

1 been the Health Secretary in the Conservative Government for some time and was closely
2 allied to the Trust Board, who had proposed Trust status for the Bristol Royal Infirmary.
3 There appeared little interest in the Conservative Party for criticisms of their new policy
4 of NHS Trusts.

5 I met the 2 MPs at their office in Bristol and gave the background information to my
6 concerns about the paediatric cardiac surgery programme. I also provided the details of
7 the results that I had available to me with some indication of the comparative results at
8 other centres. The MPs agreed to look into the matter and promised that they would be in
9 touch with me if they needed extra information to formulate parliamentary questions. I
10 was contacted by one of their associates when the parliamentary questions were tabled
11 and also given copies of the replies. The questions were not precisely defined so that the
12 answers were able to avoid implied criticism of the Trust.

13 Ms Primarolo also wrote to Dr Roylance as the Chief Executive of the UBHT and
14 received what I consider to be a misleading and inaccurate response. I suspect that Dr
15 Roylance would have had to have cooperation from a local expert in paediatric cardiac
16 surgery to formulate the reply and this is most likely to have come from Mr Wisheart. The
17 concerns expressed by local MPs should have alerted the Trust and the Trust Board to
18 serious concerns about paediatric cardiac surgery. I am not sure that the Trust Board were
19 informed of the concerns of these MPs; also I am not sure that the Trust Board members
20 were aware that questions were being asked in Parliament about their Trust.

22 ***Surgical clinical audit meeting***

23 On Thursday 2nd June 1994 a clinical audit meeting was held. I believe this was the
24 meeting at which Mr Wisheart presented informal data relating to the Fontan procedure.
25 Mr Dhasmana was not able to attend that meeting as he was operating and no other data
26 for the unit was presented. We were never presented with the data Mr Dhasmana "would
27 have presented at that meeting" and there appeared to be a distinct unwillingness to share
28 outcome results with other members of the team and cardiac surgical colleagues. Mr
29 Wisheart made general reassurances that the performance of paediatric cardiac surgery in
30 the unit was improving; no figures were provided to support this assertion.

32 ***Department of Health involvement: Mr Peter Doyle***

33 On Tuesday 19th July 1994 Peter Doyle, senior medical officer at the Department of
34 Health, visited the Bristol Royal Infirmary to meet Dr Andy Black, Professor Angelini,
35 Mr Alan Bryan and myself to hear presentation from us about the advantages and
36 feasibility of a national cardiac surgical and cardiological audit programme. During this
37 meeting Professor Angelini mentioned the problems of paediatric cardiac surgery at the
38 Bristol Royal Infirmary. Due to pressure of time it was not possible for me to discuss in
39 detail these problems with Mr Doyle but in the taxi on the way to Temple Mead station I
40 provided the background information and the figures that were available to me at that
41 time. These included the results of the Bolsin/Black data analysis/collection; the arterial
42 switch mortality rates (provisional); the recent A-V canal data for Mr Wisheart. The
43 discussion on the journey centred on the most appropriate way to deal with problem.

1 Three possible scenarios were discussed; reporting the matter to the Secretary of State for
2 Health, Mrs Virginia Bottomley, reporting to the president of the Royal College of
3 Surgeons and an investigation by Professor Angelini locally. Peter Doyle and I concluded
4 that the first two courses of action would result in the suspension of paediatric cardiac
5 services at the Bristol Royal Infirmary prior to an investigation conducted by the
6 Department of Health or the Royal College of Surgeons. The latter course would allow
7 services to continue while a solution was rapidly developed. We agreed that this should
8 be instituted as soon as possible and Peter Doyle wrote to Professor Angelini within a few
9 days of this meeting. I believe that Professor Angelini subsequently produced a report,
10 which proposed appointment of a new paediatric cardiac surgeon to the Bristol Royal
11 Infirmary.
12

13 ***Anaesthetists' concerns***

14 In August 1994 I drafted and sent to Dr Monk, Director of Anaesthesia, a letter from all
15 of the other cardiac anaesthetist indicating their concerns about the arterial switch
16 programme being undertaken in the Bristol Royal Infirmary. The letter had been
17 discussed with Dr Monk before I sent it and Dr Monk suggested that I should send the
18 letter to him and not to the paediatric cardiac surgeons. This he argued would empower
19 him to obtain the open review of paediatric cardiac surgical practice, especially for the
20 arterial switch procedure, which we had all been requesting for some time. I produced a
21 first draft of the letter and after consultation with the other paediatric cardiac surgical
22 anaesthetists we were able to all sign a revised version of the letter. The purpose of the
23 letter was to enable Dr Monk to obtain an open review of the arterial switch procedure,
24 which he undertook to do. It is interesting to note that at the GMC inquiry Mr Wisheart
25 claims that he was never privy to the contents of the letter and had not seen the letter that
26 Dr Monk received until 1996 or later.

