

You ask me what I would have done, faced with knowledge of the events as described by Dr. Roylance, and was Dr. Roylance's response adequate and reasonable. I find the best way to deal with this question is to follow generally the sequence of each of the main events identified by Prosecuting Counsel as significant points at which Dr. Roylance could have acted.

First is Dr. Bolsin's letter of 7th August 1990. It needs to be borne in mind that this letter will have been one of many comments on a very contentious public consultation. It does not address the main thrust of the consultation document but uses the opportunity on the face of it to promote some departmental concerns of the writer, including funding of some equipment he would like, failure to support research he is interested in and the tone is one of disaffection at a time when many medical staff were disaffected by management changes being forced through as part of the NHS reforms. One would like to think one might have had the perception to realise that very serious issues underlay the final paragraph, but I doubt it. I think I would have found it odd and perhaps done exactly as Dr. Roylance in passing the letter to the Medical Committee Chairman to see if there was anything in it. If Dr. Bolsin or anyone else wished Dr. Roylance to pay serious attention to very serious concerns then he should have written on the topic, not as one comment among a number on a consultation document about management changes, or preferably have had the matter raised with Dr. Roylance by a senior anaesthetist.

Next is the Regional General Manager's letter of 20th November 1991. I can see nothing in this letter which would lead me to think there were serious questions being raised about patient safety. Miss Hawkins refers to Business Managers being identified as "problems". This is exclusively a concern about management relationships. In the early years of the NHS reforms there was very often friction between managers representing first wave NHS Trusts and staff of District Health Authorities. She then raises questions about volume, which are not matters of patient safety and to which Dr. Roylance replies very fully in his letter of 3rd January 1992. A general but unspecified concern is raised about "quality of performance". Quality in this context could have referred to questions of access, i.e. waiting times, of patient satisfaction or clinical outcome. The letter is not specific. Dr. Roylance addresses briefly but adequately the question of clinical outcome. Miss Hawkins' letter is about cardiac surgery in general, not paediatric cardiac surgery in particular. He then addresses at length issues relating to access. This is very reasonable since the general context of Miss Hawkins' letter is the statement that the Region has

invested in Bristol in order to improve access for people living in the South-West outside of Avon Health Authority. She implies that waiting times for non-Avon residents are such that these District Health Authorities are sending patients to London and Oxford. I think London hospitals do draw many patients from the South West. In cardiac surgery the Royal Brompton Hospital in particular draws patients from South-West England. Had Miss Hawkins been raising concerns about safety of any element of the Bristol programmes then I would have expected her to express such a serious concern very differently and very explicitly.

Private Eye is a humorous magazine, which for a time ran a column satirising the NHS reforms and in particular targeted NHS Trusts in the first and second waves. I have no idea whether I or my Trust featured in the column since like Dr. Roylance I did not read it. Because it is a satirical and humorous publication, reports in Private Eye need have no substantial foundation in fact. It is read by journalists, and in my experience a good test of whether a report in Private Eye should be taken seriously is whether the story is taken up by other journalists. If not the report is very likely so speculative a serious journalist is not willing to repeat it.

You asked me to comment on the evidence of Professor Prys Roberts, and in particular on his account of a meeting with Dr. Roylance in early 1992.

Professor Prys Roberts recalls that after a discussion with Dr. Bolsin, he undertook to make some representations to the Chief Executive about the implications of Dr. Bolsin's studies. I am surprised that Professor Prys Roberts thought the appropriate response was to raise the issues in the first instance with the Chief Executive rather than with his surgical colleagues. In Dr. Roylance's position I would have advised him to take the matter up with the Clinical Director of Surgery, or the surgeons concerned. I believe in these matters that is the advice that was normally given by Dr. Roylance himself, and is implied by the colloquial phrase "its up to the medics concerned". The notion that it was up to Trust management to "do something about it" before an attempt had been made to resolve questions within the profession is I think mistaken.

If in a meeting with Dr. Roylance the phrase "you cannot afford to sweep this matter under the carpet" was used that could have implied that Professor Prys Roberts was seeking a clinical review of the programme. But if that was the intent it was an obscure and indirect way of doing so. In Dr. Roylance's place

I think I should have taken Professor Prys Roberts to have been expressing general concern in somewhat rhetorical language. Had he wished Dr. Roylance to take specific action he could have said " I believe the audit shows the surgery may be unsafe and there should be a clinical review or inquiry". Such a statement could not have been misunderstood. Professor Prys Roberts recalls saying to Dr. Roylance that " Dr. Bolsin has some numbers which he would be prepared to discuss with you ". Had this been said to me in similar circumstances, I should not have understood what was meant and I certainly would not have taken an implication that there were questions about the safety of the programme.

