

between the age of 9 to 12 months but that was not the ideal operation as it was not the anatomical correction.

4. Mr Bwye in his statement on the page 3 paragraph 9, mentions that a doctor sat with them after the septostomy procedure, drew a diagram and gave a risk of 30% for the operation which Jason required. In his evidence to the Public Inquiry on 24th March 99, Mr Bwye dilated it further by stating that "swapping of arteries" was mentioned during this discussion. This means that the Arterial Switch was mentioned and therefore should have been considered imminent. But in the next paragraph (10) he makes a different statement. He recalls being told that the operation could be delayed until Jason was between 9 and 12 months old and his coming home was imminent. Therefore, it now appears that Mr Bwye is confused between those two meetings which took place approximately seven years ago and muddled up parts of their contents in his recollection.

5. Mr Bwye also made a statement and gave his evidence to the G.M.C on 27th November 1997 (GMC Transcripts Day 14, pages 4-10). There he quoted the medical doctor to give him a figure of "80% success rate – 20% failure" on the page 4(G) and quoted me to give him the same figure "around about 80%" on page 5(G). It appears that Mr Bwye has given a different risk figure of 30% when recalling his discussion with the doctor, in his present statement (page 3 paragraph 9). So a discrepancy has crept in between his two statements.

6. Mr Bwye has quoted me to give him a success rate of 80% on the page 5 paragraph 12 of his statement, while I have mentioned a risk of 25% during our preoperative discussion (page MR 0403 0068). I have noted his remarks to the Counsel of this inquiry, when asked to give his views on the disparity during his evidence on 24th March 99. He has attacked my integrity by stating "In view of the type of person that I have learned Mr Dhasmana is, that does not surprise me, that he would write down some thing that has not been said". I certainly resent his remark and stand by my written account. On the same day, in his evidence, Mr Bwye has refused to recognise my hand drawn sketches on the page 0403 0101, being shown to him on the 27th, but admits to seeing similar sketches (including the one with circulation on right) during his previous meeting with the other doctor. I submit that these were hand

drawn by me during our discussion on 27th July 92, on the back page of the consent form, which he signed after the meeting (page MR 0403 0100).

7. Jason was transferred to the Bristol Royal Infirmary and operated on 28-7-92 (pages MR 0403 0069-0073). Jason became severely hypoxic once anaesthetised, requiring hand ventilation and hurried to establish cardio-pulmonary bypass. The coronary abnormality was recognised and managed satisfactorily, though it did take a bit longer. The problem started after the technical part was completed and attempts were made to wean the patient off bypass. The difficulty arose because of severe hypoxia (oxygen saturation of 60-70%). Tests on the table raised suspicion of intra-cardiac right to left shunt. Therefore I had to go back on bypass and re-explore but no such shunt was found. Finally the cardiopulmonary bypass was withdrawn after increasing amount of inotropic support and persistent hand ventilation. Obviously the long bypass resulted in marked oedema and it took more than two hours after the termination of bypass, that the chest could be partially closed. The patient arrested while being moved from the operating table and could not be resuscitated (page MR 0403 0075 – anaesthetic chart).

8. A coroner's post-mortem examination was carried out on 30-7-92 (pages MR 0403 0089-0094). This showed that both lungs were oedematous, firm, purple and poorly aerated. The coronary abnormality was noted and the transfer appeared technically satisfactory. Both coronaries contributed to the anterior descending territory. A small ventricular septal defect (VSD), measuring about 3-4mm in size was found in the mid part of inter ventricular septum. Pathologist thought that it could have been clinically insignificant.

9. I believe that this patient died because of the problem with maintaining satisfactory oxygenation. Right lower lobe pneumonic changes were noted from the first day of life and treated by a week's course of antibiotic. The post-mortem findings of firm and oedematous lungs with purple coloration meant that there was marked congestion due to his congenital heart problem and the pneumonia had not completely resolved. The anaesthesia and surgery most probably aggravated the lung problem resulting in hypoxia, evident soon after anaesthetised. Though the small VSD on its own could have been clinically insignificant, but