27 There was a meeting of the cardiac anaesthetists at 1030 a.m. on Monday 7th November;
28 the meeting was held on level 4 at the BRI. This was in the cardiac theatre sisters' office.
29 This meeting discussed the existing bad results of the arterial switch procedure and Dr Ian
30 Davies, Dr Chris Monk and myself agreed that we would not undertake anaesthesia for
31 this operation because of the results and the fact that we had not be involved in the
32 Birmingham retraining programme. I'm not sure if there is any record of this meeting
33 occurring.
34

35 ***The Nottingham City Hospital application***

36 In August 1994 I had applied for post as consultant cardiac anaesthetist to the Nottingham
37 City Hospital. During the month of September 1994 I was visiting the City Hospital in
38 Nottingham where I had applied for a post as a consultant anaesthetist. During my visits I
39 met Mr Peter Tatham, Professor Aitkenhead (Professor of Anaesthesia in Nottingham), Dr
40 Morgan (medical director of the City Hospital Trust) and Mr Salamar (Consultant
41 Thoracic Surgeon) as well as other anaesthetists in the Department. The interview for
42 this appointment was on Friday 7th October. I asked Mr McKinlay to provide a reference
43 for me to the Chief Executive of the Nottingham City Hospital Trust. I provided him

1 with the contact numbers and name of the Chief Executive (Thelma) and he undertook on
2 my behalf to provide me with a reference. I was unsuccessful in my application to be
3 appointed to the City Hospital Nottingham; the interview had been on October 7th. I have
4 since spoken to Dr Henry Connell at Green Lanes Hospital, Auckland, NZ, who had also
5 expressed an interest in applying for the post at the City Hospital, Nottingham. Dr
6 Connell spoke to Dr Peter Tatham, who was the Director of Anaesthesia at the City
7 Hospital, after the closing date for applications for the post. Dr Tatham explained to Dr
8 Connell that 2-3 senior registrars had applied for the post as well as "an established
9 consultant from elsewhere who was unemployable". Dr Connell did not ask who that
10 person was but he did know that I was the only other "established consultant" who had
11 applied for the post. Dr Tatham was not on the selection committee for the consultant
12 post but would have had considerable input into the decision making process.

13
14 I have since learned from other applicants for this post that I was described by consultants
15 in Nottingham as "unappointable" because of the information coming from Bristol. Dr
16 Rob Ray was working as a locum consultant anaesthetist at the Queen's Medical Centre
17 in Nottingham during this time and was aware of the opinions that were being expressed
18 by senior and junior staff in the City at that time.

20 ***Dr Roylance issues threats***

21 I have a record in my diary of a meeting with Dr John Roylance on Friday the 25th
22 November 1994 at 10 a.m. in the Trust headquarters. I do not have a record of this
23 meeting but at the end of this meeting which took place in Dr Roylance's office in the
24 Trust headquarters Dr Roylance asked me about the recent investigation concerning
25 possible charges against me, relating to the death of a patient undergoing cardiac surgery.
26 The case was not pursued after investigation and a coroner's court returned a verdict of
27 death by natural causes on a patient who had died more than two weeks after cardiac
28 surgery. During the operation the patient had received two units of blood, not cross-
29 matched for them.

30 Dr Roylance then issued what I perceived to be a very real threat to my employment at the
31 Bristol Royal Infirmary. He introduced this by saying that the Trust now had a new
32 chairman, Mr Bob McKinlay, who had a background in the aircraft industry. In that
33 industry, Dr Roylance elaborated, if an employee is paid to bolt the blades on helicopters
34 and one of the blades he has bolted on comes off with subsequent loss of life, that
35 employee is never allowed to bolt the blades on helicopters again. Dr Roylance asked me
36 if I understood what he meant by this analogy and also told me not to take this as a threat.
37 I had no doubt that this was a threat to me to stop raising the issue of paediatric cardiac
38 surgery within the Hospital.

39 I was particularly angry with this 'singling out' of me in the context of implied criticism
40 because in the same week a report had appeared in the Daily Mail newspaper announcing
41 an out of court settlement against Mr Wisheart. The parents of a child that had died as
42 result of surgery to correct tetralogy of Fallot had been awarded a payment because Mr
43 Wisheart had cut the right coronary artery in error during the operation. I was sure that no

1 similar threat had been made to Mr Wisheart although I suspect he should not have been
2 "bolting the blades on helicopters".

3 Later that week I was contacted by Dr Coates, an anaesthetist, and also a BMA place of
4 work accredited representative (POWAR). He provided me with a computer sheet giving
5 details of a meeting he had had with Dr Roylance that week. Dr Coates had been asked to
6 see Dr Roylance about an industrial issue but at the end of the meeting the same analogy
7 about Dr Bolsin had been given to Dr Coates. Dr Coates was very concerned about the
8 threat to my employment and was prepared to provide the same document to the BMA for
9 their opinion.

