Inquiry the action taken, once it was decided to set up an external inquiry:

> 'Dr Roylance asked me as Medical Director to take the initial steps in setting up the enquiry. I sought the advice of Mr John Parker, who is now deceased, but was then

99 UBHT 0061 0282 – 0283; letter dated 25 January 1995
100 PAR2 0001 0026 – 0027; letter dated 26 January 1995
101 Professor Marc de Leval: consultant paediatric surgeon, Professor of Cardiothoracic Surgery, Great Ormond Street Hospital
102 PAR2 0001 0027; letter dated 26 January 1995

President of the British Cardiac Society. He advised me to approach Mr de Leval and Dr Hunter.'[103]

92 Professor Marc de Leval and Dr Stewart Hunter[104] were invited by Mr Wisheart to:

'… assist us resolve some problems arising out of the fact that we are receiving conflicting professional advice in the field of paediatric cardiac surgery. The Trust is committed to the maintenance of the highest standards in this field and now ask you for your authoritative and disinterested advice. The conflicting advice has arisen in the area of the Switch operation for neonates, but has now broadened beyond that.'[105]

93 Professor de Leval explained in his written evidence to the Inquiry:

'I was contacted by Mr James Wisheart in his capacity of Medical Director at UBHT to assist them in resolving some problems in the field of paediatric cardiac surgery … We were urged to visit UBHT as soon as possible and to issue a report without delay.'[106]

February

94 Dr Doyle wrote to Dr Roylance on 3 February 1995:

'… I and my colleagues are content for the Trust to act in the way agreed during our recent telephone conversation based on the advice offered by the President of the British Cardiac Society. It was agreed that at least two, and preferably three, outside advisors should be invited to look into the situation and offer advice. I was pleased to hear [that] Marc de Leval has already agreed to help.'[107]

95 Rachel Ferris, General Manager of the Directorate of Cardiothoracic Services at the BRI from 1994, stated in her written evidence to the Inquiry:

'My impression in late 1994 early 1995 was that the Chief Executive, … Dr John Roylance responded dismissively to the concerns raised with him. He appeared to protect Mr Wisheart, even to the extent of allowing him to organise the Marc de Leval visit himself which I believe was inappropriate.'[108]

103 WIT 0073 0108 Mr Wisheart
104 Dr Stewart Hunter: consultant in paediatric cardiology, Academic Department of Cardiology, Freeman Hospital, Newcastle upon Tyne
105 UBHT 0061 0337; letter from Mr Wisheart dated 25 January 1995
106 WIT 0319 0001 Professor de Leval
107 UBHT 0061 0286; letter dated 3 February 1995
108 WIT 0089 0105 Mrs Ferris

96 Professor Angelini in his written evidence to the Inquiry stated:

> '… this culture of keeping everything under control remained, and Mr Wisheart was, I believe, put in charge of organising the external enquiry on his own practice.'[109]

97 Dr Roylance, when asked by Counsel to the Inquiry who organised the visit, told the Inquiry:

> 'Primarily, the visitors. I gave them full authority to ask for anything and guaranteed the Trust would provide them. I sent them off, I am fairly sure, with this manager as a sort of guide so they did not get lost.'[110]

98 Mr Wisheart stated that his part in the inquiry was:

> '… limited to the initial approach to Mr de Leval and Dr Hunter, acting on the advice of the President of the British Cardiac Society … Mrs Ferris … describes how she arranged the venue, the programme and the people who should attend … .'[111]

99 Mrs Ferris was responsible for making the logistical arrangements necessary for Professor de Leval and Dr Hunter to visit Bristol. She told the Inquiry that '… it was all arranged in a rush.'[112]

100 Mr McKinlay, Chairman, UBHT, from July 1994 to November 1996, commented on the arrangements for the conduct of the review in the following exchange:

> 'I actually thought at the time there would be a button you could press in the National Health Service which was marked "investigation" and the procedures would follow and I thought that something fairly normal would be put in place. I did not interfere with how the inquiry would be set up.
>
> 'Q. You thought that somewhere in the Health Service there would be an investigative unit, something of that sort?
>
> 'A. Not necessarily an investigative unit. I think I knew enough then that that was possibly unlikely. But there would be an accepted procedure.'[113]

109 WIT 0073 0018 Professor Angelini
110 T89 p. 76 Dr Roylance
111 WIT 0089 0114 Mr Wisheart
112 T87 p. 167–8 Mrs Ferris
113 T76 p. 67–8 Mr McKinlay

101 Dr Hunter and Professor de Leval spent one day visiting Bristol. Professor de Leval stated:

> 'We were urged to visit UBHT as soon as possible and to issue a report without delay. I made it clear that I had booked one week's holiday from 11.2.95 and that if the visit to UBHT had to take place before I went away I could come only on 10.2.95. This was found to be acceptable.'[114]

102 Dr Hunter told the Inquiry:

> '… basically if we were going to be able to do anything significant in the time which we were being given … it is a continuing problem that I have just been through in another centre recently, where you are asked for very important decisions and to do very detailed examination of facts in a very short time. I think the sort of gun that was pointed at our heads was that it was critical and crucial to know whether the surgery should continue, or whether the decision had to be made that it should be referred elsewhere before Mr Pawade arrived.'[115]

103 The experts' remit was recorded in the first version of their report as follows:

> 'To advise the Trust on the best action to take following recent recommendations received by the Department of Health to stop complex neonatal and infant open-heart surgery.
>
> 'To make recommendations on the future of the paediatric cardiac services in the Trust.'[116]

104 In the second version of the report, the reference to the DoH's recommendations was omitted. In this version of the report, the remit of the review was expressed as:

> 'To advise the Trust on the best action to take to resolve conflicting professional advice in the field of paediatric cardiac surgery in general and, in particular, complex neonatal and infant open-heart surgery'.[117]

105 Dr Hunter's contemporaneous notes of the visit recorded that:

> 'Dr Roylance offered carte blanche in the investigation and stated his concerns about the service and also about professional loyalty in some members of staff involved in the dispute.'[118]

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114 WIT 0319 0001 Professor de Leval
115 T60 p. 127–8; Dr Hunter. Mr Ashwinikumar Pawade, consultant paediatric cardiac surgeon, BRHSC (1 May 1995–)
116 UBHT 0052 0263; first version of the Hunter/de Leval report
117 UBHT 0061 0378; revised draft of the Hunter/de Leval report; (the differences in the two versions of the remit are considered later in this chapter)
118 WIT 0319 0013; Dr Hunter's notes

He told the Inquiry that Dr Roylance '… was very general in saying he wanted us to have free access to whatever information we wished … .'[119]

106 Dr Roylance, in his written evidence to the Inquiry, stated that he '… wanted Mr de Leval and Dr Hunter to be completely frank (and blunt, if necessary) in their report … .'[120]

107 Dr Roylance told the Inquiry that when speaking to Dr Hunter and Professor de Leval at the outset, he told them that there were:

> '… three things [he needed] to know: first of all, is it right that the appointment of the paediatric cardiac surgeon is a proper solution to the problem? … Secondly, is moving up the hill [to the BRHSC] proper? Thirdly, what should the Trust, the service, do between the time of them reporting and the arrival of Ash Pawade?'[121]

108 Professor de Leval recalled Dr Roylance's alluding to:

> '… the difficulty of Mr Wisheart's position being on the one hand investigated in this particular problem, and at the same time, being Medical Director. … He explained to us that there had been complaints about the results of cardiac surgery and that he wanted to have an outside opinion … and asked again that [the] report be issued with the shortest possible delay … .'[122]

109 Mrs Ferris stated that she accompanied Professor de Leval around the Trust on the day of his visit. She stated that Professor de Leval took the opportunity of asking her whether she thought there were any problems with paediatric cardiac surgery, to which she replied that she did not think so. She was asked about this reply by Counsel to the Inquiry:

> 'Q. … did you think there were any problems with paediatric cardiac surgery as at 10th February 1995?
>
> 'A. I really think my answer at that stage would be, "I do not really know, but perhaps possibly I think there may be something to this". That was the view I was starting to form, and really around that visit, so when I said "No, I do not think so", I was not being absolutely straight with him.

119 T60 p. 128 Dr Hunter
120 WIT 0108 0130 Dr Roylance
121 T89 p. 75 Dr Roylance
122 T60 p. 17–20 Professor de Leval

'Q. If in fact you thought that the true answer was, "I do not really know but there might be", to say "I do not think so" gave a false impression to Mr de Leval of your true feeling?

'A. Yes, it did, and I obviously regret having given him the false impression. I was very worried that this had been presented to me as something that came about as a result of troublemaking and I think at the same sort of time, when I was advised about this, although we were having external advisers coming in, there was this sense that I had that this was something we did not want to be dealt with outside of the Trust.'[123]

110 Mrs Ferris also stated that she saw Dr Roylance on the day of the visit. She recalled that she:

'… walked over to Trust Headquarters with [him]. He made some comment that he "should not really have let James organise the day", but thought "it might be good for him". He gave the impression of treating the whole day very casually.'[124]

111 Dr Roylance denied making such a comment to Mrs Ferris:

'… that is quite wrong … I would not have discussed, with her, the review … . I certainly would not have said to her that it might be good for him.'[125]

112 Mrs Ferris in her written evidence to the Inquiry stated:

'I recall, probably towards the end of February [or] the beginning of March 1995 (but I cannot be precise about the date), Mr Wisheart asked me to come into his office, to discuss his figures. I felt intimidated by this request and during the meeting itself. Mr Wisheart gave the impression that he had heard I had been asking questions, and wanted to put me right. I could tell that Mr Wisheart was angry because he was so quiet and controlled. He spoke slowly. I felt I was being "warned off" and that Mr Wisheart felt I had no role in a discussion of clinical outcomes.'[126]

113 Mr Wisheart was questioned by Counsel to the Inquiry about the meeting in the following exchange:

'Q. … Did a meeting to that effect happen?

'A. It may have done, I do not have a precise recollection of the details of such a meeting; I have a vague recollection that we had such a conversation, that is all.

123 T87 p. 171–2 Mrs Ferris
124 WIT 0089 0099 Mrs Ferris
125 T89 p. 76 Dr Roylance
126 WIT 0089 0100 Mrs Ferris

'Q. Mrs Ferris gives a description here of you wanting to put her right and her description of your being angry because you were quiet and controlled and feeling that she had been warned off; do you recognise yourself in that?

'A. I was quite confused by that sentence, I was not really sure how much was fact, how much was interpretation and how much was accurate.'[127]

114 Dr Hunter and Professor de Leval stated that they met many of those involved in paediatric cardiac surgery for interview and discussion. They stated that the cardiac surgeons produced the detailed results of the neonatal Switch; and mortality data relating to closed-heart surgery during the period 1990 to March 1994 and, in respect of open-heart surgery, from January 1992 to January 1995.[128] Dr Bolsin stated in his written evidence to the Inquiry that, when he met them, he provided Dr Hunter and Professor de Leval with the 'best evidence' he had, which included:

'1. The Bolsin/Black data collection and analysis.

'2. The most complete record for the arterial switch available.

'3. My data on neonatal and non-neonatal arterial switch record.

'4. The unit's data from the annual report of 1990–91.'[129]

115 Dr Hunter stated that the fact that two sets of data covering different periods of time were produced was confusing.[130]

116 Dr Bolsin stated in his written evidence to the Inquiry that he faced a 'tirade of hostile questions'[131] from Professor de Leval in relation to the data he presented. He was asked about this in the following exchange:

'Q. You talk about a "tirade of hostile questions" from Mr de Leval?

'A. Yes.

'Q. Was it all like that?

'A. No, no, it was just this very early bit and when I went through my explanation that the bit that seemed to have got him worked up was actually not my data, that was data produced within the unit by Mr Wisheart, he suddenly changed, he changed his whole effect completely.'[132]

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127 T94 p. 128–9 Mr Wisheart
128 WIT 0322 0005 Dr Hunter, WIT 0319 0002 Professor de Leval
129 WIT 0080 0127 Dr Bolsin
130 WIT 0322 0005 Dr Hunter
131 WIT 0080 0127 Dr Bolsin
132 T83 p. 126 Dr Bolsin

117 Dr Hunter stated in his written evidence to the Inquiry:

> 'Those who initiated the auditing activities gave the impression that they were intent on policing the surgical activities rather than working together to see a solution. The figures presented by Dr Bolsin were incomplete and failed to give a total view of the problem. There was in general a lack of understanding of the problems of paediatric cardiac surgery.'[133]

118 Professor de Leval told the Inquiry:

> 'What I recollect is that during the meeting there was a sense of conflict which was present there and I think the way Dr Bolsin presented his data or the calendar of events was conflictural. Obviously it is difficult to blame someone, to adopt that attitude knowing what he had done for several years to try to solve the problem.'[134]

119 Dr Hunter's notes record discussions with Mr Dhasmana and Mr Wisheart.[135] They indicate that discussion took place about the impending move of the paediatric cardiac surgery department to the BRHSC and the arrival of the new surgeon, Mr Pawade. There was also discussion of the Switch programme at Bristol and the results which had been achieved.

120 Dr Hunter and Professor de Leval stated that they also interviewed the cardiologists Dr Martin and Dr Hayes (Dr Joffe was on holiday at the time), although it was not clear from their notes whether they saw the cardiologists at the same time as they saw Mr Wisheart and Mr Dhasmana, or whether they were seen separately. Dr Hunter told the Inquiry that he thought that they were seen separately but added that the Inquiry may have information to the contrary.[136] Dr Martin also was not sure:

> 'My general feeling was that we had met separately, but whether that is correct or not, I do not know.'[137]

121 Dr Hunter told the Inquiry that, having spoken to the cardiologists, he formed the view that there was:

> '… a general support for the attempts by Mr Dhasmana and concern that he was having problems with the switch. … I think they were generally supportive of their colleagues and worried about the effect of surgery, obviously, and where they should go from there.'[138]

122 Professor de Leval and Dr Hunter saw various other staff over the course of the day.

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133 WIT 0322 0006 Dr Hunter
134 T60 p. 30 Professor de Leval
135 WIT 0319 0014 – 0015; Dr Hunter's note
136 T60 p. 139–40; the Inquiry did not have information to the contrary
137 T77 p. 79 Dr Martin
138 T60 p. 141–2 Dr Hunter

123 Professor de Leval stated that Dr Stephen Pryn, consultant intensivist, felt the:

> '… surgical results were suboptimal but deplored the lack of hard data to prove it.'[139]

124 Dr Pryn told the Inquiry:

> '… It frustrated me that people were having these grumbling conversations without any data to go with it, and the night before the meeting with Marc de Leval was the first time I had seen those results … I was frustrated that we could not move the unit forwards in a constructive way.'[140]

125 Professor de Leval stated that Sister Fiona Thomas, the Clinical Nurse Manager, expressed concerns to him and Dr Hunter about the post-operative care of patients who had undergone paediatric cardiac surgery, and told them that there were 'considerable conflicts between surgeons and anaesthetists and a lack of expertise for children.'[141]

126 Professor de Leval told the Inquiry that he formed the impression from talking to Sister Thomas that:

> '… the decision-making [in intensive care] was highly disorganised … There was a complete lack of cohesion in the management of those patients. Nobody knew who was in charge of the patients.'[142]

127 Both of the visiting experts stated that they found Dr Monk, the Clinical Director of Anaesthesia, to be '… one of the most lucid and logical of the people they met during the visit.'[143] Professor de Leval told the Inquiry that he was impressed by Dr Monk's overall view of the problem, which went wider than the conduct of surgery to cover the overall management of the patient.[144]

128 Dr Hunter told the Inquiry that he thought that Professor Angelini's attitude would '… not have made the department a happier place to work in, and would not have been conducive to healing and improving matters.'[145] Professor de Leval commented that Professor Angelini:

> '… had reached a stage of being rather aggressive vis-à-vis the other two surgeons … . I felt that he was rather hostile and aggressive … .'[146]

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139 WIT 0319 0003 Professor de Leval
140 T72 p. 120 Dr Pryn
141 WIT 0319 0003 Professor de Leval
142 T60 p. 39 Professor de Leval
143 WIT 0319 0017; Dr Hunter's note
144 T60 p. 44 Professor de Leval
145 T60 p. 144 Dr Hunter
146 T60 p. 111 Professor de Leval

129 Professor de Leval accepted that Professor Angelini's attitude could have been 'just an indication of desperation' on his part.[147]

