Statement of Dr Stephen Bolsin to the Bristol Royal Infirmary Public Inquiry.

The statement will confine itself to the evidence for block 3; relating to issues B & H from the issues list.

Issue B1

a) The services offered on the BRI site consisted of all paediatric cardiac surgical operations requiring open-heart surgery and cardiopulmonary bypass. At the time of my commencement in 1988 the paediatric cardiac surgery service did not offer arterial switch operations but concentrated on the Senning procedure, for which the in hospital mortality rates were reasonable compared to the national average standard. During 1989 the unit commenced arterial switch operations, which I believe was to maintain a favourable comparability with other supra-regional and non-designated paediatric cardiac surgical centres. The unit did not undertake operations for hypoplastic left ventricle (Norwood's procedure) or other new complex operations (Kuono procedure).

b) The services were funded on the basis of supra-regional paediatric cardiac surgical designation and the funds flowed directly from the Department of Health. During my time in Bristol other centres (Southampton, Leicester and others) applied for supra-regional paediatric cardiac surgical designation and there was competition to retain the funding associated with this designation. I believe that to have suspended an arterial switch programme in this competitive environment would have cost the unit a considerable amount of top-sliced funding. This put considerable pressure on the unit to provide advanced services (including the arterial switch procedure) and may well have contributed to the excessive mortality in the operations undertaken.

c) The organisational set up would best be described under Classical Management theory as an internalised structure with classical hierarchical arrangements. Power devolved from seniority within the organisation and proximity of association to committees of management. Essentially change could only be approved by senior members of the organisation and these were the senior cardiac surgeon and the director of anaesthetics. If these individual clinicians were not committed to a process of change or improvement the process would inevitably founder. The internal nature of the organisation allowed it to ignore external pressures from the Royal College of Surgeons, the Department of Health, the District Health Authority and the Regional Health Authority. Communication was very difficult in the circumstances and required tacit approval from the specialty director for cross specialty approaches.
Accountability for the service was exercised through the director of the service but for paediatric cardiac surgery the responsibility and accountability for results resided entirely with the department of paediatric cardiac surgery and the two paediatric cardiac surgeons. I am not sure that the paediatric cardiologists were involved in systematic audit processes relating to cardiac surgical outcomes; it is not clear that they necessarily wanted to be involved. There was little scope for non-medical expression of interest or concern in the outcomes the unit was achieving; there was certainly no directed interrogation of the nursing body to gain opinions or input into decision-making processes. Managers in this system were required to provide services for the surgeons (and anaesthetists) but were not empowered to take any clinical responsibility and were certainly not encouraged to do so.

d) The reorganisation of the hospital at the time of Shadow Trust and Trust status led to joint clinical and managerial meetings at which senior nursing staff were also present. The managerial issues discussed at these meetings related mostly to funding opportunities/restrictions and cost-

effectiveness measures. These meetings were almost entirely consumed with budgetary and strategic managerial issues. Outcomes and audit were not considered at these meetings.

e) The major throughput of cardiac surgical cases on the BRI site was related to adult cardiac surgery. In 1988 3 paediatric cardiac surgical cases each week would be undertaken compared to 12 adult cases. The intensive care unit provided care for both adult and paediatric patients and some of the intensive care nurses had paediatric training. The anaesthetists providing paediatric cardiac surgical Anaesthesia had all undertaken extensive training at centres providing paediatric cardiac surgery and were involved in the management of the patients in the postoperative period. Unfortunately the unit was managed on a day to day basis by the most junior cardiac surgical staff who did not necessarily have such experience but remained the key decision makers. Initiating changes in the care processes on patients on the intensive care unit required the approval of the junior surgical staff who would discuss changes with surgical consultants who were not present on-site. I'm sure that this indirect chain of command led to sub-optimal care delivery on numerous occasions. This chain of command was also criticised by the de Leval and Hunter report. These junior surgeons were also not skilled in counselling relatives on the expectation of adverse outcomes or serious disability. This led on more than one occasion to relatives being told that a normal recovery was occurring when actually a catastrophic event had taken place, about which the parents should have been informed.