10 During the investigation of the case Dr Roylance alluded to in his threats my defence
11 association (Medical Defence Union) provided me with a solicitor, Mr Ian Barker of
12 Hempson's. I had many meetings and telephone conversations with Mr Barker during the
13 year it took to conclude there was no evidence to support the case against me. At the
14 reconvened coroner's court a death by natural causes was recorded for patient. During
15 the year (in which Mr Barker also was married) I told Mr Barker of the threats made to
16 me by Dr Roylance and the confirmation of these threats provided by Dr David Coates.
17 Mr Barker agreed that he should discuss this unnecessary and bullying behaviour with his
18 colleagues before deciding on a course of action vis-a-vis the UBHT. I do not know the
19 outcome of this decision but Mr Barker did contact me in Australia before the
20 commencement of the GMC hearing to tell me that he remembered the threats that had
21 been made and of the concerns about paediatric cardiac surgery that I had unofficially
22 mentioned to him. This had been in the context of demonstrating the reason for Dr
23 Roylance to threaten me at that time.

24 25 ***The last switch operation***

26 In December 1994 the cardiac surgeons' proposed operating lists for January 1995
27 indicated that Mr Dhasmana intended to undertake an arterial switch operation that
28 month. When Dr Black, Professor Angelini and I discovered this proposal we
29 approached as many influential clinicians and others as possible in order to attempt to
30 have the operation postponed or transferred to another centre. Professor Angelini
31 believed that the result of the report that he had written earlier that year indicated that the
32 cardiac surgeons had agreed not to undertake further switch operations. He also believed
33 that the Department of Health understood that the agreement he had reached with the
34 paediatric cardiac surgeons was that no further arterial switch operations, in any age
35 group, would be undertaken. I personally contacted the following people: --

36 Dr Sheila Willats, Vice President of the Royal College of Anaesthetists and director of
37 intensive care at the BR I.

38 Dr Peter Baskett, Past President of the Association of Anaesthetists and cardiac
39 anaesthetist at the BR I.

40 Dr Chris Monk, Director of Anaesthesia and cardiac anaesthetist at the BR I.

41 Mr Peter Doyle, senior medical officer at the Department of Health.

42 My concerns at this stage were that the child was being exposed to an unnecessary risk of
43 death on the basis of the records that were available to me from the Bristol Royal
44 Infirmary paediatric cardiac surgery unit. There had been no open review of the

1 performance of the paediatric cardiac surgery unit with specific reference to the arterial
2 switch operation, although this had been requested by all of the cardiac Anaesthetists in
3 August 1994.

4 During this time I was in contact with Mr Bill Brawn, consultant paediatric cardiac
5 surgeon at the Birmingham Children's Hospital. I had several telephone conversations
6 with Mr Brawn in an attempt to determine whether the results from Bristol were
7 acceptable or not. Mr Brawn informed me that his operative mortality rate was one death
8 in over 200 cases. The death had occurred in the first switch operation he had undertaken
9 in Birmingham and that after changing many of the procedures in that hospital he had had
10 no subsequent deaths. When I explained that I believed Mr Dhasmana's operative
11 mortality rate was > 60% for the neonatal arterial switch procedure he assured me that I
12 was correct in believing that no more arterial switch procedures should be undertaken by
13 Mr Dhasmana. I did not ask Mr Brawn if Mr Dhasmana had shared with him his actual
14 results for the arterial switch procedure.

15 Mr Brawn had been involved in the unofficial retraining of Mr Dhasmana when he had
16 visited Birmingham on two occasions with other members of staff to try to improve the
17 results for the arterial switch programme in Bristol. The response that I obtained from Mr
18 Brawn was along the lines that if Mr Dhasmana had not demonstrated his skills with the
19 neonatal arterial switch then he was not justified in undertaking the more complex and
20 technically difficult repairs in older children who had undergone previous palliative
21 surgery. The operation booked for January 1995 fell into this category and I believe I was
22 perfectly justified in raising my fears for the safety of this child at the highest levels in
23 both the UBHT and also the Department of Health. In January 1995 before the planned
24 arterial switch operation when I spoke to Mr Brawn he asked me who he had to speak to
25 at the Department of Health in order to get the operation stopped. I gave him the name of
26 Mr Peter Doyle and explained that I had already spoken to Peter on the matter but that
27 Bill's experience in the field would carry much more weight than my local knowledge
28 alone. I do not know if Mr Brawn contacted Mr Doyle.

29 At the time of the meeting that took place the day before the operation the following
30 clinicians, managers and civil servants were aware of serious problems with the arterial
31 switch programme at the Bristol Royal Infirmary.