At this point the issue is the extent of concern the analysis gave rise to, as interpreted to Dr. Roylance by those who were expert in the field. It is a common approach to seek to revitalise a faltering service, particularly a very specialised service, by creating a post to recruit someone at the leading edge of practice in the field. There are several branches of surgery where over the last 10 or 20 years, work with children has passed from adult surgeons to specialist paediatric surgeons. There is also a very widely held view that a service of this kind would be better located in a paediatric centre. The question for a manager is whether the issue is that the service under scrutiny is not as good as some others, and within what is after all a probability distribution some other centres achieve better results or whether the results achieved are quite out of line with contemporary expectation and patients are being exposed to unreasonable and unjustifiable risks such that the programme should be considered unsafe. If the former then the steps taken by Dr. Roylance were reasonable. If the latter then the programme should have been suspended. I think the onus was on Professor Prys Roberts to make clear to Dr. Roylance how he regarded the seriousness of the audit. If Professor Prys Roberts had any continuing doubts one might have expected him to follow the matter up with Dr. Roylance. When Dr. Roylance in fact managed to achieve the measures to strengthen the programme that seem to have been generally agreed as appropriate, and he received no further approaches by Professor Prys Roberts, in his place I should have assumed Professor Prys Roberts was content.

You asked me to consider Professor Angelini's evidence. Professor Angelini saw Dr. Roylance between January and March 1994. Dr. Roylance recollects his main concern was to promote a new appointment, which is very often the topic of meetings between the Chief Executive and members of the clinical staff. Professor Angelini does not seem from his evidence to accept the extent of financial constraint in the health service and that identifying funding for

such an appointment, and the revenue consequences of such an appointment, was a major issue for the Chief Executive as I believe it must have been. It may well be that difference of perspective made relationships difficult. Also differences between the head of an academic department and the NHS consultant body in the specialty do arise from time, and can cause difficulties for relationships both among the clinicians and with management. In Europe the Professor may well also be head of the service as is in fact the case traditionally at one my Trust's hospitals, the Hammersmith. But in English undergraduate hospitals the convention is that the senior NHS consultant is the person who advises management, which can make the Chief Executive's relationship with the academic head difficult. In Dr. Roylance's position I would have sought to avoid becoming involved in differences of opinion between the Professor and NHS colleagues, so long as I had no reason to suppose the safety of patients might be in question.

In my view while Professor Angelini was not responsible for advising management on the service, as Professor of Cardiac Surgery he was an authoritative person who had access to the Chief Executive, and by whom the Chief Executive might expect to have been told clearly and unequivocally if aspects of paediatric cardiac surgery might be unsafe. The Chief Executive might expect Professor Angelini as an academic to be particularly well placed to evaluate expertly the significance of Dr. Bolsin's analyses and advise the Chief Executive of the implications if they were very serious. The phrase in Professor Angelini's subsequent letter to Dr. Doyle "there have been audits carried out which have shown a greater mortality than perhaps could be expected in a particular surgical procedure" is not consistent with the view that the programme is unsafe and should be suspended. If these were the terms in which he expressed his professional view to the Chief Executive, I do not think the Chief Executive could be expected to intervene, any more than did Dr. Doyle to whom the letter is addressed.

You asked me to comment on Ms. Maher's evidence, as it relates to her meeting with Dr. Bolsin on 18th May 1994, and whether I would have acted any differently from Dr. Roylance on her report of that meeting. In the management hierarchy a Directorate General Manager or equivalent is a middle management position, which has very important operational responsibility but it is the Clinical Director who is responsible in professional and strategic matters. In a health service management career a position of this kind is analogous to that of a registrar in hospital medicine. I explain this because I would not expect a Directorate Manager to have experience or be able

to make good judgements about the kind issues raised with Ms. Maher by Dr. Bolsin. I would expect her to do exactly as she did, that is advise all relevant senior staff of the conversation including Dr. Roylance.

