

**Janardan Prasad Dhasmana**  
**Response to Mrs Erica Jane Pottage's**  
**Statement to the B.R.I. Inquiry**

1. I, Janardan Prasad Dhasmana, served the Bristol Royal Infirmary and the Children's Hospital as a Consultant Cardiothoracic surgeon from the 1st January 1986 to the 9th September 1998. I operated on Mrs Pottage's son, Thomas Nigel on the 13th July 1993 at the age of 10 days when a Neonatal Arterial Switch procedure was performed for repair of Transposition of Great Arteries (T.G.A.). Sadly, Thomas died in the operating theatre at the end of the repair.
2. I have read Mrs Pottage's Statement (WIT 0260) and submit my response to her comments on the relevant paragraphs concerning my role in the management of her son.
3. Thomas was born on the 3rd July 1993 with T.G.A with intact septum and transferred to the Bristol Children's Hospital on the 4th July 1993 under Dr. Joffe's care. A Cardiac Catheter examination and Balloon Atrial Septostomy was performed (report over pages MR 2509 0065-0067). Thomas was then referred and accepted for Neonatal Switch at a Joint Cardiac Surgical meeting on the 12th July 1993 (page MR 2509 0064).
4. Thomas was operated on 13th July 1993 (pages MR 2510 0021-0022) which was unfortunately not successful. I have summarised the events of the operation and post-mortem findings in my summary addressed to their G.P., Dr. Keane (pages MR 2510 0033-0034).
5. Mrs Pottage's criticisms centre around pre-operative communications (as mentioned in paragraphs 7 and 11 of her statement). I did not lie to them as implied in paragraph 7. I believed that the Neonatal Switch programme was progressing satisfactorily after my re-training and changes in management made after my visit to Birmingham in December of 1992. During this period (January-June 1993) five such operations were performed and three survived. Out of two deaths, one had a highly abnormal coronary

arterial pattern, known to carry particularly high risk. At the same time my operative mortality in this procedure in older children had improved considerably. One death in the 11 consecutive patients operated on from 1990 to June 1993. I therefore felt confident in recommending this operation to these parents when I talked with them on the 12th July 1993. I could not quote my figures in the Neonatal Switch procedure because of small numbers, and thus, risks could not be predicted with any certainty. I have already submitted this explanation during my evidence to the G.M.C., and recently to the Inquiry.

6. My regret and disappointment in the failure of this operation was expressed to parents on the 13th July 1993 (paragraph 9) and in my summary to their G.P. These regrets expressed were genuine.
7. The contents of the above statement are correct to the best of my knowledge, belief, and consultation of notes MR 2509 and MR 2510.

**SIGNED: Janardan Prasad Dhasmana**

**DATED: 10 April 2000**