- 32 1. Mr Peter Durie (ex-Chairman UBHT Trust Board)
- 33 2. Mr Bob McKinley (Chairman UBHT Trust Board)
- 34 3. Dr John Roylance (Chief Executive UBHT)
- 35 4. Mr James Wisheart (Medical Director UBHT)
- 36 5. Mr Peter Doyle (Senior Medical Officer UBHT)
- 37 6. Dr Jane Ashwell (Senior Medical Officer UBHT)
- 38 7. Professor John Farndon (Professor of Surgery UBHT)
- 39 8. Professor Gianni Angelini (Professor of Cardiothoracic Surgery UBHT)
- 40 9. Professor John Vann-Jones (Professor of Cardiology & Director of Cardiac Services
41 UBHT)
- 42 10. Professor Cedric Prys-Roberts (Professor of Anaesthesia UBHT & President of the
43 Royal College of Anaesthetists)
- 44 11. Professor Paul Dieppe (Professor of Rheumatology UBHT & Dean of the Clinical
45 Medical School University of Bristol)

- 1 12. Sheila Willatts (Director of Intensive Care UBHT & Vice President Royal College of
2 Anaesthetists)
- 3 13. Dr Peter Baskett (Consultant Cardiac Anaesthetist UBHT & Ex-President Association
4 of Anaesthetists)
- 5 14. Dr Andy Black (Senior Lecturer University Department of Anaesthesia & Consultant
6 Anaesthetist UBHT)
- 7 15. Dr Alan Bryan (Senior Lecturer University Department of Cardiothoracic Surgery &
8 Consultant Cardiac Surgeon UBHT)
- 9 16. Mr John Hutter (Consultant Cardiac Surgeon UBHT)
- 10 17. Mr Paul Durdy (Senior Lecturer University Department of Surgery & Consultant
11 Surgeon UBHT)
- 12 18. Dr John Zorab (Director of Medicine Frenchay Hospital Bristol & Consultant
13 Anaesthetist Frenchay Hospital)
- 14 19. Dr Hyam Joffe (Consultant Cardiologist Bristol Royal Children's Hospital & Director
15 of Paediatric Services UBHT)
- 16 20. Dr Steve Mather (Consultant Paediatric Anaesthetist Bristol Royal Children's
17 Hospital & UBHT)
- 18 21. Dr Alison Hayes (Consultant Cardiologist Bristol Royal Children's Hospital)
- 19 22. Dr Rob Martin (Consultant Cardiologist Bristol Royal Children's Hospital)
- 20 23. Dr David Hughes (Consultant Paediatric Anaesthetist Bristol Royal Children's
21 Hospital & Director of Paediatric Services UBHT)
- 22 24. Sir Terence English (Consultant Cardiac Surgeon Papworth Hospital & Ex-President
23 of the Royal College of Surgeons)
- 24 25. Mr John Parker (Consultant Cardiac Surgeon St George's Hospital & President of the
25 British Cardiac Society)
- 26 26. Ms Janet Maher (General Manager Directorate of Surgery UBHT)
- 27 27. Ms Kathy Orchard (Ex-General Manager Directorate of Surgery UBHT)
- 28 28. Ms Leslie Salmon (General Manager Associate Directorate of Cardiac Surgery
29 UBHT)
- 30 29. Dr Chris Monk (Director of Anaesthesia UBHT)
- 31 30. Dr Brian Williams (Ex-Director of Anaesthesia UBHT)
- 32 31. Salley Masey (Consultant Cardiac Anaesthetist UBHT)
- 33 32. Su Underwood (Consultant Cardiac Anaesthetist UBHT)
- 34 33. Ian Davies (Consultant Cardiac Anaesthetist UBHT)
- 35 34. Steve Pryn (Consultant Cardiac Anaesthetist UBHT)

36 ***The eve of the operation***

37 On the day before the operation was due to take place I was contacted by Dr Monk and
38 asked to attend a meeting of paediatric cardiac Anaesthetists, paediatric cardiologists and
39 paediatric cardiac surgeons at the Bristol Children's Hospital that evening. I duly
40 attended having already learnt that Dr Underwood and Dr Pryn had been completing an
41 analysis of the arterial switch procedures undertaken at the BRI. This 'audit' was
42 presented at the meeting and data from this audit was used to modify the figures
43 produced, in table form, by the paediatric cardiac surgeons.

1 The significance of this is that if the paediatric cardiac surgeons had undertaken a
 2 thorough and complete review of the arterial switch programme, at any time, they would
 3 have picked up the correction provided by Dr Prynne and Dr Underwood's data. The
 4 second significant point is that this was the first complete audit of the arterial switch
 5 programme of which I, or anyone else, had been aware. There is little doubt in my mind
 6 that this information was being presented for review for the first time. The reason for
 7 reaching this conclusion is that the data was set out to compare the performance in Bristol
 8 with the "national average" data derived from the cardiac surgical register, but with
 9 specific reference to one type of condition; the condition that was present in the child due
 10 to be operated on the next day.