130 At the end of the day's visit an open meeting was held. Mr Wisheart told the Inquiry:

> '… The only comment I can make is that that was the meeting at which it emerged for the first time, to me, that Dr Bolsin had undertaken an audit, and that he had given it to Dr Hunter and Mr de Leval, and I am not always good at concealing my feelings, and it is quite possible that my body language was visible on that occasion. I mean, I was absolutely shocked; profoundly shocked.
>
> 'Q. Just shocked?
>
> 'A. Yes.
>
> 'Q. Angry?
>
> 'A. Well, I expect so.'[148]

131 Professor de Leval and Dr Hunter set out a number of preliminary conclusions arising from their visit, including:

> '… A major review of post-operative care was needed. The chain of command in the existing intensive care unit was hopelessly vague. … Better communication and trust between the various parts of the service was essential to solve the problems existing and to heal the serious divisions that had arisen. … A monthly morbidity and mortality conference attended by all parties where results, policies and practices would be openly discussed within the department … The critical factor in solving the overall problem was the appointment and imminent arrival (April 1995) of a new surgeon with a proven track record in a major centre.'[149]

132 Professor de Leval was asked about the methods he and Dr Hunter had used in the following exchange:

> 'Q. How confident are you, or how happy are you, with the method of investigation that you were obliged to adopt as a means of reaching a conclusion upon the adequacy of care at the Unit?'
>
> 'A. I think that the report was carefully written. I think that the report indicated its weaknesses and the report mentioned the fact that the investigation should go well beyond the surgeons but through the systems. I think that was in the initial report. So I do not think that the report was misleading or that the report did not achieve what it had to do; I believe that the report provided some information which could

147 T60 p. 111 Professor de Leval
148 T94 p. 163 Mr Wisheart
149 WIT 0322 0006 – 0007 Dr Hunter

have been useful for the Chief Executive to investigate further, to try to have a better understanding of what was happening and what had to be done.'[150]

133 Professor de Leval told the Inquiry that he recognised that reports were:

'… as robust or as weak as the data we received to make the report. We certainly agreed that there was a problem. We commented on ways to alleviate some of those problems and make recommendations for the future based on the decision that the Trust had already made when we visited them. But I think that the strengths or weaknesses of the report is parallel or relates to the strengths or weaknesses of the data we had.'[151]

134 Professor de Leval stated in his written evidence to the Inquiry that there was:

'… no evidence that the data collection had been validated. We did not have any form of risk stratification and we did not have the figures of the other UK units for comparison. With hindsight one could argue that it was unwise to produce a report based on such weak data.'[152]

135 Professor de Leval told the Inquiry:

'I think that the lack of a statistician is a deficiency of the report. There is more than that. I think that first of all the data we were presented with were deficient themselves, and I think that a statistician is as good as the data you provide to the statistician. I think that the deficiency was the weakness of the data and the pressure of time which just made it impossible to have good data. I do not disagree that a statistician would have been much more demanding than we were to produce a report, and any competent statistician would have simply refused to comment on this … .'[153]

136 Professor de Leval explained:

'It was quite clear from Dr Bolsin's interview and from the head of anaesthesiology [Dr Monk], that they had great difficulties to obtain the results. It was, I think, clear also that when they met in 1993, the surgeons made a statement which was not supported by data and that a number of the people we had seen on that particular day in February had been presented with the surgical results for the first time, so there was an obvious reticence from the surgeons … .'[154]

150 T60 p. 28–9 Professor de Leval
151 T60 p. 96 Professor de Leval
152 WIT 0319 0002 Professor de Leval
153 T60 p. 5–6 Professor de Leval
154 T60 p. 59 Professor de Leval

137 Professor Angelini stated in his written evidence to the Inquiry:

> 'I never received from Mr Dhasmana or Mr Wisheart specific data relating to their individual surgical performance. The first time I was provided with a full picture of results was literally half an hour before I was invited to speak to Mr de Leval and Dr Hunter on their visit to Bristol. … I had no way of verifying whether the data were correct … .'[155]

138 Commenting on Professor Angelini's observation, Mr Dhasmana told the Inquiry:

> '… he would have seen it [the data] for the year 1993/94. … The copy of annual unit returns to the Society's Annual Cardiac Register was regularly circulated to him along with other consultant members of staff. He never asked me for the surgeon specific figures and also never showed me the data provided by Dr Bolsin.'[156]

139 Dr Martin told the Inquiry:

> 'I did not get the impression that they [Mr Dhasmana and Mr Wisheart] were reluctant to reveal their figures … My perception was that the surgeons were analysing their own results.[157]

140 Dr Joffe, when asked by Counsel to the Inquiry about the comment in the Hunter/de Leval report that the surgeons were reticent in producing their results, told the Inquiry: 'It was not [the cardiologists'] experience. We always had access to those results … .'[158]

141 Dr Hunter told the Inquiry that he remembered 'a number of people saying to us that they had not been aware of the surgical data until literally a few days before, or shortly before'[159] his and Professor de Leval's visit.

142 Mr Wisheart stated in his written evidence to the Inquiry that the more detailed material was not provided to other clinicians until shortly before the arrival of Dr Hunter and Professor de Leval because:

> 'In less than two weeks and in addition to our regular commitments we had to (1) prepare the summarised results for 1992–95 and (2) complete a data sheet for each of 450 open-heart procedures carried out during those years.'[160]

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155 WIT 0073 0010 Professor Angelini
156 WIT 0073 0059 – 0060 Mr Dhasmana
157 T77 p. 4 Dr Martin
158 T90 p. 123 Dr Joffe
159 T60 p. 147 Dr Hunter
160 WIT 0073 0097 Mr Wisheart

143 Dr Monk, who had been aware of Dr Bolsin's audit from September 1993,[161] told the Inquiry about attempts to establish its meaning:

> 'The final meeting … was just preceding the de Leval/Hunter external audit. Even at that stage we had still not sat down with Dr Bolsin and said: "What about this data?" We held that meeting and he did not come. So even when I went in to see de Leval and Hunter, we still did not have a joint opinion amongst the Cardiac anaesthetists of what the data actually meant, nor, as a group, what we should be doing about it.'[162]

The first version of the Hunter/de Leval report

144 The full text of the first version of the Hunter/de Leval report was as follows:

> '**VISIT OF CARDIAC SERVICES DIRECTORATE OF THE UNITED BRISTOL HEALTH CARE NHS TRUST. FRIDAY, 10 FEBRUARY 1995**
>
> 'REMIT OF THE VISIT
>
> 'To advise the Trust on the best action to take following recent recommendations received by the Department of Health to stop complex neonatal and infant open-heart surgery.
>
> 'To make recommendations on the future of the paediatric cardiac services in the Trust.
>
> 'PROGRAMME OF THE VISIT
>
> 'Following a welcome meeting by the Chief Executive, Dr Roylance, who briefly outlined the problem, we met first the two paediatric cardiac surgeons, Mr Dhasmana and Mr Wisheart, who were then joined by two of the paediatric cardiologists, Dr Martin and Dr Hayes. We then met Dr Bolsin, consultant anaesthetist, Dr Monk, clinical director of anaesthesia, Sister Thomas, clinical nurse manager, and Professor Angelini, Professor of department of cardiac surgery. After lunch we met Dr Hughes, clinical director, and Mr Barrington, general manager, of the Bristol Children's Hospital, and then we met Dr Brynn [*sic*], consultant anaesthetist. The visit was closed by a general meeting that attempted to put forward a satisfactory proposal for the immediate future.

161 WIT 0105 0020 Dr Monk
162 T73 p. 123–4 Dr Monk

'CURRENT PAEDIATRIC CARDIAC SERVICES

'Paediatric cardiac services are currently provided on the two sites, the Bristol Children's Hospital and the Royal Infirmary. The paediatric cardiology services are in the Children's Hospital where closed-heart surgery is performed. Open-heart surgery is carried out at the Royal Infirmary. The operations are done by two surgeons, Mr Wisheart and Mr Dhasmana. The latter seems to have taken over the greater bulk of the paediatric practice. Anaesthesia is provided by three anaesthetists working on both sites. The postoperative care in the Children's Hospital is done by the surgeons, supported by paediatricians, cardiologists and anaesthetists. The junior staff on site is a paediatric SHO. At the Royal Infirmary the postoperative management is dealt with by the cardiac surgical team (adult) and the anaesthetic team. The person on site on a 24-hour basis is a surgical SHO. During the daytime there are currently two or three anaesthetic sessions which are dedicated to postoperative care. The paediatric cardiologists help with the postoperative management of the children at the Royal Infirmary. The overall postoperative management at the Royal Infirmary appears to be highly disorganised with conflicting decisions between the surgical senior registrar and the SHO who do rounds at 8.00 am, the anaesthetists who see the patients at 9.00 am, and the intensivists who work three days a week.

'BACKGROUND OF CURRENT PROBLEM

'From 1989 concerns about the surgical results of the paediatric cardiac surgeons have been raised by members of the anaesthetic department. Dr Bolsin undertook an audit of the paediatric cardiac surgical results from 1990–1992. The auditing showed: (1) that the results of the arterial Switch operation were poor; (2) the results of Bristol for more classical conditions, such as tetralogy of Fallot, AV canal and VSD, were worse than the national average; and (3) that one surgeon had results statistically worse than the other one.

'In 1993 one paediatric cardiac surgeon went to the Children's Hospital in Birmingham to improve his technique on the Switch operation.

'Professor Angelini, who joined the Trust in 1992, was informed as well as Professor Farndon (Professor of Surgery) of the results of the audit. A joint meeting between the cardiac surgeons, the paediatric cardiologists and the cardiac anaesthetists was called and the surgeons reassured their colleagues that the results were improving.

'Several members of staff who were interviewed during the visit confirmed that the surgeons failed to report and update their results until the day before our visit. Meanwhile, the results of the neonatal arterial Switch failed to improve and sometime in 1994 four cardiac anaesthetists agreed that they could no longer anaesthetise patients for a neonatal arterial Switch.

'On 19 July 1994 Dr P Doyle (Senior Medical Officer, DoH) visited Bristol and was shown the results of the audit (we assume that those were the 1990–1992 results). Three alternatives were proposed by Dr Doyle: inform the Secretary of State, ask Mr John Parker as President of the Cardiac Society to conduct an inquiry, or ask the President of the Royal College of Surgeons to conduct an inquiry. We understand that Mr John Parker was contacted to deal with the matter.

'On 24 July 1994 Professor Angelini and Professor Farndon informed the UBHT Chairman of the problem with paediatric cardiac surgery.

'This calendar of events was obtained in part from the interviews but mainly from a detailed report written by Dr Bolsin.

'In January 1995 a *non-infant* Switch was put on the surgical schedule. The wisdom of operating on this patient was discussed by a committee with representatives of all parties involved and an agreement was reached to proceed with the operation. The patient unfortunately did not survive and this allegedly led to the letter received from the Department of Health, advising to stop open-heart surgery for neonates and complex infants (we have not seen the letter from the Department of Health).

'FORWARD PLANNING

'The Trust has taken a number of positive steps to improve the paediatric cardiac services. They can be summarised as follows:

'From next October all paediatric cardiac services will be provided at the Children's Hospital where an operating theatre will be dedicated to cardiac work. The intensive care unit will expand from five to twelve beds. Professor Peter Fleming will run the paediatric intensive care unit and provision for a round-the-clock service will be made.

'Mr Ash Pawade has been appointed as paediatric cardiac surgeon and he is expected to take up his post within the next two or three months with the intention of putting him in charge of neonatal and complex paediatric cardiac surgery.

'The anaesthetic department will provide four paediatric cardiac anaesthetists. The fourth post will be created after the forthcoming retirement of a senior paediatric anaesthetist.

'PERCEPTIONS COLLECTED DURING THE VISIT

'1. Although well intentioned, the auditing activities of the surgical results by the anaesthetic department was lacking the collaborative attitude that such a delicate endeavour would have required.

'2. The surgeons' reticence to produce and analyse their own results has obviously contributed to tension and eventually conflict between the department of cardiac surgery and the department of anaesthetics.

'3. The channel that was followed by those concerned about the problem that led to the Department of Health before professional bodies is unfortunate. Admittedly, Dr Doyle has rectified this situation in suggesting to approach the Cardiac Society or the Royal College of Surgeons.

'4. The members of the anaesthetic department were unanimous in claiming that not only the mortality but the morbidity was excessive. Mortality figures will be discussed later. There was no hard data on morbidity.

'5. The tension which has arisen from this long saga has created an atmosphere of distrust and lack of confidence, which have made the working conditions for the surgeons nearly untenable.

'DATA ANALYSIS

'Two sets of data were displayed during the meeting. The data produced by Dr Bolsin were the results of the 1990–1992 audit which compared the results of Bristol with the national average performance of 1991. They concluded that the results of tetralogy of Fallot (all ages), ventricular septal defect (all ages) and atrioventricular canals (under one year) were significantly worse in Bristol than the rest of the UK. Leaving aside the neonatal arterial Switch operation, "the data for other procedures do not show any statistically significant differences"(Dr Bolsin's report). Dr Bolsin also produced the results of the arterial Switch operation up to July 1994: there were thirty-three arterial Switch operations with a mortality of 66% (eight out of twelve) under one month of age, and 42% (nine out of twenty-one) over the age of one month. He also summarises the results of AV canals operated by Mr Wisheart between 1992 and 1994.

'The second set of data received from the cardiac surgeons included a detailed report of the results of the neonatal arterial Switch operation, the results of closed heart surgery from 1990 to March 1994 and the results of open-heart surgery from January 1992 to January 1995.

'There were nine deaths out of thirteen neonatal arterial Switches: one patient had an undiagnosed coarctation of the aorta, two patients had the whole coronary system arising from the same sinus, one of them with an intramural pathway:

neither of those patients survived. Two patients had a circumflex coronary artery arising from sinus 2 (known to be a risk factor in a multi-institutional study); one of these patients died.

'The results of closed heart surgery are excellent with a mortality of 5.3% for patients under one year of age and a mortality of 2.8% for patients over the age of one year.

'For the results of open-heart surgery from January 1992 to January 1995, we have extracted the results of tetralogy of Fallot, VSD and AV canal to compare them with the 1990–1992 results produced by Dr Bolsin and we individualised the two surgeons (Consultant 1 and Consultant 2) (Fig 1, 2 & 3).

'Consultant 1 has a mortality of 0% for ventricular septal defects, 13.5% for tetralogy of Fallot and 87% for AV canals.

'Consultant 2 has a mortality of 0% for ventricular septal defects, 0% for tetralogy of Fallot and 8.6% for AV canals.

'The current results of the other UK units are not available to us. There is little doubt that Consultant 2 would certainly compare very favourably with the best UK institutions. Consultant 1 would be amongst the higher risk surgeons.

'WEAKNESSES AND DEFICIENCIES OF THE ANALYSIS

'1. We assume that the mortality figures relate to the hospital mortality, though we have not specified this.

'2. There is no recommended standard against which the performance of a unit can be compared. This emphasises the great need for a proper audit of the performance of each UK unit dealing with paediatric cardiac surgery. The use of the average UK results may be misleading. If one postulates, for example, that two or three larger units have better results than two or three smaller units, the poor results of the latter will be hidden, so to speak, by the average figures.

'3. It is therefore not possible to make any objective and fair recommendations to a unit without knowing what the performance of every single unit in the UK is, so as to set up a standard.

'4. Performance assessment should also take into consideration morbidity.
Dr Bolsin's report includes an attempt to compare the performance of the two surgeons in looking at bypass time, extubation time, ITU time and hospital time for tetralogy of Fallot and AV canals. Here again, those data suffer the lack of standard to which they should be compared.

‘CONCLUSIONS AND RECOMMENDATIONS

‘The following has to be taken in the context of the above described deficiencies of this report.

‘1. On the basis of the mortality figures presented to us, there is a significant improvement between the 1990–1992 results and the 1992–1995 results.

‘2. The results of the neonatal arterial Switch operation should improve. It is not possible to determine the cause of these poor results. To blame surgical skill as the sole reason would be shortsighted. It is most likely a multifactorial and multidisciplinary problem.

‘3. Leaving aside the neonatal arterial Switch repairs, based on the mortality figures produced for 1992–1995, the results produced by Consultant 2 are, we believe, comparable to the results of the so-called low risk institutions (although the hard data for the UK are not available).