There is an ambiguity in Ms. Maher's evidence as to the seriousness she attributed to Dr. Bolsin's approach. On the one hand she refers to being concerned that questions of patient safety were being raised. That is very serious indeed. However in the detail of her evidence the extent of her concern can seem to stem simply from the fact that Dr. Bolsin was implying the results of the unit at Bristol were not as good as some other units. That is very different. As well as Dr. Roylance. Ms. Maher informed the relevant Clinical Directors, Dr. Monk and Mr. Wisheart. She also gave Dr. Bolsin appropriate advice, to raise his studies through the established Audit processes, to raise them with the surgeons concerned and to raise his concerns with his own Clinical Director. In Dr. Roylance's position, having established the action Ms. Maher had taken and the advice she had given Dr. Bolsin I think I should have been satisfied that what was essential had been done. One might also have done as Ms. Maher anticipated and raised the matter with a Clinical Director or the Medical Director. But these additional steps would have depended very much on how it was presented to Dr. Roylance by Ms. Maher and what judgement he made about her concerns. I should not have felt it imperative to pursue the matter further, because what was essential had been done.

In May 1994 Professor Angelini and Professor Vann Jones wrote to the Chairman of the Trust. The letter seeks advice as whether funding might be made available for a new appointment to take the service forward, because the subject has become very specialised and required a dedicated paediatric surgeon. Had I received such a letter it would not have suggested to me that paediatric surgery was unsafe or that the programme should be suspended.

I have read Dr. Doyle's evidence to the committee. Dr. Doyle's letter does not require that surgery be suspended and neither Dr. Roylance or Professor Angelini offer any assurances that it will be. Whether the act of recruiting a new surgeon leads to a reasonable assumption that surgery will be suspended until the new surgeon arrives is debatable. In Dr. Roylance's position I would not have considered Dr. Doyle's letters on this subject either informal or unofficial. He is an officer of the Department and seems to be writing as such. Dr. Roylance by his reply treats it formally. The role of Departmental medical officers in circumstances of this kind is ill-defined, but I would take it that Dr.

Doyle in this matter acted in his capacity as a policy advisor on cardiac surgery. By his letters of the 20th September and 3rd October to Dr. Roylance he endorses the Trust's response, and in Dr. Roylance's place I would certainly take this letter as confirmation that the action I had initiated was sufficient and appropriate. There is nothing in the letter to suggest he writes to Dr. Roylance as one medical practitioner to another. He addresses the letter to Dr. Roylance in his capacity as Chief Executive. However Dr. Doyle may well have believed that surgery was suspended, although that is not said in the correspondence, and there may well have been genuine misunderstanding between Dr. Doyle and Dr. Roylance. If Dr. Doyle had continuing substantial concerns I would have expected the Regional Director of Public Health to become involved, and to have raised the issues with the Trust.

The letter to Dr. Monk of 21st June 1994, signed by six consultant anaesthetists, is very specific and unambiguous. A letter signed by several consultants about a clinical concern is significant and requires a response. This would be particularly so if all these consultants were engaged in support of paediatric cardiac surgery. The obvious response was to convene the review they requested, while suspending the surgery until the review was completed. If there were good reasons to adopt an alternative course of action, then it would be best for that to be explained in a written response or a minute of a committee. If the surgeons were unwilling to cooperate in a review of the kind suggested, then the Clinical Director should have raised the problem with the Medical Director or Chief Executive. I would expect a matter of this kind to be dealt with between the Clinical Directors. I would not expect the Chief Executive to have become involved unless the Clinical Director of Anaesthesia felt unable to resolve the issues to his professional satisfaction with his surgical colleagues.

The final event is the operation on Joshua Loveday. This is difficult. A new surgeon had been appointed and presumably no such operations had been carried out for a while. Then it emerges the clinical team is intending a further operation. Professor Angelini is very concerned and speaks to Dr. Roylance. Dr. Doyle speaks to Dr. Roylance. The full clinical team responsible for Joshua Loveday's care, including anaesthetists, surgeons and the referring cardiologist agree that the operation should proceed. Dr. Roylance I assume was advised of this by Mr. Wisheart. Subsequent papers suggest there was at least an implicit understanding that some paediatric cardiac surgery would be suspended until Mr. Pawade had taken up his appointment. But Dr. Roylance believes this related to neo-natal surgery. Joshua Loveday was 18 months ie. not a neonate.

To a non-specialist a restriction on procedures involving neonates would be quite different and distinct from a wider restriction on all infants or very young children. Assuming that the general restriction was understood to apply to neo-nates only, and that Dr. Roylance was advised as the statements confirm that the full clinical team with responsibility for care of Joshua Loveday were intent on proceeding, then for the Chief Executive to acquiesce in that decision despite the reservations of authoritative but essentially extraneous persons to the care of Joshua Loveday was reasonable.