11 Present at this meeting were the following clinicians:--

- 12 1) Mr Wisheart
- 13 2) Mr Dhasmana
- 14 3) Dr Joffe (consultant paediatric cardiologist)
- 15 4) Dr Martin (consultant paediatric cardiologist)
- 16 5) Dr Monk
- 17 6) Dr Masey (consultant cardiac anaesthetist)
- 18 7) Dr Underwood (consultant cardiac anaesthetist)
- 19 8) Dr Prynne (consultant cardiac anaesthetist)
- 20 9) Dr Bolsin (consultant cardiac anaesthetist)

21

22 Not present at this meeting were the following important staff: --

- 23 1) Professor Angelini
- 24 2) Dr Roylance
- 25 3) Dr Wilde (consultant radiologist)
- 26 4) Professor Vann Jones (director of cardiac services)
- 27 5) Dr Basket (consultant cardiac anaesthetist)
- 28 6) Dr Willats
- 29 7) Dr Roylance (CEO)
- 30 8) Prof Dieppe (Dean of the Faculty of Medicine)

31

32 The meeting began by discussing the data that had been produced by Dr Prynne and Dr
 33 Underwood and agreeing the correction, produced by them, to the tables produced by the
 34 surgeons. Dr Underwood and Dr Prynne then left for prior arrangements. This led me to
 35 believe that the meeting had only been convened at the last-minute and that nobody had
 36 received more than 24 hours notice of its organisation.

37 The tables produced were then used as a discussion point for the proposed operation. The
 38 mortality rates were compared and were, I believe, 20% in Bristol and 12% in the national
 39 average figure. No reference was made to data from other centres with respect to the
 40 Birmingham experience or Marc deLeval's published work with the arterial switch
 41 operation.

42 I voiced my opposition to the operation preceding the following day on the basis that
 43 there was an institutional problem in Bristol and until the reasons behind that problem
 44 had been resolved it was not safe to proceed with switch operations on any children. I had

1 recently become aware of Marc de Levals proposal to undertake research into institutional
2 factors leading to failures in operations in paediatric cardiac surgery.

3 I also argued that the operation was not an emergency operation and should either be
4 postponed until a new surgeon arrived or transferred to another centre with a better
5 operative record. I mentioned at this meeting that I had contacted Peter Doyle at the
6 Department of Health and there was an air of anxiety and disconcertion that I should have
7 taken perceived problems relating to the unit to the Department of Health. Both Mr
8 Wisheart and Dr Masey were unhappy at the communication of results, especially
9 potentially poor results, outside the unit.

10 Towards the end of the meeting Mr Wisheart, who was taking notes, asked if there was a
11 consensus from the meeting that the operation should proceed. When all the other parties
12 agreed that the operation should proceed the following day in Bristol, I asked that my
13 objection to the operation proceeding tomorrow in Bristol should be minuted.

14 During the meeting my pager and indicated I had an outside telephone call. At the end of
15 the meeting I contacted switchboard to find that Mr Peter Doyle had tried to contact me
16 and had left a return phone number. I rang Mr Doyle, who informed me that he thought
17 the operation would not be proceeding the next day because he had just had a telephone
18 conversation with Dr Roylance during which Dr Roylance had intimated that he thought
19 that the operation would not proceed. Mr Doyle did not give me the reasons for Dr
20 Roylance's belief that the operation would be postponed or transferred but was pleased
21 with the outcome of the conversation. I then informed him that I had just left a meeting at
22 which the clinicians involved had agreed that the operation should proceed. Mr Doyle
23 was surprised and undertook to contact Dr Roylance again that evening in order to clarify
24 the matter with him.

25
26 That evening I discussed with my wife the possibility of one of us going to the parents of
27 the child in an effort to persuade them to take the child to another centre. We considered
28 that the risks to our careers were too great to undertake this step.

29
30 The following day I deliberately avoided the BRI site and at around 7 p.m. I telephoned
31 the cardiac operating theatre to find out how the switch operation had gone. I was
32 devastated to hear that the operation was still proceeding but that the clinicians involved
33 had been unable to successfully separate the child from the bypass machine. I knew then
34 that the child would not survive the operation.

35
36 Gianni and I were contacted by Peter Doyle to find out what the result of the operation
37 was and to provide some explanation if possible.

38 39 ***The consequences***

40 A meeting took place between at least one senior civil servant from the Department of
41 Health, Peter Doyle, Dr Roylance and senior Trust officials in Bristol. My understanding
42 of this meeting was that the Trust was now required to undertake an investigation into
43 paediatric cardiac surgery and abide by the findings and recommendations of the
44 investigators. I believe that the Department of Health also required that the UBHT would

1 publish the resulting report to deal with the adverse publicity and disquiet that had been
2 perceived in some quarters.

3

4 ***The Hunter/deLeval report: process***

5 In February/March 1995 two investigators were appointed, who were Dr Stewart Hunter
6 and Mr Marc deLeval. They attended the Bristol Royal Infirmary and the Bristol Royal
7 Children's Hospital. There was a considerable time constraint for the investigation and
8 report, partly attributable to a holiday one of the investigators had booked.