‘4. We understand that Consultant 1 has decided to concentrate his activities on adult cardiac surgery when the new appointee starts.

‘5. We believe that it would be a great mistake to ask the new appointee to do all neonatal and complex cardiac surgery using Mr Dhasmana as a “spare wheel”. We would recommend that both surgeons help each other for the most complex pathologies. For this Mr Dhasmana should be relieved from part of his duties in adult cardiac surgery. The Trust may have therefore to consider appointing another adult cardiac surgeon should their workload justify it. This might be the case as the move of the paediatric cardiac surgery to the Children’s Hospital will create more facilities at the Royal Infirmary.

‘6. There is a great need for improving communications between the various departments. We would strongly recommend to organise multidisciplinary audit meetings (at least monthly). We would also recommend joint cardiac conferences, attended by the cardiologists, the anaesthetists, the intensivists and the surgeons weekly to discuss cases which have been investigated and those who are on the operating schedule for the following week.

‘7. An atmosphere of cooperation and understanding between the various departments is essential, so as to alleviate the tension, the distrust and the present untenable atmosphere which without any doubt jeopardise the outcome of the patients.

‘8. We believe that it would be inappropriate to do neonatal arterial Switch operations before the new appointee takes up his post. From the mortality figures presented to us, we have no reason to believe that Mr Dhasmana should not continue to carry on operating on the other conditions. *This, however, would be*

possible only if he receives the full support he deserves from his colleagues. This requires a change of attitude to alleviate the stressful conditions under which he has had to work in the recent past.

'9. It is hoped that the new appointee will be more successful with the arterial Switch repair and that when the failure rate has returned to low values Mr Dhasmana will start afresh with the operation.'[163]

BRISTOL Open-heart surgery January 1992 – January 1995				
FALLOT				
	< 1 year Patients	< 1 year Deaths	> 1 year Patients	> 1 year Deaths
Consultant 1	1	1	21	2
Consultant 2	2	0	23	0
VSD				
	< 1 year Patients	< 1 year Deaths	> 1 year Patients	> 1 year Deaths
Consultant 1	20	0	13	0
Consultant 2	21	0	20	0
AV CANAL				
	< 1 year Patients	< 1 year Deaths	> 1 year Patients	> 1 year Deaths
Consultant 1	7	6	1	1
Consultant 2	18	2	5	0

NB UBHT 0052 0263 – 0269; first version of the Hunter/de Leval report

145 Mrs Ferris told the Inquiry that she thought that the comment about post-operative care being 'disorganised' was fair.[164]

146 Mr Wisheart told the Inquiry that this conclusion was based solely on information given to the visiting experts by Fiona Thomas and was not therefore a conclusion 'based on canvassing a broad spectrum of opinion'.[165]

147 Dr Roylance stated in his written evidence to the Inquiry that he gave the visiting experts his assurance that the report was confidential to him.[166] Dr Roylance told the Inquiry that the reason for the confidentiality of the report was that:

'… it was not refined, it was blunt, it was clear and it was helpful to me … and to make sure there were no punches that were pulled, I promised them they could say

163 UBHT 0052 0263 – 0269; first version of the Hunter/de Leval report (emphasis in original); see Chapter 3 for an explanation of clinical terms
164 T87 p. 180 Mrs Ferris
165 T93 p. 79 Mr Wisheart
166 WIT 0108 0131 Dr Roylance

whatever they liked and it would remain confidential to me and I would act on their advice.'[167]

148 Dr Roylance told the Inquiry that a further reason was because Dr Hunter and Professor de Leval were 'to a certain extent, dealing on hunch and impression.'[168]

149 Professor de Leval stated in his written evidence to the Inquiry that the report was not written for public consumption: '… [The] report contained a number of statements which, in my opinion, could not be in the public domain without further investigation.'[169]

150 He told the Inquiry:

> 'The report was produced as a confidential document to the Chief Executive … I think that if I had known that the document was going to be part of the public domain, I would have been more careful in the wording of the document. I think that it is totally unfair to say that a surgeon is a high risk surgeon with that type of data, and I think that it was irresponsible to say that with the data we had.'[170]

151 Dr Hunter discussed the status of the first version of the report in the following exchange:

> 'Q. [The report] has been described as being variously "confidential" or "a draft". What did you understand it to be?
>
> 'A. I understood it was a confidential report which was for the UBHT.
>
> 'Q. And by "confidential", who did you understand it would be circulated to?
>
> 'A. I assumed that that would be up to the UBHT. We were asked by the UBHT, by Mr Wisheart on its behalf, to do the report, and therefore our remit was to send it to them.
>
> 'Q. Did you understand that the first report that you had sent through was, as it were, a working draft that other people might comment on and ask you to revise, or a final version that —
>
> 'A. I thought that it was a draft.

167 T89 p. 81–3 Dr Roylance
168 T89 p. 84 Dr Roylance
169 WIT 0319 0001 Professor de Leval
170 T60 p. 84 Professor de Leval

'Q. By which you mean what?

'A. That "this is what we intend to say and we would like to hear your comments". That is what I have done on other reports.'[171]

152 Dr Roylance went on annual leave on 24 February 1995. Mr Graham Nix was acting Chief Executive in his absence. Mr Nix, in his written evidence to the Inquiry, recalled:

'Within a few days of Dr Roylance going on leave, the Trust began to be approached by people from outside the Trust asking for information, which tended to suggest that the fact of there being a report available and to some extent its contents were already in the public domain … My own first involvement was I believe some time during the week of 27 February 1995 when the faxed report became known to me following Press interest.'[172]

153 Mr Nix stated that he consulted Mr McKinlay (Chairman, UBHT) about the appropriate response to be made by the UBHT.[173] Mr McKinlay stated that Dr Roylance had told the Board on 24 February 1995 that:

'Mr Wisheart would review the contents of the report with Dr [Professor] Vann Jones and Dr Hyam Joffe and would have discussions with Dr Winyard, who was Medical Director of the NHS Executive.'[174]

154 Mr McKinlay, in a letter to Ms Rennie Fritchie, Chair of the South & West Regional Health Authority (S&WRHA) dated 3 March 1995, wrote:

'To protect Mr Wisheart, I have requested him not to deal with the media queries and to leave the internal action in the hands of Gabriel Laszlo [Chairman, Hospital Medical Committee].'[175]

155 Mr Nix stated that:

'The report was immediately considered by Dr Laszlo, as Chairman of the Hospital Medical Committee [HMC], Dr Joffe, Consultant Paediatric Cardiologist, Dr Monk as Clinical Director of the Directorate of Anaesthesia and Dr [Professor] John Vann Jones as Clinical Director of the Directorate of Cardiac Services. This led to a report of their combined views dated 3 March 1995, which was produced to assist Mr McKinlay and myself.'[176]

171 T60 p. 60 Dr Hunter
172 WIT 0106 0071 Mr Nix
173 WIT 0106 0072 Mr Nix
174 WIT 0102 0030 Mr McKinlay
175 UBHT 0052 0260; letter dated 3 March 1995
176 WIT 0106 0072 Mr Nix

156 The report of the HMC concluded:

> 'No data are presented to show how [Mr Wisheart] is ranked nationally. In the tables provided, there is no significant difference between the mortality figures of the two surgeons. The total number of deaths in 1992–5 was very similar; the team which operated on the smaller number of children had a non-significantly higher mortality. A total of only four fewer deaths would have yielded equal percentages. There were four excess deaths in the "miscellaneous" group among patients with very unusual diagnoses not all of whom had operations.'[177]

157 Mr McKinlay wrote to Ms Fritchie confirming the UBHT's intention to act on the report's recommendations and stating that: '… While disagreeing with several of the comments made in the report we accept the recommendations.'[178]

March

158 On 6 March 1995, the NHS Executive arranged a meeting between the Regional Health Authority, the UBHT and NHS Executive representatives, to take place on 9 March.[179] The minutes of that meeting record Mr McKinlay as saying that he:

> '… believed that the Trust had the situation under control from the middle of 1994 but, following an unsuccessful "switch" operation on an older child in January this year, earlier concerns had resurfaced. It was then decided that external paediatric cardiac experts should be brought in to analyse the paediatric surgical audit results and make recommendations.'[180]

159 At the meeting, the UBHT representatives, Mr McKinlay, Mr Nix, Professor Vann Jones, Dr Laszlo and Dr Joffe,indicated that they felt that:

> '… some sections [of the report] could have been better worded and the conclusions to be drawn were open to interpretation.'[181]

It was also noted that disappointment was expressed that more detailed analysis had not been performed on the data, but it was acknowledged that such analyses would have taken much longer. Mr Nix is recorded as saying that, because of the wording of parts of the report, wider circulation within the UBHT was not desirable.[182]

160 The representatives of both the Region and NHSE stated at the meeting that they would not support the report's being kept confidential and that the UBHT should be prepared to make it public.[183]

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177 UBHT 0061 0371; HMC report
178 UBHT 0052 0260; letter dated 3 March 1995
179 WIT 0106 0104 – 0106; note of meeting on 9 March 1995. Those attending were Ms Fritchie, Mr McKinlay, Mr Nix, Professor Vann Jones, Dr Laszlo, Dr Joffe, Dr Gabriel Scally, Dr P Doyle, Isabel Nisbet, John Churchill and Billy Flynn
180 WIT 0106 0104; note of meeting on 9 March 1995
181 WIT 0106 0106; note of meeting on 9 March 1995
182 WIT 0106 0106; note of meeting on 9 March 1995
183 WIT 0102 0032 Mr McKinlay

161 It was agreed at the meeting that the approach set out in Dr Roylance's letter to Dr Doyle of 26 January 1995 would be adhered to, namely that:

> '… the Trust has decided not to carry out complex neonatal or infant open heart surgery until there has been resolution of the conflicting professional advice.'[184]

162 At Mr McKinlay's request, Mr Nix organised two meetings of all relevant consultants to discuss the report. These were held on 13 and 14 March. Mr Nix stated in his written evidence to the Inquiry that:

> '… both of the meetings were attended by… Mr Hutter, Mr Bryan, Mr Dhasmana, Mr Wisheart; Drs Davies, Bolsin, Pryn, Masey, Underwood, Joffe, Wilde; Prof. Angelini, Prof. Vann Jones. Dr Gabriel Laszlo also attended, as Chairman of the Hospital Medical Committee. Mr McKinlay chaired both meetings. I prepared the overheads for the meetings, which were of copies of the report.'[185]

163 Mr Nix went on:

> 'At each meeting, we went through the report paragraph by paragraph. Everyone was encouraged to say what they wanted to say, and they did so. There were a number of issues that were raised in the course of the discussions. These included a debate about the naming of individual clinicians in the report … There were concerns about the accuracy of the data set out in the report … There were some concerns about the wording of the report, including matters of emphasis and use of particular words … It emerged in the course of the meetings that a number of consultants had not seen Dr Bolsin's data. … It was also noted that Mr Wisheart had already agreed to stop operating on paediatric cases when Mr Ash Pawade took up his appointment.'[186]

164 Mr Bryan stated in his written evidence to the Inquiry:

> '… those invited were shown acetates of selected passages from the original report … The meeting was asked to endorse the findings of the report. A number of people at the meeting, including myself, found the request to endorse the original report unacceptable since we were asked to endorse a report we had not read. Professor Angelini expressed this view most vociferously, but it was my impression that it was the general view of the meeting that people wished to read the report.'[187]

165 Mr Nix explained in a statement to the Inquiry that:

> '… it was not appropriate to distribute widely copies of the report in its current form. … [so we] instead arranged for [the consultants involved] to read a copy of

184 WIT 0106 0106; note of meeting on 9 March 1995
185 WIT 0106 0073 Mr Nix
186 WIT 0106 0073 – 0074 Mr Nix
187 WIT 0081 0029 Mr Bryan

the report in Mr McKinlay's office … There was some disquiet about this, but in view of the various concerns raised, it was felt at the time that this was the most appropriate way to deal with it, until some of the concerns and anxieties could be addressed.'[188]

166 Professor Angelini said that he felt Mr McKinlay was asking them to 'underwrite' the report. He continued:

'After a longer argument, the people were allowed to look at the report. This was literally for less than five minutes. In my case, with Dr Laszlo looking over my shoulder, I could take no notes whatsoever. I did not have more than five minutes to read it and this created, obviously, a lot of dissatisfaction and complaint.

'After that, Mr McKinlay decided then that the full report was going to be shown to this group of 10 or 15 people, and there were two meetings … during which the report was discussed literally word by word. None of us had the opportunity to actually have the report copy in front of us, but there were acetates which discussed the report word by word.'[189]

167 Mr Bryan in his written evidence to the Inquiry recalled discussion about the future of the Switch programme:

'There was a lot of emotional discussion, principally from Dr Joffe and Mr Dhasmana, that the "switch" programme should continue with Mr Dhasmana continuing to lead the paediatric cardiac surgery service up to and following Mr Pawade's arrival. I expressed my view clearly that no further "switch" operations should be performed in any age group before Mr Pawade's arrival.'[190]

168 Professor Angelini told the Inquiry:

'To me that report was absolutely shocking. In a way, if you like, it was a vindication of what people like me had been saying for a very long time. Despite that report, I felt that particularly myself and Dr Bolsin, we were very much victimised by Mr McKinlay and some of the other people present, almost like accused of having been responsible, of having dragged the Trust into this situation and we were responsible for this report and everything else.'[191]

169 Mr Bryan stated that:

'Dr Bolsin and Professor Angelini were admonished for their involvement in this affair by Mr McKinlay. I found this both inappropriate and unacceptable.'[192]

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188 WIT 0106 0075 Mr Nix
189 T61 p. 194–5 Professor Angelini
190 WIT 0081 0029 Mr Bryan
191 T61 p. 195 Professor Angelini
192 WIT 0081 0030 Mr Bryan

Mr McKinlay told the Inquiry that Professor Angelini was 'being a little sensitive there' and that Professor Angelini 'had a slight tendency to ignore some of the statistics'.[193]

The revised draft Hunter/de Leval report

170 Dr Bolsin stated in his written evidence to the Inquiry that when Dr Roylance returned from holiday he immediately stopped the circulation and reading of the first report and insisted that the report was an interim document, to be used as a draft from which a final report would be produced.[194]

171 Dr Roylance told the Inquiry that when he returned from holiday, and found that the report had achieved a wide circulation in his absence and had been promised to Harlech Television (HTV), he:

> '… informed the authors that a decision had been made to make their report public and asked them whether they would wish to modify it in that knowledge.'

