Janardan Prasad Dhasmana

Response to Supplementary Statistical Evidence to the Inquiry

I have now had an opportunity to view the above mentioned bundle of papers submitted to the Inquiry by Doctors Spiegelhalter and Aylin together with Professors Campbell, Evans and Murray. I have a very limited knowledge of statistics and . I am there fore not in any position to challenge renowned experts in their field. However I was saddened to see some part of the main Statistical report which appeared in October 1999 (Inq. 12. 13, 14, 15).

2. As mentioned I neither have expertise nor knowledge of their data source and coding system so as to question their interpretation, but I am very familiar with the information contained in my "Log book". Almost all medical entries have been filed by me and my secretary and personally checked by me. Patients were categorised in different groups on the basis of their main diagnosis and the primary operation. For example the ASD group comprised of patients whose main pathology was secondum or sinus venosus type of ASD and where closure of ASD was the main open-heart surgical procedure. Patients, in whom ASD was an asociated lesion, were categorised with the main pathology group ie. Tetralogy of Fallot, VSD, DORV, TGA or other. When patients had a combination of major and/or complex pathology, they were placed in the miscellaneous group.

3. My main concerns in the main report ranged around Statistical expert's interpretation of my data in the Surgeon's Log, particularly the Table 5.4 (INQ 0012 0041). I do not have my original logbook with me, which was taken away by the hospital authorities for submission to the Inquiry but a copy was provided, which has been used by me for reference and preparation of my reports. First, my Logbook does not contain any close heart operations except for Coarctation of Aorta in young adults, who could not be admitted at the Children Hospital and one patient with PDA. No closed shunts were performed at BRI. Therefore the twelfth group of closed shunts (4/6 with 67% mortality) does not exist and therefore should not have been mentioned here.

Secondly, there are 95 patients with one death in the ASD group in my logbook with an overall mortality of 1.05%. As mentioned these were children under 15 yrs of age (only one 17 yr old) who were mainly operated for repair of ASD at BRI. An 8 month old child operated on 25-5-89 died on 7-6-89. The patient died of repeated episodes of pulmonary hypertension in the postoperative period. There was no death in the remaining 65 patients since. Therefore there is a major error in the sixth group of ASD which mentions 19/134 with 14% mortality. I fail to understand the source of these numbers, as the quoted source is my logbook, which I have checked repeatedly.

5. Similarly, I have grave reservations about the inferences drawn about mortality results in paragraph 2.3.4 over page INQ 0013 0028. As explained in the previous paragraph, the quoted mortality figure of 63% in ASD is wrong and I believe that mortality of 43% in AVSD is exaggerated and required re-examination.

6. I raised my reservations about the statistical report to the Inquiry during my oral evidence, quoting ASD as an example. I was reassured by the Chairman of the reassessment of the study (day 87 page 0014 line 11 to page 0016 line 15). A similar request was made in writing with my supplementary closing submission WIT 0084 0149-0150).

7. Having reviewed the supplementary bundles, I do not believe that the aforementioned errors have been remedied particularly with ASD. Dr Spiegelhalter et al have submitted "A Response to Submission on behalf of Mr J D Wisheart: Appendix 2 The Inquiry's Statistical Analysis". I have difficulty in comprehending their comments in the outcome section (2nd paragraph on page 14), when they describe 10 cases in my log. I have checked my logbook again and fail to find these 10 patients in this ASD Group. Authors have admitted that most of these have more than one diagnoses recorded. Four of these had congenital anomalies of great vessels (TGA) and tow had congenital ostium atrioventriculare commune (Common AV Canal) and one cong. mitral stenosis. I have not found any of these pathological diagnosis mentioned in the

group of ASD patents in my log. I therefore believe that a different group is being described over these pages than the ASD categorised in my logbook.

I therefore also do not agree with author's conclusion in the summary "that there were some deaths in the period 1991 to 1995 for operations that were coded solely as ASDs, and not zero deaths as stated by Mr Wisheart". I cannot speak for Mr Wisheart but for myself, I would insist that there were no deaths in ASD group as per my logbook.

9. Similarly I disagree with author's inference in s2.2.6 over page s9 and table s2.5 over page 28 wherein the mortality in ASD has been mentioned to be 63%, 17 times higher than elsewhere (Supplementary analysis of Hospital Episode Statistics for the Bristol Royal Infirmary Inquiry: by Dr Aylin et al). I strongly believe that there must have been some error either in the data source or in the coding. It is very hard to accept a mortality of 63% in straightforward ASD group and still worse, not to have appreciated it over more than 15 years at Bristol. Equally no concern in this regard was raised by any of the clinical groups concerned with the patients care.

10. I would appreciate very well an opportunity to talk or have a communication with the experts so as to understand the apparent discrepancy between the information contained in their report and my interpretation of the information contained in my own logbook.

Dated: 22 September 2000

Signed:.....
Janardan Prasad Dhasmana