9 They were met on the evening they arrived in Bristol by Dr Roylance and other senior
10 figures involved in the paediatric cardiac surgery service and undertook their
11 investigation the next day. I believe that these investigators were given biased and
12 incorrect information about the nature of the criticisms that were being made of the
13 paediatric cardiac surgical unit at this meeting.

14

15 I gave evidence to Mr deLeval and Dr Hunter the following afternoon in a room in the
16 Bristol Eye Hospital. I provided the investigators with the best evidence that I had to date
17 of the results of the paediatric cardiac surgery Department. This included: --

- 18 1. The Bolsin/Black data collection and analysis
- 19 2. The most complete record for the arterial switch procedure available
- 20 3. My data on the neonatal and non-neonatal arterial switch record
- 21 4. The unit's data from the annual report of 1990-91

22 Mr de Leval immediately looked at the data from the annual report and began a very
23 hostile interrogation concerning the definitions included in that data. My response was to
24 wait for the end of the tirade of hostile questions about who had defined major and
25 intermediate operations and where the data had come from before I continued.

26

27 I explained that the data produced in that report had come from the paediatric cardiac
28 surgeons (probably Mr Wisheart) and that I had nothing to do with its generation.
29 However the data did indicate that there was a problem for major paediatric cardiac
30 surgery in Bristol. At this point it became apparent to me that Mr deLeval and Dr Hunter
31 were now considering the possibility that there was a problem with paediatric cardiac
32 surgery in the Bristol Royal Infirmary for the first time. Having been confronted with
33 evidence generated within the unit by the paediatric cardiac surgeons themselves the two
34 investigators were now prepared to take seriously the evidence from other sources that
35 there may have been a problem with the performance of paediatric cardiac surgery in the
36 Bristol Royal Infirmary for some considerable time.

37 The two investigators also took evidence from Professor Angelini, Mr Dhasmana, Mr
38 Wisheart, Dr Prynne, Dr Hughes, Mr Barrington, sister Thomas and others.

39

40 ***The Hunter/deLeval report: results***

41 The report was produced in a relatively short time but was not distributed within the
42 Hospital. The only mechanism for viewing the report was to arrange with either Mr
43 Wisheart or Professor Vann Jones to go to the Trust headquarters, sit in one of the offices

1 with the director concerned while the report was unlocked and placed on the desk in the
2 office. Professor Vann Jones explained when I went to see the report that I was not
3 allowed to bring a camera into the room.

4
5 The copy of the report that I saw had pencil writing on the first page with the phrase
6 "damage limitation". The writing appeared to be that of Mr Wisheart. The report
7 indicated that there had been problems with the provision of paediatric cardiac surgery at
8 the Bristol Royal Infirmary and indicated actions that needed to be taken in order to
9 address this issue. Several specific phrases were important. These were: --

- 10 1. "...surgeon 1 [Mr Wisheart] must be seen as a higher risk surgeon.."
- 11 2. "...Mr Wisheart will cease operating on paediatric cardiac surgery patients..."
- 12 3. "...Mr Dhasmana will need to undertake retraining for the material switch
13 procedure..."
- 14 4. "...no further arterial switch operations should be undertaken until the arrival of
15 the new surgeon..."

16
17 There were two evening meetings of the cardiac surgical and cardiac anaesthetic group, at
18 which the report in it's original version was discussed. Those present at these meetings
19 included: --

- 20 1. Mr Alan Bryan
- 21 2. Professor Gianni Angelini
- 22 3. Mr James Wisheart
- 23 4. Mr Janardan Dhasmana
- 24 5. Dr Chris Monk
- 25 6. Dr Sally Masey
- 26 7. Mr John Hutter
- 27 8. Dr Sue Underwood
- 28 9. Dr Peter Wilde
- 29 10. Mr Graham Nix
- 30 11. Myself

31
32 The meetings were chaired by Mr Bob McKinlay, chairman of the UBHT Trust Board.
33 The meeting agreed the contents of the report, approved the findings of the report and
34 agreed the implementation of the conclusions. There were no objections made by any
35 staff to the more outspoken claims of this report. At the end of the second meeting Mr
36 McKinlay asked me directly if I was happy with the findings of the report; my reply
37 indicated that I was happy with the report. He then asked me directly "No more secret
38 audits then?" My response was that my audit was never secret.

39
40 When the second meeting in the Trust headquarters broke up I was approached by
41 Graham Nix, who was the acting Chief Executive of the Trust. He asked me if I felt that
42 the meetings had been fair and represented my opinions adequately and then went on to
43 advise me that if I felt that at any stage the Trust, or its employees, were in any way
44 discriminating against me then I should come and speak to him. He did not appear to
45 want to elaborate on this suggestion and as it was late I was keen to leave anyway. Mr

1 Nix gave no reason for this comment and even when I was leaving the Trust did not
2 explain his reasons for making it.

3
4 When Dr Roylance returned from his holiday he immediately stopped the circulation and
5 reading of the first report and insisted that the report was an interim document, which
6 would be used as a draft from which a final report would be produced. The next report
7 that was produced under the heading of the "Hunter/deLeval report" was a much more
8 benign document. The references to a "higher risk surgeon" and other criticisms of the
9 current service had been removed and a statement inserted inferring that the criticisms of
10 the service made by the anaesthetists had led to the high mortality by undermining the
11 confidence of the cardiac surgeons.