Dr Roylance told the Inquiry that release to HTV 'would not have been a proper step', given the terms upon which the report was commissioned and written.[195]

172 Dr Roylance was asked by Counsel to the Inquiry whether he had objections to the information about the report being in the public domain:

> 'I had no objection at the time to the fact of the review, the fact of the independent inquiry and the nature of the response, in other words the report being in the public domain, no anxiety about that at all.
>
> 'I did have an anxiety that I could not place the authors in a position of risk by breaking my word to them.
>
> '… I was a Chief Executive of a public organisation which lived in the public sector. … There was never any question that the issue was to be debated in public. At the absolute minimum, it would have been debated at a public meeting of the Health Authority:
>
> 'The reason for two reports was nothing to do with publication or not publication; it was because I had not asked them for a report which was fit for public view.'[196]

173 He told the Inquiry that Professor de Leval was responsible for deciding what parts of the report were to be changed.[197]

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193 T76 p. 81 Mr McKinlay
194 WIT 0080 0129 Dr Bolsin
195 T89 p. 80–1 Dr Roylance
196 T89 p. 111–12 Dr Roylance
197 T89 p. 80 Dr Roylance

174 Mr McKinlay in his written evidence to the Inquiry stated:

> '… the Trust's endorsement of a report with conclusions based on unreconciled data could constitute defamation of Mr Wisheart. I recall that Dr Roylance communicated this to Mr de Leval, whereupon Mr de Leval altered the report.'[198]

175 Professor de Leval told the Inquiry that he did not think it was fair:

> '… to have a public document which is making a very strong comment … without having this confirmed by the people most involved with the patients, who are the anaesthetists, the surgeons and the cardiologists and intensivists … . I spoke with Mr Wisheart and Mr Nix after the first report, some discussions I think over the telephone, not in writing, that I have to make some amendments.'[199]

176 Changes were made to the report. Professor de Leval explained that:

> 'The main reason for changing the document was that we did not expect this document to be part of the public domain as it stood. … I think that the truth is that I did not expect to have to change the document if it had remained within the knowledge of the Chief Executive. The reason for changing it is that the nature of the document had changed, in my view, after it had been sent to the Chief Executive.'[200]

177 Dr Laszlo in his written evidence to the Inquiry stated that some of the minor amendments emanated from within the UBHT:

> '… Mr Nix and Mr Wisheart showed me a few amendments to the Report which they hoped to have made in the event of the Trust being asked to publish the document. These were only minor, and in one or two places they asked for some of the phrases to be softened and made less colloquial. … I was assured that Professor de Leval himself had made the major changes, on the basis that he had not expected the original report to be made public.'[201]

178 Dr Hunter told the Inquiry that Professor de Leval telephoned him and said that he had spoken to Mr Nix about softening some of the statements in the report. Dr Hunter said that Professor de Leval made the changes and sent the report to Dr Hunter for his approval.[202]

179 The Inquiry was unable to establish precisely when the amended report was sent to the UBHT.

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198 WIT 0102 0032 Mr McKinlay; see also T89 p. 84 –5, where Dr Roylance told the Inquiry that he took the advice of the District Solicitor, who stated that the contents of the report as they stood might be libellous; and UBHT 0332 0001 (letter from Osborne Clark, solicitors, which contained advice to the same effect)

199 T60 p. 88 Professor de Leval

200 T60 p. 81–2 Professor de Leval

201 WIT 0100 0026 Dr Laszlo

202 T60 p. 158–60 Dr Hunter

180 Dr Bolsin in his written evidence to the Inquiry described the amended report as a 'much more benign document.'[203] He said:

> 'When I read the revised report I immediately asked for an appointment to see Dr Roylance to explain my unhappiness with this conclusion and the removal of the critical elements of the first report.'[204]

181 The full revised report, with the amendments made to it noted, is reproduced below:[205]

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>
> 'REMIT OF THE VISIT
>
> 'To advise the Trust on the best action to take ~~following recent recommendations received by the Department of Health to stop complex neonatal and infant open-heart surgery~~ to resolve conflicting professional advice in the field of paediatric cardiac surgery in general and, in particular, complex neonatal and infant open-heart surgery.
>
> 'To make recommendations on the future of the paediatric cardiac services in the Trust.
>
> 'PROGRAMME OF THE VISIT
>
> 'Following a welcome meeting by the Chief Executive, Dr Roylance, who briefly outlined the problem, we met first the two paediatric cardiac surgeons, Mr Dhasmana and Mr Wisheart, who were then joined by two of the paediatric cardiologists, Dr Martin and Dr Hayes. We then met Dr Bolsin, consultant anaesthetist, Dr Monk, clinical director of anaesthesia, Sister Thomas, clinical nurse manager, and Professor Angelini, Professor of department of cardiac surgery. After lunch we met Dr Hughes, clinical director, and Mr Barrington, general manager, of the Bristol Children's Hospital, and then we met Dr Prynn, consultant anaesthetist. The visit was closed by a general meeting that attempted to put forward a satisfactory proposal for the immediate future.
>
> 'CURRENT PAEDIATRIC CARDIAC SERVICES
>
> 'Paediatric cardiac services are currently provided on the two sites, the Bristol Children's Hospital and the Royal Infirmary. The paediatric cardiology services are in the Children's Hospital where closed-heart surgery is performed. Open-heart

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203 WIT 0080 0129 Dr Bolsin

204 WIT 0080 0129 Dr Bolsin. The Inquiry received no confirmation that such a meeting actually took place. Dr Roylance was able to recollect only one meeting with Dr Bolsin in 1995 (see T89 p. 87)

205 UBHT 0061 0378 – 0387. The parts removed from the previous version of the report are struck through, whilst the additions are underlined

surgery is carried out at the Royal Infirmary. The operations are done by two surgeons, Mr Wisheart and Mr Dhasmana. The latter ~~seems to have~~ has taken over the greater bulk of the paediatric practice since Mr Wisheart became Medical Director of the Trust. Anaesthesia is provided by three anaesthetists working on ~~both~~ each of two sites. The postoperative care in the Children's Hospital is done by the surgeons, supported by paediatricians, cardiologists and anaesthetists. The junior staff on site is a paediatric SHO. At the Royal Infirmary the postoperative management is dealt with by the cardiac surgical team (adult) and the anaesthetic team. The person on site on a 24-hour basis is a surgical SHO. During the daytime there are currently two or three anaesthetic sessions which are dedicated to postoperative care. The paediatric cardiologists help with the postoperative management of the children at the Royal Infirmary. The overall postoperative management at the Royal Infirmary appears to be ~~highly disorganised with conflicting decisions~~ less organised with multiple decision making processes between the surgical senior registrar and the SHO who do rounds at 8.00 am, the anaesthetists who see the patients at 9.00 am, and the intensivists who work three days a week. Consultant surgeons appear to have the last say in management.

'BACKGROUND OF CURRENT PROBLEM

'This calendar of events was obtained in part from the interviews but mainly from a detailed report written by Dr Bolsin.

'From 1989 concerns about the surgical results of the paediatric cardiac surgeons have been raised by members of the anaesthetic department. Dr Bolsin undertook an audit of the paediatric cardiac surgical results from 1990–92. The auditing showed~~: (1)~~ that the results of the arterial Switch operation were poor~~; (2)~~ and that the results of Bristol for more classical conditions, such as tetralogy of Fallot, AV Canal and VSD, were worse than the national average~~; and (3) that one surgeon had results statistically worse than the other one~~.

'In 1993 one paediatric cardiac surgeon went to the Children's Hospital in Birmingham to improve his technique on the Switch operation.

'Professor Angelini, who joined the Trust in 1992, was informed as well as Professor Farndon (Professor of Surgery) of the results of the audit. A joint meeting between the cardiac surgeons, the paediatric cardiologists and the cardiac anaesthetists was called and the surgeons reassured their colleagues that the results were improving.

'Several members of staff who were interviewed during the visit confirmed that the surgeons failed to report and update their results until the day before our visit. Meanwhile, the results of the neonatal arterial Switch failed to improve and sometime in 1994 four cardiac anaesthetists agreed that they could no longer anaesthetise patients for neonatal arterial Switch.

'On 19 July 1994 Dr P Doyle (Senior Medical Officer, DoH) visited Bristol and was shown the results of the audit (we assume that those were the 1990–92 results). ~~Three~~ Various alternatives were proposed by Dr Doyle~~: inform the Secretary of State,~~ amongst them to ask Mr John Parker as President of the Cardiac Society to conduct an inquiry, or ask the President of the Royal College of Surgeons to conduct an inquiry. We understand that Mr John Parker was contacted to deal with the matter.

'On 24 July 1994 Professor Angelini and Professor Farndon informed the UBHT Chairman of the problem with paediatric cardiac surgery.

~~'This calendar of events was obtained in part from the interviews but mainly from a detailed report written by Dr Bolsin.~~

'These events were followed in ~~In~~ January 1995 when a non-infant Switch was put on the surgical schedule. The wisdom of operating on this patient was discussed by a committee with representatives of all parties involved and an agreement was reached to proceed with the operation. The patient unfortunately did not survive and this allegedly led to the letter received from the Department of Health, advising to stop open-heart surgery for neonates and complex infants (we have not seen the letter from the Department of Health).

'FORWARD PLANNING

'The Trust has taken a number of positive steps to improve the paediatric cardiac services. They can be summarised as follows:

'From next October all paediatric cardiac services will be provided at the Children's Hospital where an operating theatre will be dedicated to cardiac work. The intensive care unit will expand from five to twelve beds ~~Professor Peter Fleming will run the paediatric intensive care unit~~ and ~~provision for~~ a round-the-clock service will be made.

'Mr Ash Pawade has been appointed as paediatric cardiac surgeon and he is expected to take up his post within the next two or three months with the ~~intention of putting him in charge of neonatal and complex paediatric cardiac surgery.~~ expectation that he will contribute to the future development of neonatal and complex paediatric cardiac surgery.

'The anaesthetic department will provide four paediatric cardiac anaesthetists. The fourth post will be created after the forthcoming retirement of a senior paediatric anaesthetist.

'Mr Wisheart has decided to divide his activities between adult cardiac surgery and administration and to give up paediatric cardiac surgery when Mr Pawade starts.

‘PERCEPTIONS COLLECTED DURING THE VISIT

‘1. Although well intentioned, the auditing activities of the surgical results by the anaesthetic department was lacking the collaborative attitude that such a delicate endeavour would have required.

‘2. The surgeons’ reticence to produce and analyse their own results has obviously contributed to tension and eventually conflict between the department of cardiac surgery and the department of anaesthetics.

‘3. The channel that was followed by those concerned about the problem that led to the Department of Health before professional bodies is unfortunate. Admittedly, Dr Doyle has rectified this situation in suggesting to approach the Cardiac Society or the Royal College of Surgeons.

‘4. The members of the anaesthetic department ~~were unanimous in claiming that not only~~ by and large claimed that the mortality~~but the~~ and the morbidity ~~was~~ were excessive. Mortality figures will be discussed later. There was no hard data on morbidity.

‘5. The tension which has arisen from this long saga has created an atmosphere of distrust and lack of confidence, which has made the working conditions for the surgeons ~~nearly untenable~~ very difficult indeed.

‘DATA ANALYSIS

‘Two sets of data were displayed during the meeting. The data produced by Dr Bolsin were the results of the 1990–92 audit which compared the results of Bristol with the national average performance of 1991. They concluded that the results of tetralogy of Fallot (all ages), ventricular septal defect (all ages) and atrioventricular canals (under one year) were significantly worse in Bristol than the rest of the UK. Leaving aside the neonatal arterial Switch operation, “the data for other procedures do not show any statistically significant differences”(Dr Bolsin’s report). Dr Bolsin also produced the results of the arterial Switch operation up to July 1994: there were thirty-three arterial Switch operations with a mortality of 66% (eight out of twelve) under one month of age, and 42% (nine out of twenty-one) over the age of one month. ~~He also summarises the results of AV canals operated by Mr Wisheart between 1992 and 1994.~~

‘The second set of data received from the cardiac surgeons and the paediatric cardiologists included a detailed report of the results of the neonatal arterial Switch operation, the results of closed heart surgery from 1990 to March 1994 and the results of open-heart surgery from January 1992 to January 1995.

'There were nine deaths out of thirteen neonatal arterial Switches: one patient had an undiagnosed coarctation of the aorta, two patients had the whole coronary system arising from the same sinus, one of them with an intramural pathway: neither of those patients survived. Two patients had a circumflex coronary artery arising from sinus 2 (known to be a risk factor in a multi-institutional study); one of these patients died.

'The results of closed-heart surgery that is carried out at the Children's Hospital are excellent with a mortality of 5.3% for patients under one year of age and a mortality of 2.8% for patients over the age of one year.

'For the results of open-heart surgery from January 1992 to January 1995, we have extracted the results of tetralogy of Fallot, VSD and AV canal repaired by Mr Dhasmana, who currently does the majority of these operations to compare them with the 1990–92 results produced by Dr Bolsin ~~and we individualised the two surgeons (Consultant 1 and Consultant 2)~~.

~~'Consultant 1 has a mortality of 0% for ventricular septal defects, 13.5% for tetralogy of Fallot and 87% for AV canals.~~

~~'Consultant 2 has a mortality of 0% for ventricular septal defects, 0% for tetralogy of Fallot and 8.6% for AV canals.~~

'There was 0% mortality for ventricular septal defects (41 patients), 0% mortality for tetralogy of Fallot (25 patients) and 8.6% mortality for AV canals (23 patients). The current results ~~of the other UK units~~ for individual units in the UK are not available to us. There is little doubt ~~that Consultant 2 would certainly~~, however that the above results compare very favourably with the best UK institutions. ~~Consultant 1 would be amongst the higher risk surgeons.~~

'WEAKNESSES AND DEFICIENCIES OF THE ANALYSIS

'1. We assume that the mortality figures relate to the hospital mortality, though we have not specified this.

'2. There is no recommended standard against which the performance of a unit can be compared. This emphasises the great need for a proper audit of the performance of each UK unit dealing with paediatric cardiac surgery. The use of the average UK results may be misleading. If one postulates, for example, that two or three larger units have better results than two or three small~~er~~ units, the poor results of the latter will be hidden, so to speak, by the average figures.

‘3. It is therefore not possible to make any objective and fair recommendations to a unit without knowing what the performance of every single unit in the UK is, so as to set up a standard.

‘4. Performance assessment should also take into consideration morbidity. Dr Bolsin’s report includes an attempt to ~~compare the performance of the two surgeons~~ assess surgical performance in looking at bypass time, extubation time, ITU time and hospital time for tetralogy of Fallot and AV canals. Here again, those data suffer the lack of standard to which they should be compared.

‘CONCLUSIONS AND RECOMMENDATIONS

‘The following has to be taken in the context of the above described deficiencies of this report.

‘1. On the basis of the mortality figures presented to us, there is a significant improvement between the 1990–92 results and the 1992–95 results.

‘2. The results of the neonatal arterial Switch operation should improve. It is not possible to determine the cause of these poor results. To blame surgical skill as the sole reason would be shortsighted. It is most likely a multifactorial and multidisciplinary problem. An arterial Switch procedure fulfils all the criteria of high-technology activity with complex sociotechnical interfaces. Some of the deaths were probably related to patients’ risk factors (presence of a coarctation in the patient, single coronary system in two patients). The excellence of the results obtained for closed-heart surgery even in sick neonates in the Children’s Hospital may suggest that the paediatric environment provides more appropriate skills for the overall management of those patients. The interface between the various teams has probably suffered from the recent conflictual events. Last but not least, whatever the causes of the failures, there is an inevitable lack of confidence amongst those at the sharp end which in itself could become a vicious circle.

~~‘3. Leaving aside the neonatal arterial Switch repairs, based on the mortality figures for 1992-1995, the results produced by Consultant 2 are, we believe, comparable to the results of the so-called low risk institutions (although the hard data for the UK are not available).~~

~~‘4. We understand that Consultant 1 has decided to concentrate his activities on adult cardiac surgery when the new appointee starts.~~

'~~5~~.3. We believe that it would be a great mistake to ask the new appointee to do all neonatal and complex cardiac surgery using Mr Dhasmana as a "spare wheel". We would recommend that both surgeons help each other for the most complex pathologies. For this Mr Dhasmana should be relieved from part of his duties in adult cardiac surgery. The Trust may have therefore to consider appointing another adult cardiac surgeon should their workload justify it. This might be the case as the move of the paediatric cardiac surgery to the Children's Hospital will create more facilities at the Royal Infirmary.

'~~6~~.4.There is a great need for improving communications between the various departments. We would strongly recommend to organise multidisciplinary meetings (at least monthly). We would also recommend joint cardiac conferences, attended by the cardiologists, the anaesthetists, the intensivists and the surgeons weekly to discuss cases which have been investigated and those who are on the operating schedule for the following week.

'~~7~~.5.An atmosphere of cooperation and understanding between the various departments is essential, so as to alleviate the tension, the distrust and the present ~~untenable~~ unhappy atmosphere which ~~without any doubt~~ could jeopardise the outcome of the patients.

'~~8~~.6.We believe that it would be inappropriate to do neonatal arterial Switch operations before the new appointee takes up his post. From the mortality figures presented to us, we have no reason to believe that Mr Dhasmana should not continue to carry on operating on the other conditions. *This, however, would be possible only if he receives the full support he deserves from his colleagues.* This requires a change of attitude to alleviate the stressful conditions under which he has had to work in the past.

'~~9~~.7.It is hoped that the new appointee will be more successful with the arterial Switch repair and that when the failure rate has returned to low values Mr Dhasmana will start afresh with the operation.'

182 Various changes had been made to the report. In particular, references in the first version of the report to Mr Wisheart as a 'higher risk surgeon' had been removed.

183 The second version of the report also omitted reference to Mr Wisheart's AV canal results.[206] Professor de Leval told the Inquiry that he thought that he:

> '… should have left in comments on the poor results for AV canal requiring full investigation'.[207]

[206] See Chapter 3 for an explanation of clinical terms
[207] T60 p. 95 Professor de Leval

Dr Hunter told the Inquiry that he was surprised, on seeing the second version of the report again while he was giving evidence, that the adverse comments in the first version about Mr Wisheart's AV canal series had been removed.[208]

184 The Chairman asked Dr Hunter about this further:

> 'Q. When you said you thought something had been left in, … who are you saying took it out?
>
> 'A. I am assuming that Mr de Leval felt that that was one of the points where we had been over-strong in what we said. I was not aware of the fact that it was out until I looked at it earlier today … .'[209]

185 There was also a change in the description of the role that Mr Pawade would play. In the first version, mention was made of his being 'in charge of neonatal and complex paediatric surgery.'The second version removed reference to his being 'in charge'.

