

discussed with them , the catheter findings, evidence of pulmonary vascular disease and the plan of management. I would have definitely mentioned that the pulmonary vascular resistance of 9.9 units would make Sophie inoperable, but in view of her age, I would like to give her a chance. An open lung biopsy was recommended to establish the extent of her pulmonary vascular disease and operate if the damage has not gone beyond repair. There is a sketch of plan for the operation to repair the Truncus in my hand on the page MR2459 0132. My discussion has been summarised in my letter to Dr Joffe, dated 19th October 1988 on the page MR2459 0128. Mrs Plackett mentions that I was vague and remote during this meeting and did not inspire any confidence. If she believed that , she should have asked for second opinion for the sake of her daughter and not agreed to my recommendations.

4. Sophie was admitted to the Children Hospital on 24th October as planned and the Open Lung biopsy was carried on the 26th (page MR2459 0041). She was discharged on the 28th October without any problem.
5. Mrs Plackett has raised few questions in the paragraph 10 on page of her statement. I do not have clear recollection of my telephone conversation with her, but I would like to refer to Dr Howarth's report on page MR2206 0065. She has noticed structural changes in all arteries up to most peripheral parts, i.e. even alveolar duct and wall vessels were completely surrounded by a muscle coat but in absence of intimal proliferation, these changes were termed "potentially" reversible. Dr Howarth used the term potentially reversible, not reversible as Mrs Plackett mentions. Mrs Plackett finds hard to reconcile my telephone conversation with Dr Howarth's report, but it was the term "potentially reversible" combined with the high pulmonary vascular figure that I was still sceptical and said that I have decided to operate on Sophie to give her a chance.
6. On page 5 paragraph 11, Mrs Plackett implies that she was not given correct information. She is right in that she was told that Sophie would lead a normal life if the operation were a success. As regards to the risk of the brain damage, I believe that she is not recalling it correctly. I may not have specifically mentioned brain damage in

1988, but always I have stated that after a major and complex cardiac operation, there was possibility of injury to other organs of body like lungs, brain and kidneys. Cardiopulmonary bypass machine was used during the procedure, which may it self cause damage to blood cells resulting in clotting and embolization. Patient is cooled and circulation may be stopped for a short period, which could also cause problem to these organs. Extent of injury to these organs could not be known till about 48 hours after the operation, only after the patient starts waking up and the cardiovascular state is stabilised. I am sure Mrs Plackett would have been talked in similar vein, as the repair of Truncus is a major procedure. However in 1988 I may not have mentioned any figures relating to incidence of such risk. I am surprised that she feels that she was not informed about the complex nature of the procedure. The hand drawn sketch on page MR2459 0132 does show that I drew a normal pattern on the left side and Sophie's abnormality on the right with my plan for repair. This does show the complexities involved. She knew that a homograft was to be inserted which by it self was a complex procedure in a small baby.

7. In the same paragraph she questions my record. I would have definitely given her my figures if asked for it. In a rare condition like Truncus, I would have told her that a surgeon normally does not see more than 2 or 3 cases in a whole year. I started as a Consultant in 1986 and did not have enough cases of my own to quote with any confidence. I was involved with management of only 4 cases till that time. None of these were uncomplicated. Though three of these were Type 1, which is technically easier to correct, each of these had other complicating features. All of these were in severe heart failure with severe pulmonary hypertension requiring full ventilation prior to surgery. First patient died few hours after return to I.T.U. This patient was stable immediately after surgery but suffered sudden cardiac arrest from which could not be resuscitated. The post-mortem examination revealed the presence of blood clot in the right coronary artery, which was the cause of cardiac arrest. Second patient died 26 days after surgery, having been extubated and transferred from the I.T.U at one stage. She died of Aspergillus ball thrombosis of the homograft, a fungal infection acquired in the post operative period and known to be almost fatal in such circumstances. The third patient was a very complex Truncus. This patient arrested in