12 An extraordinary meeting of the hospital medical staff was arranged at which Dr Gabriel
13 Lazlo and Dr Hyam Joffe both spoke. There were no implied criticisms of the
14 Department of Anaesthesia or me personally at this meeting.

15
16 When I read the revised report I immediately asked for an appointment to see Dr
17 Roylance to explain my unhappiness with this conclusion and the removal of the critical
18 elements of the first report. I requested that Dr Roylance, through the Trust public
19 relations office, should issue a statement on my behalf (as an employee of the Trust) and
20 that this should document my disagreement with the second report and make reference to
21 the first report. Dr Roylance was not prepared to do this.

22 The second report was made public by the Trust and the local BBC television station
23 wanted to make a News documentary about the issues raised in the report. I was asked to
24 participate and Dr Roylance agreed that he could not stop me from participating but he
25 advised against it.

26 27 ***Contractual changes as a result of the Report***

28 At this time I arrived for work in the cardiac theatres one morning to find that Dr Masey
29 was also working in my theatre. When I asked what the explanation was she informed me
30 that I had been rostered to undertake her general surgery list while she did my cardiac
31 surgery list that day. When I clarified this with Dr Monk, the director of Anaesthesia, he
32 explained that the surgeons had been unwilling to continue working with me as a result of
33 the issues arising from the paediatric cardiac surgery service. He then asked me if I
34 would agree to a temporary change in my work arrangements to accommodate the
35 sensitivities of the cardiac surgeons. I agreed that this could be done on a short-term basis
36 but that my reputation, nationally and locally, as an adult cardiac surgeon required that I
37 rapidly restore myself to 2 days of adult cardiac surgery each week. Dr Monk agreed that
38 this would happen when sensitivities on all sides had settled.

39 After several weeks of the new arrangement I told Dr Monk that I wished to return to 2
40 full days of cardiac Anaesthesia each week and that I had contacted the BMA locally and
41 they were advising me that I was within my rights in making this request.

1 ***Further threats to my employment***

2 Within a few days I was contacted by Dr Monk, who asked me to attend a meeting with
3 him one afternoon. The meeting took place in Professor Prys-Roberts office and was
4 attended by Dr Monk, Dr Trevor Thomas, Professor Prys-Roberts and myself. Dr Monk
5 presented the view that there were perceived difficulties with the staffing of paediatric
6 and adult cardiac surgery. These were being contributed to by my request to maintain my
7 adult cardiac surgical workload at two days per week. The situation that Dr Monk wished
8 to communicate to me was that if I persisted with my request to maintain two days of
9 adult cardiac surgery per week the Trust would consider that it was more likely to be able
10 to dismiss one cardiac anaesthetist than two cardiac surgeons.

11 I was shocked to hear this projection of Trust Board thinking and offered the information
12 that nobody needed to be dismissed; all that was required was that I was allowed to work
13 to my contract. Dr Thomas put forward, more firmly, the situation that it would be much
14 easier for the Trust to dismiss one anaesthetist over his contractual arrangements than it
15 would be for the Trust to dismiss without previous disagreement two cardiac surgeons,
16 one of whom was very senior in the Trust management.

17 I protested that the problem in cardiac surgery and cardiac Anaesthesia was not related to
18 my contract but was more related to the ability to perform paediatric cardiac surgery.
19 This issue had been pursued half-heartedly by the Trust and the paediatric cardiac
20 surgeons (not the paediatric cardiac anaesthetists) had been criticised in an independent
21 report. I did not believe it was appropriate for the Trust to then threaten to dismiss a
22 cardiac anaesthetist because of sensitivities expressed by two of the cardiac surgeons.
23 Professor Prys-Roberts, in partial defence of my position, indicated that while he believed
24 it was unfair of the Trust to take that stand he could understand why they might want to
25 do that because of the history and involvement of personnel, especially the paediatric
26 cardiac surgeons.

27 This meeting represented an undeniable threat to my employment at the Trust and given
28 the two threats issued by Dr Roylance to myself and Dr Coates in the preceding weeks I
29 was now well aware of the Trust's attitude to my continuing employment with them. It
30 now became a matter of considerable importance to me that I should leave the UBHT and
31 find alternative employment.

