

5. Mr Wishart rang the following morning to state, that in his view, the results for operations on children over 1 year had been reviewed and shown to be equal to the national average and that his colleagues had agreed that, in view of the child's condition, the operation should go ahead. I again suggested to him that it might be better to postpone.
6. I learned on Friday (13th) that the operation had been performed the previous day and that the child had died at 1930hrs towards the end of a very long and complicated procedure. I also learned that Prof. Angelini and Steve Bolsin had not been party to the decision to operate, nor had they agreed to the interpretation put on the audit results. Both rang me on Friday to tell me the sad news and to discuss what could be done.
7. I understand that Prof. Angelini is intent on setting up an enquiry to look into both the conduct of the operation and, on the basis of a detailed examination of the audit results, the advisability of the decision to operate in the first place. He will be inviting outside experts to take part and help frame recommendations about the future organisation and delivery of paediatric cardiac surgery in Bristol. He is concerned that, even though he has an academic appointment and not therefore directly answerable to the Trust, his initiative may well be opposed by the Trust management.
8. I was later contacted by James Wishart to be (again) told the sad news. I asked him what he intended to do. His view is that nothing should be done until the coroner has decided what to do and the results of the PM are available. Depending on the findings they might then need to have some sort of enquiry. He conceded that an independent view might be helpful. I reminded him that, as I was in possession of many of the facts I would have to pass them on to my colleagues and that we were obliged to protect the position of the SoS. I'm not sure that he took the point.
9. This has been a difficult and traumatic episode for all concerned. There will doubtless be a good deal of heart searching among those involved and a lot of questions have been raised. Perhaps the first question is whether the death was avoidable? We may not know the answer to that question for some time (if ever?). If it was, where does the blame lie? What could/should have been done? Possibly most importantly, how can differences of professional opinion or interpretations of audit data, be resolved without putting patients at risk? It would seem that we need a well recognised and acceptable mechanism for getting independent advice on such difficult questions.

Suggested action

10. I have spoken to Dr Roylance (Trust CE) today who assures me that he is setting up an immediate internal enquiry to establish the facts followed by an independent enquiry using outside experts (cardiothoracic surgeons). I expect to hear the results in due course including any recommendations for the future conduct of the paediatric CT service in Bristol. I do not believe any further action is required at present but am happy to be advised by yourself or copyees.