f) The numbers of nursing staff allocated to the unit were generally satisfactory and I believe that the staff were adequately trained although not all the intensive care nurses had paediatric experience. There was a major lack of cardiological experience available to those managing patients on the intensive care unit and there was no regular participation of the paediatric cardiologists in the management of patients on the intensive care unit.
The fact that surgeons operating at another institution were making critical care decisions about patients in another hospital without being present at the bedside compromised patient care. The intensive care skills and experience of the senior anaesthetic staff were not always well accessed and could have contributed to improvements in the level of care offered to paediatric patients on the intensive care unit. The surgeons were very reluctant to relinquish control of these patients and retained the right to reject advice from other specialties.

g) I believe that these were normally those that applied to NHS structures at that time. I believe that

g) I believe that these were normally those that applied to NHS structures at that time. I was aware that in 1990, after I had written to doctor Roylance, that Mr Wisheart indicated that if I wished to stay practising in Bristol I should not take criticisms of the cardiac surgery unit to others outside the unit. As a young consultant this threat had a significant impact on my future dealings with issues of this sort; I did not express my concerns to Mr Wisheart subsequently.
In 1994 I was asked to attend a meeting with Professor Prys-and Roberts, doctor Trevor Thomas and doctor Chris Monk in Professor Prys Roberts office in the University Department of and Anaesthesia. Dr Thomas and doctor Monk put forward the view that the Trust had a problem with an anaesthetist and two cardiac surgeons; the Trust was not prepared to discipline or remove the cardiac surgeons; therefore unless the anaesthetist (irrespective of the rights and wrongs of the situation) complied with the request of the Trust to alter his work patterns the Trust would have to constructively dismiss the anaesthetist. While Professor Prys-Roberts agreed with the logic of the Trust's position he did not necessarily agree with their stand.
In 1994 I was asked to see doctor Roylance in his office and towards the end of the conversation he used an analogy to illustrate my position. He explained that the new chairman of the Trust board (Mr Bob McKinlay) had worked in the aircraft industry. I had recently had a patient under my care

who had received an incompatible blood transfusion; although a recent coronial inquiry had exonerated my involvement. Dr Roylance explained that the hospital was in the process of negotiating compensation for the patients relatives and that in the aircraft industry if a worker these paid to bolt the blades on a helicopter and the blades fall off and passengers are injured, then that worker never vaults the blades on helicopters again. This very potent threat to a junior consultant from a chief executive was repeated later that week to doctor David Coates, who was the British Medical Association place of work accredited representative (POWAR), and became the next director Anaesthesia. Doctor Coates provided me with a transcript of the conversation he had had with doctor Roylance because he was very concerned about this implicit threat to my employment. He also passed on copies to the local office of the British Medical Association.
In 1995 I was advised to attend counselling sessions with the director of psychiatry and a consultant psychiatrist working for the Trust. The purpose of the contacts was to attempt to reconcile the differing opinions betraying myself and the cardiac surgeons concerning the outcomes for paediatric cardiac surgery.
I do not believe that any of these meetings, which were probably not of a disciplinary nature, have been recorded on my work record.

h) They were very little counselling and support structures in place for consultant staff in the NHS at that time. At the time I was being investigated for a potential manslaughter charge by the Avon and Somerset Constabulary I did contact the staff health clinic and was reassured about my mental approach to the problem.

i) The Department of Anaesthesia had close links with the University Department of anaesthetics which was housed in the same building. I also develop close links with the University Department of cardiothoracic surgery and with Professor wrench leaning and his first senior lecturer Mr Alan Bryan.
In expressing my concerns about the paediatric cardiac surgical programme I contacted Professor Van-Jones (director of cardiac services and University Professor of Cardiology), Professor John Farndon (University Professor of surgery) and Professor (university professor of rheumatology). Prior to contacting these professors I had already spoken to Professor Prys-Roberts and Professor Angelini. I believe that all these University Department heads made contact with senior managerial staff in the hospital.

j) I spoke to all of the managers responsible for the cardiac surgery service at The Times that they were involved with this service and I understand that they made representations to their immediate superiors. These managers included Ms Leslie Salmon and others including the divisional managers of the directorate of surgery. I cannot remember all of their names.

k) I had no experience of these activities.

B2
see B1 b) above. There were no managerial changes associated with supra-regional status.