the operating theatre following anaesthesia and opening of chest. She could not be resuscitated and before any attempt at repair could be undertaken. The post-mortem examination revealed a very complex picture, combination of Truncus and Interrupted Aortic Arch, virtually inoperable. The fourth patient died more than six weeks after surgery due to severe pulmonary vascular disease. This patient had episodes of pulmonary hypertensive crises, requiring use of pulmonary vasodilators and full ventilation. In addition, this patient was operated in the neo-natal period for another serious condition, Tracheo-oesophageal fistula. Combination of two very serious congenital abnormalities in the same baby made prognosis very gloomy. The post-mortem examination again showed that the surgical procedure was performed correctly. The mortality for the Truncus repair in the U.K. register at that time (86-88) was approximately 50 to 66%. I recall telling parents at that time that the operation carries a very high risk, either may live or die, which could be interpreted as 50:50. I saw Mr and Mrs Plackett on at least 3 occasions before the main operation, first on 19-10-88, second during admission for the lung biopsy at the Children Hospital and third at B.R.I. I do not believe that I would have said any thing different on these occasions and they had plenty of opportunity to check on our conversation and question my record. To complete my record, I have operated upon seven more patients with various types of Truncus (8 including Sophie) since that time , with no death.

8. Sophie was admitted on 18th November 1988 (Hospital records pages MR2206 0038 and 0041) and not the 19th as Mrs Plackett states on the page 6 paragraph 12. She mentions that our meeting took place on the 21st, the evening before operation and lasted for about half an hour. So this meeting was not a brief one and she had plenty of time to ask me questions as this was not our first meeting. I would have gone in detail as before. I do not believe that I would have cut down the mortality figure to 20%, as there was nothing new in Sophie's clinical condition. My mortality figures were same as discussed in the previous paragraph and the U.K. register figures were above 50%. She states to have signed the consent after this meeting with me. On page MR2206 0067, she appears to have signed consent on the 18th November and the doctor concerned could have been either the Registrar or the S.H.O. on the day. It was the usual practice in 1988, that the S.H.O. or Registrar in the unit would get the

consent signed in routine cases, where the preoperative discussion with the Consultant would have already taken place in the Outpatients clinic or at other hospital. It is possible that in recalling events of the past, Mrs Plackett could have confused my discussion with the one, which may have taken place on the 18th Nov. 1988.

9. I did tell them about Dr Masey, the anaesthetist for whom I do have a high regard. She was appointed Consultant in May 1984, when I was a Senior Registrar. She worked hard and helped to improve the anaesthetic and postoperative care of cardiac patients especially children. I did convey this to parents. I also believed that Sophie should not wait any longer because my concern regarding the pulmonary vascular disease. The pulmonary vascular resistance was known to be high and the changes seen on the lung biopsy were reported to be potentially reversible. I was clear in my mind that these changes were going to progress further because of very high pulmonary arterial pressure (120/60 on page 2206 0061) and she could not live beyond the age of one year. Even if she survived on a slim chance, she would have definitely become inoperable because of irreversible pulmonary vascular disease. The natural history of this condition is known to be poor (Kirklin, book 2nd Ed.1993). Mrs Plackett contradicts her statement that she was not given any information on the complexity of this condition (page5 paragraph11), by her own statement on page7 paragraph 13 when she quotes me to Dr Benatar.
10. I operated upon Sophie on 22-11-88 (pages MR2206 0043-0044). It appears that the operation was conducted in a planned manner satisfactorily. Post bypass pressures recorded on the page 0044 show satisfactory repair. The anaesthetic notes are missing from these notes and therefore I can not comment on the anaesthetic management and the inotropic requirement in the operating theatre. On pages 0045 and 0046, it is mentioned that she was stable on arrival in I.T.U., repeated in nurse's reports on the page MR2206 0006.
11. I.T.U. - Sophie started getting episodes of pulmonary hypertensive crises from the first postoperative day onwards, requiring full ventilation, paralysing agents, sedation and pulmonary vasodilators. It was after a week that her condition stabilised and she