

CONFIDENTIAL

THE BRISTOL ROYAL INFIRMARY INQUIRY
REVIEW OF CLINICAL RECORDS

COVER NOTE

Please complete all sections

Child's Initials: [redacted] D.O.B: [redacted] 1992 BRI number: [redacted] BRHSC number: [redacted]	Diagnosis: Tricuspid atresia Pulmonary atresia	Overall Outcome: Dead/ <u>Alive</u> Disability D1 = mild D2 = moderate D3 = severe
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Additional Comments: Unusual post operative complication at first procedure, but recognised and managed appropriately. Some aspects of management (surgical) may have complicated or added to difficulty of later procedures

Overall grade for adequacy of care: 3

Date of Review: 10.01.2000

Team No: [redacted]

Number of notes attached:
(a) pre operative care - [redacted]
(b) surgical and post operative care - [redacted]

..... Team Co-ordinator

Signature: [redacted]

Please use the following summary scores for adequacy:

[redacted]

Completed returns to: Claire Bache, Bristol Royal Infirmary Inquiry, 2-10 Temple Way, Bristol, BS2 0BY
Telephone: 0117 938 8727 Fax: 0117 938 8789/8790

CCNR 04-01

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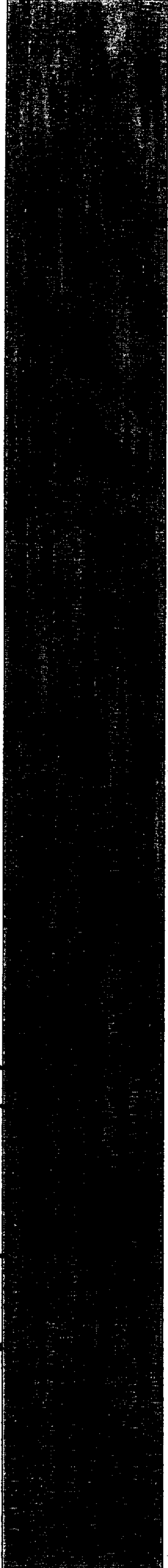
PRE OPERATIVE CARE

Child's Initials: [redacted] D.O.B: [redacted] 1992

Date of Procedure: [redacted] 10.92

Aspects of Care:	Adequacy of Care: 4, 3, 2, 1, or X	Comments - especially relevance of less than adequate care to outcome:	Specialty: GP, Cardiologist, Surgeon, Anaesthetist/Intensivist, Nursing, Technical, Pathologist,
Timing and appropriateness of initial referral/condition on arrival	4		
Clinical assessment and management	4		Dr Martin
Accuracy and completeness of diagnosis	4		
Appropriateness of initial treatment strategy	4		
Timing of planned treatment	4		
Immediate pre-operative management incl. nursing	4		

Please use the following summary scores for adequacy:



CCNR 0102

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SURGICAL & POST OPERATIVE CARE

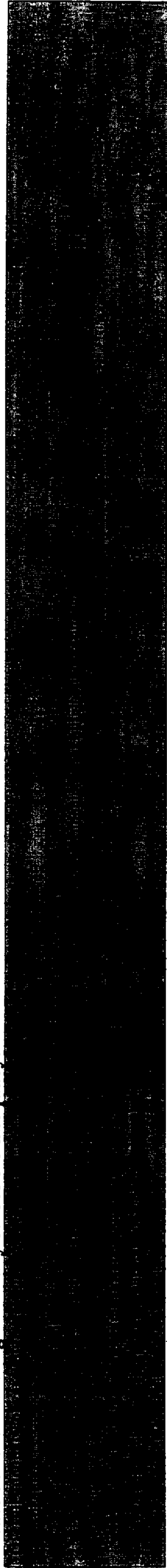
Child's Initials: [redacted]

D.O.B: [redacted] 1992

Date of Procedure: [redacted] 10.92

Aspects of Care:	Adequacy of Care: 4, 3, 2, 1, or X	Comments - especially relevance of less than adequate care to outcome:	Specialty: GP, Cardiologist, Surgeon, Anaesthetist/Intensivist, Nursing, Technical, Pathologist,
Surgical Procedure	3	Bialock shunt sited too far laterally Probable adverse longer term impact	Mr. Dhasmana
Perfusion		Not applicable to this procedure	
Anaesthetic	4		Dr Hughes
Post operative care and assessment 1. ITU - Medical	4		
Post operative care and assessment 2. Surgical	4		
Post operative care and assessment 3. Paediatric cardiological	4		
Post Mortem		Not applicable to this procedure	

Please use the following summary scores for adequacy:



CCNR 04 02

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THE BRISTOL ROYAL INFIRMARY INQUIRY
REVIEW OF CLINICAL RECORDS

PRE OPERATIVE CARE

Child's Initials: [redacted] D.O.B: [redacted] 1992

Date of Procedure: [redacted] 12.94

Aspects of Care:	Adequacy of Care: 4, 3, 2, 1, or X	Comments - especially relevance of less than adequate care to outcome:	Specialty: GP, Cardiologist, Surgeon, Anaesthetist/Intensivist, Nursing, Technical, Pathologist,
Timing and appropriateness of initial referral/condition on arrival	4		
Clinical assessment and management	4		Dr Hayes
Accuracy and completeness of diagnosis	4		
Appropriateness of initial treatment strategy	4		
Timing of planned treatment	4		
Immediate pre-operative management incl. nursing	4		

Please use the following summary scores for adequacy:



