

Bristol Royal Childrens Hospital


16 Jonathan's surgery was planned, I think, for Tuesday 23rd March and it was originally expected that he would remain in SCBU until that day when he would be transferred to the BRI at the bottom of the hill for his operation. In fact, because of a shortage of cots in SCBU, he was moved across the road from St Michaels to yet a third site at the Bristol Childrens Hospital. I have no criticism to make for this decision to move him as he did not need to be in SCBU and the cot was needed for another baby. The care he needed was available at the Childrens Hospital.

17 Jonathan was placed in a High Dependancy Ward in the Childrens Hospital. The first thing that I noticed upon seeing him was that there was a suction bottle next to his cot that was full of mould. The suction bottle had presumably not been used for some time and no one had troubled to clean it after it had been last used. I regarded this as a serious lack of nursing hygiene and it was sloppy to say the least. I asked for the bottle to be removed. This incident gave me my first feeling of unease.

Mr Dhasmana and pre-operative explanation

18 Norman and I knew from our discussion with Dr Martin on or about the 17th March that the surgery on Jonathan would be performed by Mr Dhasmana. Norman and I met him late one evening, before Jonathan was transferred to the Childrens Hospital across the road.

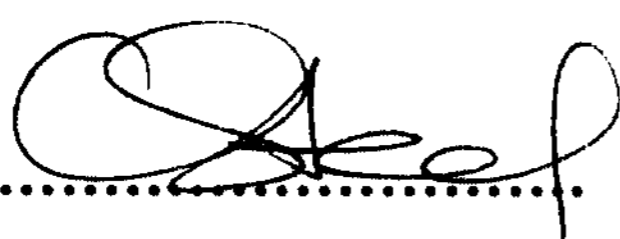
19 Mr Dhasmana explained to Norman and myself that Jonathan's condition was very serious and that it was a major operation. He told us that during the course of the operation, the heart would have to be stopped and then re-started. He said that he wanted us to understand the risk of death and of brain damage. He did

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not in so many words say that the risk of brain damage would stem from any delay or difficulty in re-starting the heart but Norman and I understood this in any event. He told us that 8 out of every 10 babies undergoing the operation did well. He told us that he did not know how long Jonathan would be in intensive care following the operation – it could be 2 or 3 weeks. He also said that until recently the operation used to be performed at 8 – 9 months but experience now showed that the lifelong result was likely to be better if the surgery was carried out at 10 days due to the possible enlargement of the heart associated with any delay as described to us during the meeting with Dr Martin in paragraph 13 above.

20 Norman and I understood that Jonathan would die or remain very sick without the surgery described by Mr Dhasmana. We were therefore bound to conclude that the surgery should proceed. We were given confidence in the knowledge that it was now known that the operation was better performed at 10 days and not 8 – 9 months. Although Mr Dhasmana told us that 8 out of 10 children undergoing the surgery did well, we were not informed that the record at the BRI was far worse. If we had been told of the poor success rate at Bristol, our consent to the surgery being performed there by Mr Dhasmana would not have been given. Jonathan could have been transferred to Birmingham or London following the septostomy. In hindsight, we would have expected him to have informed us of his own poor success rate in performing this type of cardiac operation upon infants. We would have expected him to have informed us of the option to have the surgery performed elsewhere such as Birmingham. Because we were not so informed, there was no discussion at all about the option of other centres. As far as we were aware, Bristol was a specialist centre for such

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cardiac surgery and we assumed that the 8 out of 10 success rate applied to Bristol given the context of the conversation. Had we known the true success rate at Bristol we would certainly have opted to have Jonathan transferred elsewhere.

- 21 As mentioned above, I thought it odd at the time that Mr Dhasmana was not more precise as to how long Jonathan would be in intensive care following the operation. With the benefit of hindsight I strongly suspect that this was because so few infants had so far survived the surgery at the BRI.

BRI Cardiac Unit

- 22 Jonathan was transferred to the Cardiac Unit of the BRI, (at the bottom of the hill from the other two sites), on the day prior to the surgery. The Cardiac Unit is located on one whole floor of the BRI building. The offices, theatre, ICU and wards are all on this floor. There is a small childrens ward but no separate ICU for children. Adults and children were all housed in the same ICU. During the time that Jonathan was in the ICU, there was a toddler and also, I think, an older child. The rest of the beds were occupied by adults.

- 23 Upon our arrival at the BRI I found Jonathan placed in an Intensive Care Cot. It's perspex sides were grubby and dirty. This was because when the cot had previously been used, tubes and other equipment had presumably been stuck to the sides with adhesive tape. The tape had been removed but the adhesive had not been cleaned away. I regarded this as poor hygeinic practice which might have aided the spread of infection.

- 24 Another thing that seemed to be a small omission at the time was the fact that when Norman and I had visited the BRI a few days earlier, they were unable to show us any photographs of babies who had been through the surgery in the

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