Protocol for paediatric cardiac surgery

186 After the meetings with the consultants, Mr Nix and Mr McKinlay stated that they set out what they believed was the consensus view of the way forward in the department, in a draft protocol dated 15 March 1995. The draft protocol was circulated under cover of letters of the same date, to clinicians[210] and to Professor de Leval and Dr Hunter[211] for their approval. Professor de Leval indicated his satisfaction in a letter dated 21 March 1995.[212] Dr Hunter did likewise by a letter of 27 March 1995.[213]

187 Mr McKinlay sent a copy of the protocol to Ms Fritchie inviting comment.[214] Avon Health's officials were also notified, and discussed the proposals with Dr Roylance.[215]

188 The protocol stated that for the period until the arrival of Mr Pawade on 1 May 1995:

> '1.1 No arterial switch operations will be undertaken at the Bristol Royal Infirmary by either Paediatric Cardiac surgeon.

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208 T60 p. 158 Dr Hunter
209 T60 p. 160 Dr Hunter
210 WIT 0106 0125 – 0126; letter from Mr Nix dated 15 March 1995 to: Dr Hughes, Mr Dhasmana, Professor Vann Jones, Dr Monk and copied to Mr Wisheart, Dr Joffe, Dr Laszlo and Mr McKinlay
211 WIT 0106 0133 and WIT 0106 0132; letters from Mr Nix to Professor de Leval and Dr Hunter dated 15 March 1995
212 WIT 0106 0135; letter dated 21 March 1995
213 WIT 0106 0136; letter dated 27 March 1995
214 WIT 0106 0075; letter from Mr McKinlay dated 15 March 1995 to Ms Fritchie, copied to Dr Scally and Mr Nix
215 WIT 0038 0035 – 0036. Ms Pamela Charlwood, Chief Executive of Avon Health Commission and Avon Health Authority from 1994, told the Inquiry: 'On 15 March 1995 the Deputy Chief Executive of UBHT wrote to Cardiac Services Directors … Dr Baker and I had meetings with Dr Roylance during April 1995. On 21 April 1995 Dr Morgan circulated a briefing note to members of the Avon Health Commission. On 27 April 1995 Avon Health Commission heard an oral report from Dr Morgan about concerns about paediatric cardiac surgery at BRI. … This was the first notification to the Health Authority at a formal meeting that there was a concern about paediatric cardiac surgery at BRI.' See WIT 0038 0036. See further: WIT 0074 1465; letter from Dr Roylance to Dr Baker dated 2 May 1995, and WIT 0074 1467; memorandum from Dr Baker to Ms Charlwood dated 5 May 1995

'1.2 Mr Dhasmana will continue to operate on all other conditions in neonatal, infant and older children.

'1.3 Mr Wisheart will continue to operate on children over 1 year of age for all conditions excluding the AV canal.

'1.4 Mr Wisheart will continue to see new paediatric referrals up to 1 May 1995.'[216]

189 For the period after Mr Pawade's arrival (from 1 May 1995), the protocol stated:

'2.1 Mr Wisheart, Mr Dhasmana, Mr Pawade and the Paediatric Cardiologists will discuss Mr Wisheart's outstanding waiting list, and the transfer of patients will be agreed. Mr Wisheart will continue to operate on a few children, in the couple of months following the 1st May, where the parents, children and cardiologists wish.

'2.2 Mr Dhasmana and Mr Pawade will discuss the resumption of the arterial switch operation; timing at their discretion. It is recognised that such a resumption of service will follow discussion with the Paediatric Cardiac Services Team of paediatric cardiologists, paediatric anaesthetists, paediatric radiologists etc.'[217]

190 The protocol further provided:

'3.2 Any member of staff who has concerns that they consider are not being actioned should, after discussion within the group, contact the Clinical Director or Chief Executive and, if appropriate, the Chairman of UBHT.'[218]

191 Dr Roylance agreed that Mr Wisheart should no longer continue as a paediatric cardiac surgeon.[219] Dr Roylance told the Inquiry that this had been Mr Wisheart's:

'… intention for some considerable time and he merely implemented his stated intention. There clearly was not room for three paediatric cardiac surgeons with the workload that was there …'[220]

192 The protocol contemplated that Mr Dhasmana would continue to carry out paediatric cardiac surgery. As matters turned out, once Mr Pawade arrived, Mr Dhasmana ceased to do paediatric work.[221]

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216 WIT 0106 0127; protocol
217 WIT 0106 0127; protocol
218 WIT 0106 0128; protocol
219 The District Health Authority held meetings with Dr Roylance in April 1995. Pamela Charlwood stated: 'Following a meeting on 10 April, I wrote to the Chief Executive of the UBHT asking specific questions on the arrangements … He replied on 2 May [WIT 0074 1465]. On 9 May 1995, I wrote to Dr Roylance approving arrangements to relieve Mr Wisheart's paediatric workload, appoint an Associate Director of Cardiac Services for children within the Directorate of Children's Services, and to set up a multi-disciplinary audit supported by the Health Authority's contract for clinical audit with Dr Baker. I noted that other purchasers using UBHT would be informed of our view of service development.'(WIT 0038 0036)
220 T89 p. 79 Dr Roylance
221 See para 259

Public and press attention

193 UBHT's first draft press statement in relation to the performance of the paediatric cardiac surgery team was dated 3 March 1995.[222] The final version of that statement was dated 6 March 1995.[223] It stated:

> 'As a result of the need to increase adult cardiac surgery at the Bristol Royal Infirmary (BRI) and a wish to develop paediatric cardiac surgery at the Bristol Royal Hospital for Sick Children (BRHSC) the Trust took the following actions during the summer of 1994:
>
> - 'Appointed a new paediatric surgeon, already distinguished in the field of neonatal cardiac surgery, due to commence in May 1995.
> - 'Planned expansion in the theatre and intensive care provision at the BRHSC to accommodate open heart paediatric cardiac surgery transferring from the BRI. This project will be complete by September 1995.
> - 'During 1992/3 the doctors involved in paediatric cardiac surgery had expressed some concerns that the results of one particularly complex operation (the neonatal switch) were not as good as would be wished. This operation involves treating a complex congenital heart abnormality shortly after birth.
>
> 'The Trust took the following action:
>
> – 'In October 1993, as a result of these concerns, the Trust decided to stop this particular operation and to refer the small number of cases that arise to another hospital. This is standard practice for rare and complex conditions.
>
> – 'No operations of this type have been performed in neonates since then.
>
> – 'In January 1995 a case conference was held regarding whether to conduct a switch operation on [an] older child (18 months) — the decision was taken to go ahead and unfortunately, there were additional complications and the child died.
>
> 'Further Action
>
> - 'As a result of all these events the Trust sought independent advice which has now been received.
>
> 'The advice:–
>
> - 'endorses the work being done by the paediatric cardiac surgery team and states that this work should continue;

222 PAR2 0001 0116; draft press statement dated 3 March 1995
223 PAR2 0001 0137; press statement dated 6 March 1995

- 'supports the action already proposed and implemented by the UBHT (as above);
- 'made some additional suggestions. These are:
  - 'increased regularity of multidisciplinary clinical audit;
  - 'improved liaison within the paediatric cardiac team;
  - 'developing the provision of neonatal switches locally when the new surgeon takes up his appointment and the new facilities at the Children's Hospital are ready for use.
- 'All other paediatric cardiac operations continue to be performed with excellent results.'

April

194 The UBHT was informed that the programme entitled *'Close up West'*, to be broadcast on the evening of Thursday, 6 April, would refer to the results in paediatric cardiac surgery at the UBHT. As a result, it arranged for a helpline to be available for concerned parents following the broadcast. The line would provide direct access to a consultant cardiologist, plus additional back-up support to take details from callers when the cardiologist was already occupied by a call.[224]

195 It became evident during Tuesday, 4 April that the story would be broadcast by the media that evening. Accordingly, the plans for a helpline were brought forward and the number of the BRI switchboard was broadcast on both local news programmes. The BRI switchboard was instructed to pass any calls from the press to the Trust's Public Relations Officer at home, and calls from concerned parents to Dr Joffe, who would also be available on his home number.[225]

196 On 5 April 1995, the *'Daily Telegraph'* reported:

> '**100 baby deaths linked to errors**
>
> 'A leading hospital announced yesterday that it had halted open-heart surgery on children after an anaesthetist claimed that 50–100 babies born with correctable heart defects may have died because of avoidable errors. … Operations were stopped in October 1993 and cases were referred to another hospital although in January this year surgeons decided to operate on an 18-month-old child.

[224] PAR2 0001 0137 – 0138; 'Press Statement: Paediatric cardiac surgery at the United Bristol Healthcare NHS Trust', dated 6 April 1995
[225] PAR2 0001 0137 – 0138; 'Press Statement: Paediatric cardiac surgery at the United Bristol Healthcare NHS Trust', dated 6 April 1995

'Dr Stephen Bolton [*sic*], the anaesthetist who questioned the safety of open-heart procedures, said of that operation: "It was only at a clinical case conference preceding the operation that the team fully realised what its record for the switch was.

'"There was an institutional problem within the unit but everyone said we should go ahead. The child died the next day and, at that point the Department of Health said we should put a ban on switches."

'The incident prompted the hospital to commission experts headed by Mr Marc de Leval of Great Ormond Street Hospital, to investigate the high mortality rates.

'They produced a damning report criticising doctors and managers and recommended a regular audit of cases and better liaison within the surgical team.

'Hospital officials suppressed the report claiming that they feared legal action by those who were criticised.

'The senior cardiac surgeon at the Infirmary is Mr James Wisheart, who is also medical director of the trust.

'The Infirmary has already moved to appoint a new paediatric surgeon and improve theatre facilities at the Bristol Hospital for Sick Children which is now handling the infirmary's neonatal surgical caseload.

'The Infirmary has been doing 120–140 open-heart procedures a year. Dr Bolton [*sic*] said that the overall mortality for these operations has been twice the expected rate.

'Dr Bolton [*sic*] said that he became alarmed in 1990 when an audit of 14 neonatal switch operations carried out by one surgeon on babies under one month old in 1988 showed that nine had died.

'Figures for two other operations – hole in the heart, and a more complicated variant in which several defects are repaired – showed that death rates overall in the unit were twice the expected proportion.

'Dr Bolton [*sic*], then a newly-qualified consultant anaesthetist, claimed that his superiors brushed aside his protestations when he raised questions.

'He began to keep his own records, and, in 1993, audited them with the help of Dr Andrew Black, a senior lecturer in anaesthetics.

'"We found mortality rates were twice the expected average. But when I raised this I met only opposition," said Dr Bolton [*sic*].

'He said he raised concerns with Mr Wisheart, and later showed the figures to Dr Peter Doyle, senior medical officer at the Department of Health, who was said to be "appalled". Further switches were then banned.

'Mr Robert McKinlay, chairman of United Bristol Healthcare Trust, which incorporates the Infirmary and the children's hospital, said: "In this situation with patients involved we would all wish things would have been done quicker."

'The Infirmary's spokesman said: "We had a successful switch then a series of failures, then some success then more failures. So we stopped. It is a complex operation and in some cases additional problems were not diagnosed in advance of surgery."'[226]

197 Dr Bolsin told the Inquiry about the article in the *'Daily Telegraph'* in the following exchange:

'A. What happened was, I was phoned up and I was given the story of what had happened at the Bristol Royal Infirmary and my error —

'Q. And you were asked what?

'A. "Have you got any comments to make?" My error was to say, "I am not in a position to comment but you seem to have got most of the story".

'Q. The only thing I then want to ask you about is this: having seen your name in print and comments attributed to you which you had not given, you merely endorsed in the way you described, did you write to the *"Daily Telegraph"* to complain about the fact that they had abused your trust in this way?

'A. I discussed it, I think — what I actually did, that morning I spoke to —

'Q. Perhaps it is easier if you answer the question, and then tell us what follows.

'A. The answer is no, I did not.

'Q. You were going to tell us why not. Because you discussed it and you were advised not to?

'A. I spoke to Dr Roylance and he said, "It is unlikely to do any good, and it is just going to make the whole thing more protracted; I am happy with your explanation, do not worry about it", sort of thing. "Yes, it is a difficulty but we can deal with it."'

[226] PAR1 0001 0090 – 0091; article in the *'Daily Telegraph'* dated 5 April 1995

198 Dr Bolsin was asked by Counsel to the Inquiry about the effect of the story in the '*Daily Telegraph*' on his relationships with colleagues within the Trust:

> 'Q. Did the fact that you were quoted in the "*Telegraph*" affect your working relationships within the unit, do you think?
>
> 'A. I think it may well have done, yes.
>
> 'Q. In what way do you think it did so?
>
> 'A. I think that there was probably a level of distrust of me personally for having now been associated with the paediatric cardiac surgical record getting into a national newspaper.
>
> 'Having said that, it was not necessarily my view, because I knew that the Trust had released the Hunter/de Leval report to a local television station and that they had been ordered to do so by the Department of Health.
>
> 'Q. But it is perceptions that I am concerned with. With whom do you think it may have affected your relationship?
>
> 'A. I think that the two paediatric cardiac surgeons, it would certainly have affected my relationship with them; however, I knew that Mr Wisheart knew that the Trust had been ordered to release the Hunter/de Leval report, therefore he should not necessarily have blamed me for any ensuing publicity.
>
> 'Q. Did he blame you?
>
> 'A. That was the perception I had, yes.
>
> 'Q. Based on anything he said, or upon your assumption?
>
> 'A. It was based on the assumption that we then went into reconciliation with consultant psychiatrists.'[227]

199 A number of further articles in the press and reports on television followed.[228] Dr Bolsin appeared on the BBC regional news programme on 6 April 1995. He sought advice from the British Medical Association, and was advised that his contract did not prevent him from speaking to the media.[229]

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227 T83 p. 140–2 Dr Bolsin

228 Including an article in the *'British Medical Journal'* on 15 April 1995 (BMA 0001 0007) and an article published in *'Private Eye'* on 4 May 1995 (JDW 0003 0150). Dr Joffe responded to the *'BMJ'* article by letter published on 6 May 1995 (BMA 0001 0008) and a 'correction' was also published on 20 May (BMA 0001 0014)

229 BMA 0001 0004; note of advice

200 Mr Wisheart stated in his written evidence to the Inquiry that, even if Dr Bolsin had not sought to give information to the '*Daily Telegraph*':

> '… in addition to the Daily Telegraph, and on the same day as its publication, there was a television programme on BBC locally. Dr Bolsin appeared on this programme, participated in it extensively and clearly had provided them with similar information. So I was in no doubt, and I have remained in no doubt, that Dr Bolsin had placed this information in the public arena and this was the basis for my feeling that the necessary trust between him and myself did not exist for the purpose of operating on patients.'[230]

201 Maria Shortis, mother of Jacinta who had heart surgery at the BRI, stated in her written evidence to the Inquiry that she had seen Dr Bolsin appear on a BBC news programme on 6 April 1995. As a result of this:

> 'On Friday April 8th I saw Dr Bolsin at his home and asked him if he would tell me what had led him to make his concerns known publicly.'[231] She stated that Dr Bolsin explained "in great detail" the events which had led him to speak publicly about paediatric cardiac surgery at the Trust.[232] She also stated that Dr Bolsin said: "… he would be a target for victimisation. He had already experienced some isolation from his colleagues. He also realised that he could probably not continue his career in Bristol and would have to look for another job."'[233]

202 Dr Roylance in his written evidence to the Inquiry gave this account of his approach to 'whistleblowers':

> 'I repeatedly emphasized that "whistleblowers" would not be victimized in any way. It was over time increasingly clearly emphasized that members of staff with concerns were expected to make them clear to an appropriate person within the Trust and only to go outside in the event of a continuing problem. When external complaints were made the Trust did expect people to make clear that they were making a personal observation and not representing the views of the Trust. The Chairman joined me in requesting that before such a move was made they should ensure that he and I were aware of the nature of the complaint so that we could rectify it if that was appropriate.'[234]