CCNR 01 04

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THE BRISTOL ROYAL INFIRMARY INQUIRY
REVIEW OF CLINICAL RECORDS

SURGICAL & POST OPERATIVE CARE

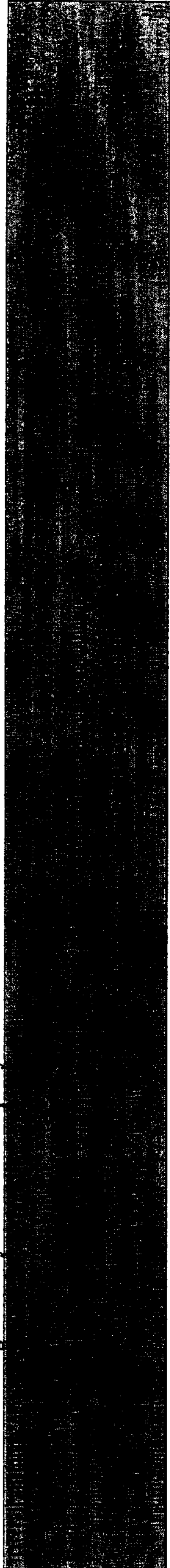
Child's Initials: [REDACTED]

D.O.B: [REDACTED] 1992

Date of Procedure: [REDACTED] 12.94

Aspects of Care:	Adequacy of Care: 4, 3, 2, 1, or X	Comments - especially relevance of less than adequate care to outcome:	Specialty: GP, Cardiologist, Surgeon, Anaesthetist/Intensivist, Nursing, Technical, Pathologist,
Surgical Procedure	3	Hemaz gas vein not ligated	Mr Dhasmana
Perfusion	-	Not applicable to this procedure	
Anaesthetic	4		Dr O'Higgins
Post operative care and assessment 1. ITU - Medical	4		
Post operative care and assessment 2. Surgical	4		
Post operative care and assessment 3. Paediatric cardiological	4		
Post Mortem		Not applicable to this procedure	

Please use the following summary scores for adequacy:



CCNR 0408

Janardan Prasad Dhasmana
Statement in response to
Clinical Case Note Review – C.C.N.R. 04

I Janardan Prasad Dhasmana served the Bristol Royal Infirmary and Children Hospital as a Consultant Cardiothoracic Surgeon from 1st January 1986 to 9th September 1998.

1. I have seen the copies of completed forms of C.C.N.R. 04, reviewed by Team No: ■ dated 10th January 2000. I note that surgical procedure on each of the two occasions has been considered less than adequate and graded 3.
2. The first procedure was carried out on ■ October 1992. The Review Team has commented that the Blalock shunt was sited too far laterally which probably resulted in adverse long-term impact. I have reviewed the operation notes of this patient (page ■ R ■) and can not find any mention of siting the shunt too far laterally. This was a 3-day-old baby who underwent a right-sided modified Blalock-Taussig shunt using a 5-mm Gore-Tex tube graft. The operation was carried out via right thoracotomy, as was my usual practice. The pulmonary artery would have been snared distally before branching and the anastomosis would have been sited behind S.V.C. I believe this could not be termed "too-far lateral" as commented by the Review Team. This can be verified further in the diagram of catheter findings dated 26th July 1994 (page MR ■) and in the text over page MR ■ that the stenosis in the right pulmonary artery was noted proximal and distal to anastomosis. The right pulmonary artery was seen to be larger laterally and towards hilum. The measurement of right pulmonary was recorded to be 2.8 mm just distal to anastomosis and 6.4 mm further laterally at hilum. This confirms that the anastomosis was not carried out "too-far lateral".
3. However I agree that there was a shunt related problem in this patient, resulting in narrowing and deformity of the right pulmonary artery. These are well known problems familiar to every paediatric cardiac surgical practice; both from there own experience and also from referred cases operated elsewhere. These were are seen more frequently in patients with modified Gore-Tex shunt, especially when the native vessel was smaller than the size of Gore-Tex tube, which was the case in this patient. I used the 5-mm Gore-Tex graft because the long-term patency of a 4-mm graft was known to be poorer.
4. The second procedure, a left sided S.V.C. to pulmonary artery anastomosis (Glenn shunt), was carried out on ■ December 1994. This has also been graded "3" with reviewer's comment "Hemiazygous vein not ligated". Reviewing the operation notes over page MR ■, a trial clamping of vena azygous was carried out after the anastomosis and no difference in the oxygen saturation was recorded, and therefore the hemiazygous vein was left open. I do not have any clear recollection but I believe that this was left open because the pulmonary artery pressure was known to

be low (mean 7 mm Hg, with low P.V.R. of 0.36 Woods unit/m) which is as noted in the diagram over page MR [REDACTED] and also mentioned in the minutes of the Joint Cardiac meeting over page MR [REDACTED]. It was hoped that the venous drainage from the left S.V.C. and upper chest (drainage area of left hemiazygous vein) would flow easily in the left pulmonary artery. The trial clamping of left hemiazygous vein did not show any improvement in oxygenation on the operating table and an inference was drawn that there was no off loading of blood flow from the pulmonary circuit and the vein was not ligated at that time. However I am now aware, with the passage of time that the collateral circulation developed between the Left hemiazygous and I.V.C. and the Glenn flow started to off load into the azygous system (Catheter report dated 11-12-95, over page MR [REDACTED]). This catheter examination also revealed that there was a bridging vein between the two S.V.Cs this time, while the earlier examinations in 1992 and 1994 had not demonstrated this connection (page MR [REDACTED]). Obviously the picture of the venous drainage was not well visualised in the earlier examinations, hence the uncertainties regarding the Vena Azygous and hemiazygous system in 1994 and decision made after trial clamping as discussed.

5. The contents of above statement are correct to the best of my knowledge and belief.

Signed: Janardan Prasad Dhasmana

Dated: 24th February 2000