32
33 ***Job applications***

34 However it now became clear that I had should leave the Trust and apply for any posts
35 that were available. The next post that I applied for was in Southampton as a cardiac
36 anaesthetist but I was also unsuccessful. The post was interviewed in late 1995 and my
37 main contact in Southampton at that time was Dr David Smith, Consultant Anaesthetist
38 and Senior Lecturer in anaesthesia at Southampton General Hospital. Dr Smith was a
39 Cardiac Anaesthetist and therefore very interested in the appointment being undertaken. I
40 had known David since my time in London as a registrar in the early 1980s when we had
41 worked together in UCH, the Brompton Hospital and on other rotations. Dr Smith had
42 then become a senior registrar in Bristol before taking a post in Glasgow.

43 David and a colleague had collected several hundred data sets for the ACTA data
44 collection that I had set up as the National Audit Coordinator for that association. When

1 he wanted to move back to a cardiac post in England I had provided extra references for
2 him in the Southampton post.

4 **Further publicity**

5 By April 1995 and with no apparent change in the paediatric cardiac service ensuing from
6 the preceding years one of the options I discussed with a friend was to alert the national
7 newspapers to the events in Bristol. The requirement of the newspaper in these
8 circumstances would be for someone to provide the newspaper with confirmation of the
9 story and if necessary documentation of the story. One afternoon I was contacted by an
10 employee of the Daily Telegraph and asked to comment on the 'Bristol story' with respect
11 to the events in paediatric cardiac surgery. The details recounted to me were well known
12 and had been circulated within the Trust. I was asked for a comment and replied that they
13 seemed to have most of the story.

14 That evening my wife and I were watching 'Newsnight' when we saw the headlines of the
15 Daily Telegraph, which indicated that >100 children had died in Bristol of Heart surgery.
16 I immediately phoned the Daily Telegraph newspaper and asked to speak to the author of
17 the article. I explained that I thought that they had gone further than the information they
18 had given me and I was concerned for my own position. I was told that the good news
19 was that the headline had only been used in the early editions but the bad news was that
20 the early editions were sent to Scotland and the West Country.

21 I asked for an appointment to see Dr Roylance that morning. When I spoke to Dr Roylance
22 and explained my position he seemed understanding and certainly not too angry with the
23 report. As I left this meeting Dr Roylance said something I will never forget. As he
24 opened the door for me to go out he said.

25 "You know something Steve? Your problem was you were too young and you were
26 right."

27 I knew what he meant and I was curious why it had taken the Chief Executive so long to
28 come to this conclusion. Also how long had he known this and why had he not dealt with
29 the issue. Youth was not a barrier to knowledge or action.

31 **Subsequent reports**

32 In 1996 I was contacted by Dr Andy Wolf about a problem in the paediatric cardiac
33 surgery unit. The workload for the new unit, with the new surgeon, was high and the level
34 and intensity of the work was very demanding. Dr Wolf and the paediatric cardiac
35 anaesthetists with intensive care interests wanted extra staff to provide the correct level of
36 cover and were negotiating to reduce their non-cardiac commitments. At one of the
37 meetings arranged to discuss this issue with Dr Monk, he suggested to the paediatric
38 cardiac anaesthetists that they should accept a lower standard of care, in the form of a
39 higher mortality, and not spend so much time on the paediatric cardiac ICU.

40 I found this attitude absolutely incredible and stunning after all the events that the unit
41 had been through in the recent past. I immediately drafted a letter to Dr Monk expressing
42 my surprise but was asked by Dr Wolf not to send the letter. This failure to learn simple
43 lessons about patient care and complete lack of understanding of the nature of the clinical

1 commitment to excellent patient care is typical of the attitude of the medical managers at
2 the UBHT. It comes as no surprise to me to hear that Dr Monk is now a Deputy Medical
3 Director of the UBHT.

4
5 Dr Wolf, director of Anaesthesia at the Bristol children's hospital, has told me that there
6 has been a persistent mortality rate attributable to "curative procedures" such as the
7 arterial switch procedures undertaken at the Bristol Royal infirmary prior to the
8 appointment of Mr Pawade. Mr Pawade has on some occasions, when operating on
9 children previously operated on by other surgeons at the Bristol Royal infirmary, found
10 that the anatomy has been difficult to elucidate and has not borne any resemblance to that
11 described in the previous operative notes. This indicates that the legacy of paediatric
12 cardiac surgical programme prior to may 1995 continues and will continue for some time
13 to come.

14 ***Other issues***

15 The issue of private practice had some impact on my decision not to stay in Bristol. The
16 number of cardiac surgery cases being referred to me had diminished in the 1990s and I
17 believed that this was related to the fact that I was criticising the paediatric cardiac
18 surgery service at the BRI.

19 I was also informed by a surgeon, with whom I undertook private cases, that he had been
20 approached in 1995 by a member of the Trust Board of the UBHT and asked not to refer
21 private cases to me. The surgeon indicated (although he did not mention the Trust board
22 member by name) that the person in question was a medically qualified member of the
23 Trust Board, and not John Roylance. I asked the surgeon if this meant it was Mr Wisheart
24 and I was not corrected.