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230 WIT 0120 0467 Mr Wisheart
231 WIT 0222 0026 Maria Shortis
232 WIT 0222 0026 Maria Shortis
233 WIT 0222 0027. Maria Shortis subsequently made arrangements to speak to other clinicians, including Professor Angelini and Dr Joffe. She had a further discussion with Dr Bolsin and Professor Angelini on 19 August 1995 (WIT 0222 0035) and with Dr Bolsin, James Garrett (Head of Current Affairs, HTV) and Michaela Willis on 14 September 1995. 'Soon after this meeting Penny Cotter, assistant producer for Channel Four, began the investigation work into the *"Dispatches"* television programme.'(WIT 0222 0037)
234 WIT 0108 0029 – 0030 Dr Roylance

203 He told the Inquiry that he made this policy clear from the early days of trust status.[235] He contrasted the UBHT's approach with the position of trusts trying to insert confidentiality clauses into contracts: 'We made it clear that there was no way the Trust would or could prevent them [employees] expressing their views in public.'[236]

Meeting between Dr Bolsin and Dr Roylance

204 Dr Bolsin referred in his written evidence to the Inquiry to a meeting with Dr Roylance which it was agreed took place in 1995:

> '… towards the end of the conversation he used an analogy to illustrate my position. He explained that the new chairman of the Trust board (Mr Bob McKinlay) had worked in the aircraft industry. I had recently had a patient under my care who had received an incompatible blood transfusion; although a recent coronial inquiry had exonerated my involvement.[237] Dr Roylance explained that the hospital was in the process of negotiating compensation for the patient's relatives and that in the aircraft industry if a worker was paid to bolt the blades on a helicopter and the blades fall off and passengers are injured, then that worker never bolts the blades on helicopters again.'[238]

205 Dr Bolsin continued:

> 'This very potent threat to a junior consultant from a chief executive was repeated later that week to Doctor David Coates, who was the British Medical Association place of work accredited representative …'[239]

206 Dr Roylance in his written comment on Dr Bolsin's statement stated:

> 'I repeated the conversation that I had with Dr Bolsin to the place of work accredited representative, Dr Coates, in order that he could understand the policy which I was hoping to steer the Trust Board towards and so that he might also support Dr Bolsin's position whilst fulfilling his duties both to Dr Bolsin and the Trust.'[240]

207 Dr Roylance told the Inquiry that he telephoned Dr Coates to explain the position because 'I was so concerned he was misunderstanding me … .'[241]

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235 T88 p. 20 Dr Roylance

236 T88 p. 20 Dr Roylance. Professor Stirrat stated in his written evidence to the Inquiry that: '… there was no policy of exclusion of Dr Bolsin – indeed, it was to the contrary.' WIT 0245 0009

237 See WIT 0080 0422 for the comments of the UBHT upon this incident; and WIT 0080 0444 for the comments of Mr Hutter (consultant cardiac surgeon), who refers to it and other criticisms of the clinical practice or care offered by Dr Bolsin as a reason why 'Dr Bolsin did not have the full respect of many of the consultants within the cardiac surgery unit. For this reason, they may have been less willing to take note of his comments on the basis that he did not appear to be pulling in the same direction as the main body of consultants, whose only aim was to work hard, continuously making improvements to the unit.'(WIT 0080 0444)

238 WIT 0080 0002 – 0003, 0121

239 WIT 0080 0003 Dr Bolsin

240 WIT 0080 0019 Dr Roylance

241 T89 p. 93 Dr Roylance

208 Dr Roylance stated that, at that time, trust boards were developing their responses to the civil actions in negligence that had become a trust's responsibility, by virtue of the cessation of Crown Immunity.[242] He noted that:

> 'A patient under Dr Bolsin's care had received an incompatible blood transfusion and died. Dr Bolsin was, for a time, under investigation by the Police for a possible manslaughter charge and an inquest was held into the death. Subsequently, no criminal charges were brought.[243] In view of the serious nature of the potential manslaughter investigation, the Trust Board were aware of this particular case.[244] In addition, civil proceedings for negligence were afoot.'[245]

209 Dr Roylance stated:

> 'At the time I saw Dr Bolsin, Matthew Hill of the BBC was preparing a programme for television, based on the report of Mr Marc de Leval and Dr Stewart Hunter. Dr Bolsin thought that this report criticized him unfairly and wished to make a personal contribution to the programme.[246] I was aware that Mr McKinlay was involved in detailed discussions with Mr Hill about the proposed content of the programme and I offered Dr Bolsin my advice that, if he became involved within the programme, he might be undermining the Chairman's discussions with Mr Hill and/or might be seen by Mr McKinlay to be doing so. This was simply meant as friendly advice and was not intended to be threatening, nor did Dr Bolsin give me any reason to believe he took it to be a threat. Indeed, he disregarded my advice, as he was entitled to do and appeared in person on the television programme.
>
> 'I used the analogy of the helicopter, which I may have chosen simply because this was the business that Mr McKinlay had been in prior to joining the Trust, because I wanted Dr Bolsin to understand that I did not want the Trust Board to adopt this "commercial" type approach to medical negligence and that I was trying to steer them in a different direction that would be supportive of and sympathetic to, doctors. I was concerned that Dr Bolsin's involvement in this programme at this time, when his own case was likely to be coming before the Board, might jeopardise my efforts to establish an appropriate policy at Board level.'[247]

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242 WIT 0080 0017 Dr Roylance's response to a statement prepared by Dr Bolsin

243 According to Mr Wisheart, the decision not to bring charges was taken by the Crown Prosecution Service in February 1995 (WIT 0080 0336)

244 See, e.g., UBHT 0007 0088; notes of the meeting of the Executive Committe of the UBHT Board on 14 October 1994, at which the incident was recorded

245 WIT 0080 0016 – 0017 Dr Roylance's response to a statement prepared by Dr Bolsin

246 Dr Roylance subsequently told the Inquiry that he agreed that Dr Bolsin was further seeking his assurance that he would say something publicly to exculpate Dr Bolsin from any criticism contained in the report (T89 p. 97)

247 WIT 0080 0018 – 0019 Dr Roylance. Dr Roylance told the Inquiry that the conversation was not 'a personal threat to Steve Bolsin. It was not. It was a personal request of mine to Steve Bolsin for help.' (T89 p. 94.) Mr Wisheart stated in his written evidence to the Inquiry that he supported Dr Bolsin: 'When the Crown Prosecution Service were considering charging him in connection with the blood transfusion error, I advised the Chief Executive that he should not be suspended.' (WIT 0080 0322)

210 Dr Bolsin recalled that he was telephoned by Dr David Coates, who was the place of work accredited representative for the BRI, and one of his consultant anaesthetist colleagues, on the evening of Dr Bolsin's meeting with Dr Roylance. Dr Coates told him that he had just received a serious threat to Dr Bolsin's career from Dr Roylance, in which the helicopter analogy had been used. [248]

211 It was put to Dr Roylance that:

> 'The natural interpretation from someone in … Dr Bolsin's position, of the analogy that if a man was paid to bolt on helicopter blades and does not do the job properly, he will not do the job again, is that if he, someone in his position, makes a mistake, then he will get sacked.'

The question went on:

> 'Q. Was that part of the message you were trying to get across to him?
>
> 'A. That was a concern. I was endeavouring to ensure that it did not happen and did not arise. I used the analogy, I have to say, because I found Steve Bolsin rather difficult to communicate with.'[249]

212 When asked what message he wanted Dr Bolsin to take from the analogy, Dr Roylance replied:

> 'I wanted him not to irritate the Trust Board … .
>
> 'Q. What was he to do to avoid irritating the Trust Board?
>
> 'A. Anything. I was appealing for his co-operation with me to ensure that we did not have any disruption of the normal relationships.'[250]

213 Dr Roylance accepted that he had spoken to Dr Coates, and repeated the analogy. The questioning followed:

> 'Q. So putting it in crude vernacular, what you were saying to him was, was it: "Nice little job you have here. Shame if anything were to happen to it. You ought to be careful it does not."
>
> 'A. No. You are converting this as a personal threat to Steve Bolsin. It was not. It was a personal request of mine to Steve Bolsin for help. It was not the reverse, as you have implied. It was because I was having difficulty in communicating with him that I asked his colleague to reinforce that message.'[251]

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248 T83 p. 138 Dr Bolsin
249 T89 p. 92 Dr Roylance
250 T89 p. 91–2 Dr Roylance
251 T89 p. 94 Dr Roylance

He added that what he was asking Dr Bolsin to specifically avoid doing was:

> 'Anything that would irritate the directors of the Trust Board which might precipitate them to take a posture I did not want them to take. Anything. There is no mention of any particular event. I did not want him to be a fall-guy. I wanted to protect him.'[252]

The cardiac anaesthetic rota

214 Dr Bolsin's anaesthetising rota was altered in April 1995. Following an initial meeting at which Dr Roylance raised the issue with Dr Monk, a meeting was held to discuss changes in Dr Bolsin's cardiac commitments, attended by Dr Bolsin, Dr Monk, Dr Trevor Thomas, consultant anaesthetist, and Professor Prys-Roberts.[253] Dr Bolsin in his written evidence to the Inquiry stated:

> 'Dr Monk presented the view that there were perceived difficulties with the staffing of paediatric and adult cardiac surgery. These were being contributed to by my request to maintain my adult cardiac surgical workload at two days per week. The situation that Dr Monk wished to communicate to me was that if I persisted with my request to maintain two days of adult cardiac surgery per week the Trust would consider that it was more likely to be able to dismiss one cardiac anaesthetist than two cardiac surgeons.
>
> 'I was shocked to hear this projection of Trust Board thinking and offered the information that nobody needed to be dismissed; all that was required was that I was allowed to work to my contract.
>
> '… This meeting represented an undeniable threat to my employment at the Trust … It now became a matter of considerable importance to me that I should leave the UBHT and find alternative employment.'[254]

215 Mr McKinlay, in his written comment to the Inquiry on Dr Bolsin's statement, stated:

> 'The Trust Board did not discuss the dismissal of Dr Bolsin and if "Trust Board thinking" was a projection by Dr Roylance it was not justified.'[255]

216 Dr Monk in his written evidence to the Inquiry stated:

> 'On many occasions following the early press coverage in 1995, it was necessary for me to defend SB [Dr Bolsin]. I was told, by JR [Dr Roylance] and JDW [Mr Wisheart], in JR's office that JDW and JD [Mr Dhasmana] had received legal advice that they should not work with SB on planned paediatric cases. I gained the impression that if this should occur the legal implications would necessitate the cancellation of the case and/or the removal of the anaesthetist concerned. To avoid

252 T89 p. 95 Dr Roylance
253 WIT 0080 0130 Dr Bolsin
254 WIT 0080 0130 Dr Bolsin
255 WIT 0080 0417 Mr McKinlay

this conflict between SB and the cardiac surgeons I had to adjust his clinical programme to avoid the threat of suspension … .'[256]

217 Dr Monk stated that he was first told of the need to change Dr Bolsin's rota by Dr Roylance.[257] Dr Monk stated that if agreement to this effect could not be reached with Dr Bolsin:

'I gained the impression that the alternative solution would be the suspension of Dr Bolsin from his cardiac commitments. At this point I informed Dr Roylance that he should not suspend Dr Bolsin, that he had no grounds to do so and that Dr Bolsin would have a case for constructive dismissal. I offered to resolve the situation to allow time for the differing views on outcome to be addressed.'[258]

218 Dr Monk stated:

'At another time, after the press publicity, JR with JDW raised the suggestion of dismissing SB. I argued that this would be an inappropriate action and bore no relation to the problems within the paediatric cardiac service.'[259]

219 Dr Monk continued:

'In an attempt to underline the effect that the continued publicity was having on his [Dr Bolsin's] own future I arranged a meeting (25th April '95) to discuss this with him in the presence of Professor Prys-Roberts and Dr Thomas. I asked my two colleagues to attend as they had both supported SB in raising the issue of the P.C.S [paediatric cardiac surgery]. At this meeting I attempted to make SB aware of the feelings held in the Trust HQ and of the progress made in achieving changes in the P.C.S.'[260]

220 Dr Monk stated that at the meeting:

'I believed then that Dr Bolsin gained the impression that I was supportive of the position taken by the Trust. This was incorrect. My concerns were over the possible suspension of my colleague by the Trust, that the conflict over the audit remained unresolved and the publicity over a suspension would obscure the true problem of the PCSS. I regretted at the time that I was unable to communicate to Dr Bolsin my concerns and support for him and my desire to speedily resolve all the issues regarding the PCSS.'[261]

256 WIT 0105 0029 Dr Monk
257 WIT 0080 0030 Dr Monk
258 WIT 0080 0030 Dr Monk
259 WIT 0105 0029 Dr Monk
260 WIT 0105 0029 Dr Monk
261 WIT 0080 0030 Dr Monk

221 On 24 April 1995, Dr Bolsin had written to Dr Monk expressing his concerns about the 'unofficial change' to his contract that had occurred in the previous two weeks, and stating that he was willing to work with all the cardiac surgeons.[262] Dr Monk replied two days later, i.e. the day after the meeting with Dr Bolsin.[263] Dr Monk asked Dr Bolsin:

> '… to agree to flexibility in your work pattern, in site but not in time, to avoid interpersonal conflict in the theatre environment, this was on an informal, temporary basis.'[264]

222 He continued:

> 'Great tensions remain unresolved between you and your colleagues and these conflicts can be viewed as an avoidable risk factor. This issue and many others have been discussed between us on a number of occasions, the action to temporarily change your programme had your active agreement in order to allow the "breathing space" to correct the breakdown in relationships, communication and trust. Your happiness at working with all the cardiac surgeons is not reciprocated and displays a lack of insight into the personal effects of recent events.'[265]

223 Dr Monk in his written evidence to the Inquiry described the changes which resulted in Dr Bolsin's rota:

> 'The initial change to Dr Bolsin's cardiac commitment was complicated by the daily commitments of the cardiac anaesthetists being planned in three monthly blocks around which clinical and personal plans are made. Therefore for the remaining weeks of the published rota an exchange between Dr Bolsin's Thursday cardiac commitment and Dr Masey's Thursday general surgery list was made, obviously this would not be needed if Dr Bolsin had no Thursday commitment. It resulted in a small decrease in his cardiac activity. The next rota was constructed by Dr Masey after my request to ensure that the cardiac workload of Dr Bolsin was restored whilst avoiding the need for the two paediatric surgeons and him working together with children. This was possible because of the flexible approach to the days worked in cardiac theatre by the anaesthetists i.e. they work two days each week out of three cardiac days defined in their job plan.'[266]

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262 WIT 0080 0303; letter dated 24 April 1995
263 WIT 0080 0304 – 0305; letter dated 26 April 1995
264 WIT 0080 0304; letter dated 26 April 1995
265 WIT 0080 0304; letter dated 26 April 1995
266 WIT 0080 0031 Dr Monk

Dr Bolsin's departure from Bristol

224 Arrangements for counselling were made by the UBHT by the summer of 1995, to mediate between the cardiac surgeons and Dr Bolsin.