The decision is complicated by the suggestion in Mr. Wisheart's oral evidence that in advance of the meeting of 11th January he and Dr. Roylance had formed the conclusion that there should be an inquiry. I understand Dr. Roylance will acknowledge that there was such an agreement between himself and Mr. Wisheart, but recollects that this conclusion was reached between himself and Mr. Wisheart after the clinical meeting, but before the operation took place.

In my view once a decision had been made that it was appropriate to have an inquiry, the programme that was subject of the inquiry should have been suspended, unless there was overwhelming clinical urgency. If the clinicians responsible for care of Joshua Loveday advised Mr. Wisheart or Dr. Roylance that Joshua Loveday could safely be referred to another centre for surgery, then Mr. Wisheart should have insisted he be referred to another centre as soon as the inquiry was decided upon. If the clinicians responsible for Joshua Loveday advised that the operation was urgent and there were overriding clinical grounds why he could not be referred to another unit, then I would expect the operation to have gone ahead. The risks of continuing a programme about which there are sufficient doubts to indicate an external review would be outweighed by the immediate risk to the patient of not operating.

If as Mr. Wisheart has recalled the decision to have an inquiry was made before the clinical meeting on 11 January, I think it was his responsibility as Medical Director to persuade the clinical team that unless there was overwhelming clinical urgency this operation should not proceed. If those with direct responsibility for care of Joshua Loveday had nevertheless decided to proceed because of the urgency of his case, and that he could not be referred to another unit, then in my view neither Mr. Wisheart as Medical Director or Dr. Roylance as Chief Executive could intervene. If the decision to have an inquiry was made after the clinical meeting, then in principle the same considerations apply. I would expect the programme to be suspended immediately, unless Mr.

Wisheart and Dr. Roylance were advised that the operation was urgent and the patient could not safely be referred to another unit. If the latter were the case then I would expect the operation to proceed.

You ask whether in Dr. Roylance's position I would have done the same thing. I cannot be sure. The circumstances and events of the operation on Joshua Loveday were extraordinary and I have never had to face such a situation. If Dr. Roylance's recollection is correct that an inquiry had not been agreed before the clinical meeting, I think nevertheless I might have suggested to Mr. Wisheart that, while the clinical decision in the end must remain with the clinical team, the clinical team might wish to consider very fully the option of referral to another centre and satisfy themselves completely that this was not a reasonable option in all of the circumstances. If Wisheart's recollection is correct, and the decision to have an inquiry was made before the clinical meeting, then I should have advised him Joshua Loveday should be referred to another centre, unless there was overwhelming clinical urgency, and asked to him put my advice strongly to his colleagues.

You ask whether Dr. Roylance was entitled to rely on the advice of Mr. Wisheart, who was the senior surgeon in the specialty and Medical Director. In general a Chief Executive has to rely on advice of the senior specialist in the field whether or not he happens to be Medical Director. Certainly it would not be usual to prefer the advice of the Professor over that of the senior consultant. In my own experience I have usually relied on the Medical Director not only for general advice but for advice about his own specialty, where the Medical Director is the senior consultant in the specialty.

If the personal professional competence of the senior consultant is at issue the position is very difficult indeed. If Dr. Roylance understood that the criticism of paediatric cardiac surgery was directed specifically and explicitly against the personal professional skill and competence of Mr. Wisheart and Mr. Dhasmana, then perhaps he should have sought out, formally or informally, other advice at an earlier stage. But it is unlikely he understood that. No one so far as I can tell pointed that out to him.

In respect of the operation on Joshua Loveday, it was to be undertaken by Mr. Dhasmana not Mr. Wisheart. There would be less reason to question Mr. Wisheart's judgement of a colleague's competence than criticism of his own competence. It is apparent from his own evidence that because of his personal and clinical authority Mr. Wisheart was the ideal person to influence his

colleagues in a matter which was personally and professionally sensitive. Mr. Wisheart's integrity was universally acknowledged, so he could be relied upon to conduct the meeting fairly and report it accurately. In Dr. Roylance's position I might have asked to attend such a meeting myself, because the circumstances were very extraordinary. But I have never done so, and had such a request been refused I would not feel able to insist on participating in a clinical meeting.

I hope this is helpful.

Yours sincerely,

A handwritten signature in black ink, appearing to read "John Cooper". The signature is stylized and somewhat cursive, with a large, sweeping flourish at the end.

John Cooper
Chief Executive