225 Dr Roylance stated in his written evidence to the Inquiry:

> 'The counselling sessions which I arranged with the agreement of the Trust Board for the two cardiac surgeons and Dr Bolsin were an attempt to reestablish a proper working relationship between them. Throughout the time that Dr Bolsin had apparently been making disparaging remarks outside the Trust about the two cardiac surgeons he had been happily working with them and anaesthetizing patients on whom the surgeons were operating. It was clearly essential that efforts were made to re-establish the necessary trust between anaesthetist and surgeon to restore a proper working relationship. The need for counselling was brought about by the mutual loss of trust and was not an attempt to persuade anyone to change their professional opinion.'[267]

226 Dr Bolsin stated in his evidence to the Inquiry that he was:

> '… advised to attend … The purpose of the contacts was to attempt to reconcile the differing opinions betraying [*sic*] myself and the cardiac surgeons concerning the outcomes for paediatric cardiac surgery.'[268]

227 Mr Wisheart stated in his written evidence to the Inquiry:

> 'The publication of his opinions in the *"Daily Telegraph"* … in April and May 1995, some of which he has since acknowledged to be factually incorrect, destroyed the mutual confidence which is essential if a surgeon and an anaesthetist are to work together in the operating theatre in the patient's best interest. Surprisingly it was *his* wish to revert to his original working programme and work with me, despite the views that he had expressed.'[269]

228 He continued:

> 'It is my belief that the Trust *never* wished to dismiss Dr Bolsin, either by constructive dismissal or any other way. On the contrary, the Trust set up a process of conciliation to resolve the differences between Dr Bolsin, Mr Dhasmana and myself. This conciliation process was conducted by two consultant psychiatrists and was carried forward actively during the months of June, July and August, 1995. During this time there were a series of meetings when the psychiatrists interviewed

267 WIT 0080 0019 Dr Roylance
268 WIT 0080 0003 Dr Bolsin
269 WIT 0080 0049 Mr Wisheart (emphasis in original)

> us individually and subsequently we all met together. All parties were acting positively until Dr Bolsin withdrew from the process in the autumn of 1995.'[270]

229 Mr Wisheart also stated:

> 'The fact that the Trust set up this process seems to contradict the suggestions of a threat to his employment.'[271]

And:

> 'At no stage was there any serious consideration, discussion or proposal to the effect that Dr Bolsin might be sacked. On the contrary there were repeated statements that Whistleblowers would not be victimised, and in the summer of 1995 there was an attempted conciliation. Dr Bolsin appeared to participate actively and positively in this process; he then walked away from it to go to Australia.'[272]

230 Dr Bolsin stated that a diminution in the volume of his private practice also had 'some impact' on his decision not to stay in Bristol:

> 'The number of cardiac surgery cases being referred to me had diminished in the 1990s and I believed that this was related to the fact that I was criticising the paediatric cardiac surgery service at the BRI.'[273]

231 Dr Monk in his written evidence to the Inquiry stated:

> 'I am unaware of the background to the statements concerning private practice nor am I aware of any reduction in his [Dr Bolsin's] practice.'[274]

232 Dr Bolsin left the Trust's employment in late February 1996, to take up an appointment in Australia.[275] Before doing so, he sought advice from the BMA as to whether he had a claim against the UBHT for constructive dismissal. He was advised that there was 'very little evidence' to sustain such a case. Whereas the Trust:

> '… may not have supported you as you would have liked, they do not appear to have left you out in the cold and appear to have tried to remain impartial to minimise the arguments between consultants.'[276]

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270 WIT 0080 0049 – 0050 Mr Wisheart. See also Mr Wisheart's comments in his 'Response to the talk entitled "The Whistleblower in Medicine" given by Dr Stephen Bolsin to the Medical Legal Society of Victoria on Friday 19 March 1999' at WIT 0080 0407– 0408

271 WIT 0080 0345 Mr Wisheart

272 WIT 0080 0412 Mr Wisheart

273 WIT 0080 0132 Dr Bolsin. In his statement Dr Bolsin implied that Mr Wisheart suggested to at least one surgeon that private cases should not be referred to Dr Bolsin. Mr Wisheart commented: 'Again this is a matter of which Dr Bolsin has no direct knowledge. I did not ask any surgeon not to refer private patients to Dr Bolsin, or seek to influence any surgeons not to refer private patients to Dr Bolsin.'(WIT 0080 0347). In BMA 0001 0023, Dr Bolsin estimated that the loss of work in private practice had cost him 'in excess of £30,000 this year'[1995]

274 WIT 0080 0031 Dr Monk

275 GMC 0004 0112; letter from Mr Ross to Dr Bolsin dated 31 January 1996

276 BMA 0001 0027; letter from Mr S Cusack, Industrial Relations Officer at the BMA, to Dr Bolsin dated 28 December 1995

233 Before Dr Bolsin left, Mr Hugh Ross (the newly appointed Chief Executive of the UBHT) wrote to him in the following terms:

> 'I write further to the series of meetings we have held in recent months. I recognise that your departure to a new career in Australia is imminent. The Chairman and I felt we should put on record our belief that your actions in recent years have been motivated throughout by your concern for the best interests of patient care. The records available to us confirm that you did raise your concerns internally within the Trust in the first instance, and only when you felt they were not being adequately recognised did you raise them outside the Trust.
>
> 'Best wishes for the future.'[277]

Andrew Peacock's surgery

234 The protocol agreed following the Hunter/de Leval report envisaged that Mr Wisheart would withdraw from paediatric practice.[278]

235 Sharon Peacock, mother of Andrew, set out in her written statement to the Inquiry that Andrew, who was born on 29 November 1993, suffered from a Coarctation of the Aorta.[279] He was admitted to the BRHSC on 8 December 1993, and operated upon by Mr Wisheart the following day.[280] Andrew was able to return home in the week before Christmas.[281] He was followed up in the outpatient clinic, but subsequently required re-admission for investigation and catheterisation. This was performed, by Dr Martin, on 5 January 1994.[282] Mrs Peacock was soon told that a further operation on the aorta would be required, in order to place a patch on the aorta.[283] This took place on 9 March 1994. Again, the operation was conducted by Mr Wisheart.[284]

236 A second catherisation took place in September 1994. Mrs Peacock was informed that a further operation on the aorta would be needed in 6–12 months' time.[285] She saw Mr Wisheart in November 1994. Mrs Peacock stated in her written evidence to the Inquiry that Mr Wisheart discussed the risks of the procedure with her, giving Andrew's operation a 94% chance of success.[286] She stated that he also explained the risks of paraplegia.[287]

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277 GMC 0004 0113; letter dated 20 February 1996
278 WIT 0106 0127 – 0128 and see above for the text of the protocol
279 WIT 0011 0002 and WIT 0011 0004 Sharon Peacock; see Chapter 3 for an explanation of this term
280 WIT 0011 0003 and WIT 0011 0006 Sharon Peacock
281 WIT 0011 0007 Sharon Peacock
282 WIT 0011 0009 Sharon Peacock
283 WIT 0011 0010 Sharon Peacock
284 WIT 0011 0011 Sharon Peacock
285 WIT 0011 0014 Sharon Peacock
286 WIT 0011 0015 Mrs Peacock added, 'He did not explain what the 6% chance of failure referred to, or what it consisted of.' Mr Wisheart in his written comment on Mrs Peacock's evidence responded: 'As this operation followed two others, which Mrs Peacock knew carried a risk of not surviving, it is hard to imagine that there would not have been a risk of death associated with this operation also. Moreover, in my explanations I always made it absolutely explicit that I was talking of the risk of a certain number of children *not surviving* the operation or the recovery period afterwards.'(WIT 0011 0041; emphasis in original)
287 WIT 0011 0015 Sharon Peacock

237 Before she received a date for the operation, Mrs Peacock stated that she saw an item on BBC television's local news:

> '… which mentioned problems with the paediatric heart surgeons in Bristol. The programme said that there was a problem with the "Switch" operation, and talked far more about Mr Dhasmana than about Mr Wisheart. There was a helpline given out at the end of the bulletin, and I called it immediately, as I felt extremely concerned for Andrew. A man, who identified himself as a cardiologist from Bristol Children's Hospital, answered the telephone. He said that there was not a problem with the type of surgery that Andrew was to undergo, and that the media had blown things out of proportion'.[288]

Mrs Peacock stated that she spoke to Mrs Vegoda, Counsellor in Paediatric Cardiology, who 'also said that the media were getting things out of proportion.'[289]

238 At his clinic on 25 April 1995, when a date for the operation had not yet been fixed, Mrs Peacock stated that Dr Martin told her of the new surgeon, and asked her who she wanted to perform surgery on Andrew. Mrs Peacock stated:

> 'I felt that Dr Martin would know who was best to carry out Andrew's surgery. I told Dr Martin that I could not make this choice, in case I made the wrong decision. He did not offer me an appointment with the new surgeon in order to discuss Andrew's case.'[290]

Andrew therefore remained Mr Wisheart's patient.

239 On the next day, 26 April, Mrs Peacock stated that she telephoned Mr Wisheart's secretary, to inquire about the state of the operating list, and was told to bring in Andrew for surgery the following day (27 April). Andrew was in fact admitted to the BRI on 28 April and surgery took place on 1 May 1995.[291]

240 Andrew did not recover after the surgery, and died on 30 May 1995. The post-mortem results revealed that he had suffered brain damage.[292]

241 Mrs Peacock stated in her written evidence to the Inquiry:

> 'If I had realised what the true state of paediatric cardiac surgery was at the BRI … I would never have taken Andrew there for his operation. Neither would I have

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288 WIT 0011 0017 Sharon Peacock. On the creation of the helpline, see para 194

289 WIT 0011 0017 Sharon Peacock. Mrs Vegoda agreed 'It is possible I said that the media is known to get things out of proportion. I would certainly have suggested that she speak directly to Dr Martin and may have offered to arrange this … I may have tried to re-assure her that if Dr Martin and Mr Winspur were advising surgery for Andrew then this was necessary'(WIT 0011 0032). Mrs Peacock acknowledged in her written evidence to the Inquiry the help and support which she received, after Andrew's death, from Mrs Vegoda and Helena Cermakova, a Hospital Chaplain (WIT 0011 0031)

290 WIT 0011 0017 Sharon Peacock

291 WIT 0011 0018 Sharon Peacock

292 WIT 0011 0043 Mr Wisheart; the timing of any such damage was a matter of controversy or uncertainty

allowed Mr Wisheart to operate on Andrew. I would have waited for Ash Pawade (who arrived on 1 May, the day of Andrew's third operation) to perform the surgery…'[293]

242 Mr Wisheart, in his written comment on Mrs Peacock's evidence, stated that:

- 'Initially (October to November 1994) Andrew's third operation was expected to take place in early 1995 before Mr Pawadi [*sic*] came, so the question simply did not arise at that time.
- 'I had already operated twice on Andrew and felt that there was a good relationship with the Peacock family.
- 'I had considerable experience in all forms of surgery for coarctation of the aorta.
- 'The events of 1995 and findings of the Hunter and de Leval report did not apply to Andrew or to surgery for coarctation. The reservations expressed were only about open heart surgery and were chiefly in relation to my surgery for complete AVSDs.
- 'The agreement of the 15 March 1995 provided for me to continue to operate on children but not on infants and not to correct complete AVSDs during the period until Mr Pawadi [*sic*] arrived. It further provided that I would do some open heart surgery in the months after Mr Pawadi [*sic*] arrived, with the agreement of the cardiologist and the parents.
- 'I understood that there was such agreement following the consultation between Dr Martin and Mrs Peacock on 25 April 1995.
- 'Mr Pawadi's [*sic*] employment did begin in Bristol on 1 May 1995 which was also the day of Andrew's operation. Mr Pawadi [*sic*] would hardly have wished to undertake such an unusual or complex operation on his very first day in Bristol before [he] had got to know either the surroundings or his colleagues.'[294]

243 Maria Shortis stated that she, and other members of the public, had been led to believe that Mr Wisheart intended to give up all paediatric cardiac surgery even before Mr Pawade came to the UBHT.[295] She referred to a letter written by Dr Joffe, Dr Martin, Dr Hayes, Mr Wisheart and Mr Dhasmana.[296] Addressed to medical colleagues who would be coping with 'questions from anxious and confused parents without the facts being available to you', it discussed the Bristol results and the investigation by Professor de Leval and Dr Hunter, and continued:

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293 WIT 0011 0030 Sharon Peacock
294 WIT 0011 0042 Mr Wisheart; see Chapter 3 for an explanation of clinical terms
295 WIT 0222 0038 Maria Shortis
296 Maria Shortis stated that the letter was dated 21 April 1995, but the letter was written on 16 April 1995

'The report concluded that the Unit should continue to perform all forms of congenital heart surgery, including *non-neonatal* switches; recommended that regular multi-disciplinary audit take place to monitor outcomes and foster teamwork; agreed with the Trust's decision to appoint a cardiac surgeon dedicated to paediatric work to join Mr Dhasmana (Mr Ash Pawade from the Melbourne Unit arrives in May); and supported the transfer of all children's open heart surgery to the Children's Hospital. … Babies with TGA who are found to be suitable for the arterial switch operation (about 10 per annum) will be referred to another centre until Janardan, Ash and the cardiologists are confident to recommence the programme. James Wisheart has decided to confine his work to adults in the future because of increasing managerial responsibilities within the trust.'[297]

Quoting risks

244 Ms Sheena Disley, Ward Sister, Ward 5, since 1984, told the Inquiry in the following exchange about Mr Wisheart's reference to risks in a conversation with parents:

'Q. Do you ever remember attending one of these discussions and hearing a risk or a benefit quoted to a patient, or a parent of a patient, that you disagreed with?

'A. I do recall such an occasion, but it was actually after the child had had surgery.

'Q. What was the occasion?

'A. It was an occasion where the child was — I cannot even recall the surgery he had. He had made slower than expected progress, and was beginning to fit, if I can recall.

'Q. What was said that you disagreed with?

'A. I cannot recall the details of the discussion, but I felt that it seemed optimistic.

'Q. The chances of survival being quoted? What was being quoted that was optimistic?

'A. The recovery that the child would make.

'Q. What did you do when you heard this being quoted that you thought was optimistic? How did you react?

'A. At the time, I did not do anything — at the time, no, I did not do anything.

'Q. When was this incident that you recall?

'A. It must have been 1995.

[297] UBHT 0052 0240 – 0241; emphasis in original; see Chapter 3 for an explanation of clinical terms

'Q. Who was the clinician who was giving what you thought was an optimistic prognosis?

'A. Mr Wisheart.

'Q. If you had a similar experience tomorrow at work with a patient and a clinician, would you react differently now?

'A. Yes, I think there are occasions perhaps when we are discussing the care of long-term patients, and — yes, I would.'[298]

May onwards

Further clarification of the 'audit figures'

245 Dr Joffe replied to the article of 15 April in the *'British Medical Journal'* in a letter published on 6 May 1995.[299]

246 Dr Black,[300] who had collaborated with Dr Bolsin in his analysis of data on PCS, responded to Dr Joffe's letter by writing to Dr Joffe on 23 May.[301] Dr Black, in his written evidence to the Inquiry, stated:

'… I expressed surprise that no attempt had been made to check the accuracy of our tabulations. I invited Dr Joffe to check at least that the patients whom he had classified as dead were indeed dead. Dr Joffe replied on 9 June[302] … and accepted my offer to supply the names and hospital numbers of the patients we believed had died after undergoing operations in the three categories about which we had concerns. This I did with the covering letter of 15 June 1995 …'.[303,304]

247 A meeting took place in June 1995, chaired by Dr Roylance, involving Dr Joffe, Mr Wisheart, Mr Dhasmana, Dr Bolsin and Dr Black.

248 Dr Black stated that it became apparent that there were:

'… serious errors in our tabulation of operations with VSD. There was 1 duplicate entry of a patient (who had been entered in error from each of the two main registers and whom I already mentioned in my covering letter): there was 1 who died after hospital discharge and readmission and, in 3 of the remaining 4, patients had undergone more serious operations than had been entered into the original registers.'[305]

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298 T32 p. 121–2
299 See footnote 228
300 A letter was also written by Dr Bolsin to the *'BMJ'* on 25 May 1995: BMA 0001 0015
301 WIT 0326 0033; letter from Dr Black to Dr Joffe
302 WIT 0326 0037; letter from Dr Joffe to Dr Black
303 WIT 0326 0039; Dr Black's letter
304 WIT 0326 0018 – 0019 Dr Black
305 WIT 0326 0019 Dr Black; see Chapter 3 for an explanation of clinical terms

249 Dr Black stated:

> 'Dr Joffe, Mr Wisheart and Mr Dhasmana were justifiably indignant and we were profoundly embarrassed over our errors in classifying the VSD operations. We apologised immediately and agreed that a full and public apology was due.'[306]

250 In September 1995, Dr Bolsin wrote to Dr Roylance indicating that he and Dr Black were 'dismayed and embarrassed to have made the mistake'[307] in relation to the VSD operations.

251 Counsel to the Inquiry discussed the figures with Dr Bolsin in the following exchange:

> 'Q. Were those figures when it came to VSD in fact in error?
>
> 'A. They were, yes.
>
> 'Q. To the tune of 500 per cent?
>
> 'A. I think we come to that "lies, damn lies and statistics". There were some errors. Another way of looking at it would be to say that we collected something like 3,000 data sets on 286 patients and we got six or seven of the fields wrong, so exactly how you look at it lies somewhere between the spectrum you have put and the spectrum I have put.
>
> 'Q. If one focused on VSDs, so this is a conclusion of the report analysis, is it right or is it wrong to say the result, as produced by the analysis, is 500 per cent wrong?
>
> 'A. That is a factual statement.'[308]

252 Mr Wisheart discussed the figures in the following exchange:

> 'Q. … in fact there was an arithmetical error which was subsequently acknowledged in that series which showed that, instead of there being the number of deaths claimed, that had been overstated by something like 500 per cent?
>
> 'A. 500 per cent, that is correct.
>
> 'Q. Far from being a miserable failure, the VSD series would be, would you say, one of the success stories of the unit in the 1990s?
>
> 'A. I believe it was, yes.'[309]

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306 WIT 0326 0019 Dr Black; see Chapter 3 for an explanation of clincial terms
307 UBHT 0061 0053; letter from Dr Bolsin to Dr Roylance (undated)
308 T80 p. 16 Dr Bolsin; see Chapter 3 for an explanation of clincial terms
309 T92 p. 98–9 Mr Wisheart; see Chapter 3 for an explanation of clincial terms

253 Mr Wisheart continued in the following exchange:

> 'Q. When ultimately were those errors corrected so that others knew they were in fact errors?
>
> 'A. The first one, the one regarding ventricular septal defect correction, was eventually corrected, in the sense that it was agreed by Dr Bolsin and Dr Black that there was an error, in the second half of September 1995 and there was a letter from Dr Bolsin to Dr Roylance following that meeting in which he acknowledges the error.
>
> 'Q. We have that letter in the Inquiry.
>
> 'A. Unfortunately, although he had placed the information in the public arena he had never placed the correction in the public arena prior to the GMC findings.'[310]

254 During the course of Counsel's questioning regarding his relationship with Dr Bolsin, Mr Wisheart was asked:

> 'Q. … do you feel that there was any impediment preventing Dr Bolsin from telling you about the results of his own audit?
>
> 'A. I absolutely do not. I mean, we worked together week in and week out in the Infirmary. I rarely operated on private patients and occasionally did so, and he shared in that practice with the other anaesthetists. We discussed his research. I believe there was every opportunity.'[311]

255 In a letter to Dr Black on 24 July 1996, Professor Farndon expressed his attitude towards the concerns over paediatric cardiac surgery:

> 'My conversations with James were prompted by anxieties expressed to me by Sheila Willatts and Cedric[312] among others. … If Sheila and yourself continue to have reservations why are these not examined openly and with a disinterested party to reach definitive decisions? If the data requires further analysis then let it be done. If the data is clear in its statement then let that statement be declared. I think I am correct in remembering from Wednesday's meeting that you had a meeting with James and that this meeting discussed the data and its meaning further. This must mean that there is still not a clear view on whether there is a problem or not. For my part, making comment on your stance, I cannot now understand how you can relinquish any responsibility to continue the search for truth. I do not know why you cannot continue to strive and correct the situation that you feel is "fundamentally wrong".

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310 T94 p. 134 Mr Wisheart
311 T94 p. 185 Mr Wisheart
312 Dr Sheila Willatts and Professor Cedric Prys-Roberts

'… All I have ever wanted to do in this whole business is to see data that we can all agree states the matter as fairly and objectively as we can. I desperately hope that I would not point the finger at a colleague unless I was absolutely sure of the reason that I were pointing that finger.'[313]

Mr Dhasmana's paediatric practice

256 The March 1995 protocol contemplated that Mr Dhasmana would continue to perform paediatric cardiac surgery.[314] Once Mr Pawade arrived, Mr Dhasmana's work began to dwindle. Mr Dhasmana told the Inquiry that he was 'very upset' that he was no longer performing paediatric cardiac surgery because:

'… I have shown in my record that I was improving, and the last five years of my work … except for the arterial switch, was better than average in the country. The de Leval and Hunter committee also in a way supported that.'[315]

257 Dr Roylance stated in his written evidence to the Inquiry:

'As it turned out, the total number of paediatric operations required was within Mr Pawade's capacity and the Paediatric Cardiologists tended to refer all of their cases to him as the dedicated Paediatric Cardiac Surgeon.'[316]

258 Dr Roylance stated in his written evidence to the Inquiry that he began discussing with Mr Dhasmana the amendment of his contract to limit him to operating on adults.[317] Dr Roylance stated that he recognised that Mr Dhasmana '… was, at first, reluctant to give up paediatric cardiac surgery, which he very much enjoyed …'.[318]

259 On 1 September 1995, Professor Vann Jones wrote to Dr Roylance:

'I came back from holiday and learned with some dismay that the recommendation of myself, Chris Monk and David Hughes has not been implemented, namely, that all the operations on children should be done by Mr Pawade. I gather that Janardan is scheduled to do five operations this month. I feel an opportunity has been missed for a reasonable honourable withdrawal from the Paediatric Service for Janardan and we would be grateful to know what course of action you are planning considering that the advice of the three Clinical Directors involved seems to have been rejected.'[319]

313 UBHT 0150 0024 – 0025; letter dated 24 July 1996
314 WIT 0106 0127; protocol
315 T87 p. 109 Mr Dhasmana
316 WIT 0115 0031 Dr Roylance
317 WIT 0115 0031 Dr Roylance
318 WIT 0115 0031 Dr Roylance
319 UBHT 0146 0027; letter dated 1 September 1995

260 Professor Vann Jones accepted:

> 'If John Roylance had been getting opinions or advice from two different sources, he was not obliged to take mine … that there were two sides to the argument, I totally accept that.'[320]

261 Mr Wisheart stated that:

> 'The Trust did not stop Mr Dhasmana or myself from operating … Dating back to the spring of 1994 (and before that to 1990–91) the proposal was that when the new paediatric cardiac surgeon came, he and Mr Dhasmana would do the paediatric work and I would withdraw. That is what happened. Later, in 1995, Mr Dhasmana also withdrew from paediatric cardiac surgery.'[321]

262 In a letter dated 13 September 1995 to Dr Roylance, Professor de Leval wrote:

> 'I am led to believe that the quality of Mr Dhasmana's work is not disputed and that the main reason for his dismissal is the public perception that he is part of the bad image that has tarnished the institution during the recent months. If that is correct it is … an extremely serious precedent and I believe that the matter ought to be discussed at the highest levels.'[322]

263 Professor de Leval sent a copy of this letter to various people, including Sir Terence English, who was by then President of the British Medical Association. Sir Terence wrote to Dr Roylance:

> 'I was aware that the review conducted by Mr de Leval and Dr Hunter this year exonerated Mr Dhasmana from any hint of professional incompetence with regard to his paediatric cardiac surgery. It does seem therefore completely unjust that he should be treated in this way which will inevitably be seen by the local community as evidence that he was indeed incompetent at his job.'[323]

264 Professor de Leval pursued the matter further, sending another letter to Dr Roylance reiterating the points made in his first letter.[324] Dr Roylance responded on 17 October 1995:

> 'I tried hard to encourage Janardan to make the decision to withdraw from paediatric cardiac surgery himself … Janardan was unwilling to make this decision, and I understand and sympathise with his reasons. I have … invited him to

320 T59 p. 199–200 Professor Vann Jones
321 WIT 0115 0029 Mr Wisheart
322 UBHT 0061 0346; letter dated 13 September 1995. Mr Dhasmana's contract of employment was terminated by the UBHT with effect from 3 September 1998
323 UBHT 0061 0348; letter dated 25 September 1995
324 UBHT 0061 0349; letter dated 12 October 1995

renegotiate his programme to provide for some of the increase in adult cardiac surgery for which we now have contracts.'[325]

Concerns 1996 and later

Professor de Leval's report

265 In November 1995, Professor de Leval was invited to write a report on the updated paediatric cardiac surgical results of the UBHT, which were included in the UBHT's final report on paediatric cardiac surgery published in January 1996.[326] Professor de Leval's report examined paediatric cardiac surgery at Bristol between January 1990 and March 1995.[327]

266 In his introduction to the report, Mr Hugh Ross, the new Chief Executive of the UBHT, wrote:

> '… it is a matter of regret that there was not an earlier in-depth and objective investigation within the Trust to resolve the concerns expressed by senior personnel. Any such investigation would have established whether concerns that were expressed were justified.'[328]

267 In the report, Professor de Leval examined the results of open- and closed-heart operations in Bristol between 1990 and 1995. These were compared with the data in UK Cardiac Surgical Register. Professor de Leval wrote:

> 'The UK Cardiac Surgical Register used in this report as a gold standard has … never been validated. The degree of reliability of the data is not known. Importantly, the confidence limits are not available; and last, but not least, the detailed results of individual units and individual surgeons are not known. It is quite possible that a number of institutions and/or surgeons have the same results for some conditions and that the worst Bristol results are actually similar to a substantial minority of their peers.'[329]

268 Professor de Leval's conclusion was:

> '… the Bristol performance over the last three years in terms of mortality matches with the average UK results as published by the UK Cardiac Surgical Register,

325 UBHT 0061 0352 – 0353; letter dated 17 October 1995
326 WIT 0319 0002 Professor de Leval
327 UBHT 0052 0097 – 0108; 'Bristol Paediatric Cardiac Surgery 1990–1995', report by Professor de Leval
328 UBHT 0052 0098 – 0099; report by Professor de Leval
329 UBHT 0052 0101

including open-heart surgery in infancy, with the exception of the results of atrioventricular septal defects and arterial switch procedures.

'I also believe that the Trust and those at the sharp end of the system have taken positive steps to improve those results'.[330]

269 On 23 January 1996, Mr Ross sent Professor de Leval's report to the regional director of the NHSE to enable him to give any final advice on its contents.[331] The final report was presented to and approved by the UBHT Board on 26 January 1996 and then presented at a public meeting on 31 January 1996. Copies were sent to the clinicians involved in the paediatric cardiac service, to MPs, to families and to other NHS bodies.[332]

The Hospital Medical Committee

270 Mr Wisheart completed his two-year term as Chairman of the HMC in April 1994.[333] In June 1996 the HMC passed a unanimous motion of support for him. Mr Wisheart prepared a statement for the clinical directors dated 3 June 1996,[334] in which he sought to answer the questions or allegations raised against him. He stated that he would not continue in post without the support of his colleagues.[335]

271 Dr Monk gave evidence that:

'The issue of Paediatric Cardiac Surgery was not discussed at the Hospital Medical Committee until after the involvement of the Press. I recall the matter was raised in April 1995, January 1996 and June 1996. When the matter was raised, neither the data from the SB/AB [Stephen Bolsin/Andrew Black] audit or detailed data from the surgeons was presented; therefore discussion was held in the absence of adequate facts. In my opinion the HMC incorrectly believed that the problem lay more with the Anaesthetists auditing the P.C.S. performance than the performance itself. Detailed P.C.S. activity data was promised to the HMC but to my knowledge was not presented. The HMC body voted to support the surgeons and the Medical Director in their actions.'[336]

Review of adult cardiac surgery

272 The performance of the paediatric cardiac surgical service inevitably gave rise as to questions as to the performance of the adult cardiac surgical service. Accordingly, the Trust decided to have an expert external review of adult cardiac surgery. The president of the Royal College of Surgeons suggested Professor Tom Treasure of St George's Hospital and Professor Ken Taylor of the Hammersmith Hospital. They accepted this

330 UBHT 0052 0102; see Chapter 3 for an explanation of clinical terms
331 WIT 0128 0044 Mr Ross
332 WIT 0128 0044 Mr Ross
333 WIT 0080 0397 Mr Wisheart
334 UBHT 0054 0004 – 0010; 'Mr James Wisheart's statement to the Clinical Directors of United Bristol Healthcare Trust 3rd June 1996'
335 UBHT 0054 0004; Mr Wisheart's statement
336 WIT 0105 0035 Dr Monk

appointment, and were subsequently joined by Professor Nick Black of the London School of Hygiene and Tropical Medicine.

273 Their report[337] set out preliminary results from their analysis of all adult cases operated on by the five cardiac surgeons from 1 January 1993 until 30 September 1995, following an examination of 2,577 case records. The report compared the mortality rates of one surgeon (designated 'consultant 1231' for the purposes of the report) with the combined mortality rates of his four colleagues, in respect of any operation which consultants conducted.[338] The overall mortality rate of consultant 1231 was 13.6% compared with 5.9% for his colleagues. The mortality rate of consultant 1231 for all coronary artery bypass grafts (CABGs) was 13.4% compared with 4.1% for his colleagues, and his mortality rate for CABGs in risk categories one to ten was 12.2% compared with 2.6% for his colleagues.

274 The assessors reported that the results for consultant 1231 were 'significantly poorer' than the results for his colleagues.[339]

275 The number '1231' had been used to anonymise the surgeon, with a view to ensuring that knowledge of individual surgeons did not influence the results.

276 When the data were presented to the UBHT, the UBHT asked to know the identity of consultant 1231. It was Mr Wisheart.

277 The assessors concluded:

> '1. that the *overall* performance of adult cardiac surgery in UBHT is satisfactory and is in line with published average figures for UK cardiac surgical units as a whole.
>
> '2. that the *individual* performance of consultant 1231 is significantly poorer than the rest of the UBHT consultants. Furthermore, in absolute terms, the assessors consider that consultant 1231's operative mortality figures are too high. The data indicated a particular problem in the area of coronary surgery.
>
> 'The assessors recommend to UBHT that consultant 1231 should not resume operating.'[340]

337 External Assessors' Report 'Independent Review of Adult Cardiac Surgery – United Bristol Healthcare Trust (UBHT)
338 As opposed to operations where the consultant was in charge whilst a junior surgeon operated
339 UBHT 0053 0066; External Assessors' Report
340 UBHT 0053 0071; External Assessors' Report (emphasis in original)

278 In the course of his evidence, the questioning of Mr Wisheart went as follows:

'Q. The purpose of this question is not to embarrass you but to lay the groundwork for what will follow in respect of paediatric cardiac surgery. Was [surgeon 1231] you?

'A. That was me, yes.

'Q. Can we go to page 71? The second recommendation: "… in absolute terms, the assessors consider that [the] operative mortality figures are too high. The data indicate a particular problem in the area of coronary surgery." You accepted their recommendation?

'A. I accepted their recommendation.

'Q. The adult surgical report had, had it, approached the analysis of one surgeon in respect of another by looking at risk stratification?

'A. To an extent.

'Q. So the results which you purported to show were results which as far as possible, gave a level playing-field for comparison?

'A. Yes, they did that, a number of — well they did it — in the actual report they used what one might call a conventional method of risk stratification and they used it to a limited degree.

'Q. When did you, if you did, first realise that your personal performance by this period of time, despite attempting to do your best, was not in line with the other adult surgical performances of your colleagues?

'A. In the proceeding November[341] when the provisional results that you referred to a moment ago were drawn to our attention and that is when I stopped operating.

'Q. But before then, despite your interest in and to an extent the retention of some of the figures relating to cardiac surgery, you had no idea?

'A. I was surprised, that is correct, but it is not only because of my own personal views. The period we are referring to here is 1997 and over a period of approximately two and a half years, just a little less than that, questions had been

[341] In 1996

asked, that is, prior to Professors Treasure, Taylor and Black holding their investigation.

'At each point when those questions were asked, the figures of all the surgeons and my figures were examined by a whole range of different people who I can tell you about if you wish to know, but the point I wish to make was that it was not only my own assessment of the figures that had given me a measure of confidence up until that time, it was the advice I had received from leading people, both inside and outside the specialty, both inside and outside the hospital, so the figures had been shared, as we knew them, fully and openly, and the judgement of those to whom I had looked for advice during that two and a half year period was entirely supportive. So that is why I was surprised, not just my own judgement.'[342]

279 Mr Wisheart said that if he had had an indication of the results earlier he would have stopped operating then, rather than later.

280 On 17 November 1994 Professor Farndon had raised with him the fact that some were questioning the adult figures for cardiac surgery. He had responded that the figures for adults had been examined especially in detail in 1992 and 1993, and that if stratified for risk category, there was little difference between consultants.[343] At that time he had been noted by Professor Farndon as saying that:

'… [the]adverse results must in part be due to (1) weighted patient population re adverse factors, and (2) natural history of AO and valves is that they will, by now, be ready for revisional surgery — : difficult? results.'[344]

He accepted that he was explaining the apparent poor results on the grounds of case mix and the fact that the surgery was revision surgery.

342 T92 p. 7–9 Mr Wisheart
343 T92 p. 11–13 Mr Wisheart
344 WIT 0087 0025; Professor Farndon's note