B3
The formation of the UBHT in 1991 confirmed the post holder's appointed to posts in the shadow Trust. In effect this confirmed the original hierarchical power structure and removed recourse to district and regional levels of involvement. The Trust was now solely responsible to the Secretary of State for Health through the Department of Health centrally. The impression created by this political move was that Trusts were a very good thing and that those who criticised Trusts were in

effect making an implied criticism of government. At that time such criticism was not well tolerated and this impression was certainly promulgated locally in Bristol.

B4
The fact that supra-regional paediatric cardiac surgical services were funded directly by the Department of Health meant that the loss of such status would incur significant losses to the institution. This mentality effectively ensured the continued operation of a sub-standard service for many years resulting in many unnecessary deaths of children.

B5
a) I kept a personal record of all the paediatric cardiac surgical cases I undertook in order to elucidate the true morbidity and mortality for the operations I was involved in. Occasional audit meetings occurred and in one of the early meetings mortality was examined for the tetralogy of Fallot operation. The minutes produced of this meeting were not acceptable to Mr Wisheart and I was advised not to keep minutes of audit meetings in future. Subsequent to that meeting mortality was not discussed in a meaningful fashion at subsequent meetings.
b) The issue of quality of care was not significantly addressed within the unit.
c) The issue of professional competence was not addressed meaningfully within the unit although I discussed the possibility of poor professional performance with a representative of the medical defence union (in 1993), with the Department of health (in 1993 and 1994), indirectly with the Royal College of Surgeons (in 1992), with the President Elect of the Royal College of Anaesthetists (in 1992) and with the Chief Executive of the UBHT (in 1995).
d) budgets were run in an efficient manner but were not allowed to impact on examination of clinical outcomes or adverts events.

B6
Some individual protocols were introduced to improve the management of specific conditions eg post-operative pulmonary hypertension.

B7
Clinical records were occasionally reviewed and some recommendations made. The nursing staff redesigned some of the intensive care unit forms in the 1990s. The formal documentation of decision-making processes within the intensive care unit was not a high priority. Anaesthetic ward rounds were often documented in the clinical care notes by the anaesthetic registrar involved in the management of the unit.

B8
I have little knowledge about this aspect of management in the hospital.

B9
I do not believe that this information was routinely made available to any of the groups mentioned in this heading.

B10
I do not have any specific information on this heading.

B11
I do not believe that there were any specific structures or mechanisms available to staff members to raise such concerns and I certainly attempted to raise clinical and managerial issues across a range of fora. There were obviously significant limitations to any mechanisms available to staff members

expressing such concerns. There were no mechanisms for securing action on the basis of clinical or managerial issues of concern.

B12

a) There is little doubt in my mind that significant power accrued to Mr Wisheart in occupying the posts of:-

1) Medical Director of the Trust
2) Chairman of the Hospital Medical Committee
3) Associate Director of cardiac surgery
4) Senior paediatric cardiac surgeon.

This allowed Mr Wisheart to control the flow of information and criticism and to stifle any efforts made by others to investigate, uncover or address the performance issues. Mr Dhasmana as a junior consultant appointed by Mr Wisheart was probably significantly indebted to Mr Wisheart and was extremely unlikely to expose his senior colleague. At the same time Mr Dhasmana was also providing a level of service which was significantly worse than other services in the country. The paediatric cardiologists were a separate group on a separate site and had little interaction with the anaesthetists or theatre and intensive care nurses. They were equally committed to the preservation of supra-regional service designation and were unlikely to seriously question their surgical colleagues. Nurses were significantly disempowered in this model structure and were not able to achieve change in their own right. Other professional groups including managers were also not able to achieve change without the intervention of medical colleagues. Managers were not sufficiently empowered to be able to address clinical issues authoritatively with clinicians. Even senior managers were reluctant to examine clinical performance or advise on methods of improvement.

The anaesthetists were expressing concerns consistently over a long period but the director of Anaesthesia appears to have been reluctant to communicate these concerns to Mr Wisheart. I know that in 1990 (after my letter to Dr Roylance) Doctor Brian Williams, who was then the Director of Anaesthesia agreed to take the concerns of the cardiac anaesthetists about the performance of paediatric cardiac surgery to Mr Wisheart. He was to be assisted in this role by Doctor Chris Monk, who at that time was the cardiac liaison anaesthetist and became the next Director of Anaesthesia.

b) The managers were seen as subservient to clinicians; the nurses were in a similar role; the anaesthetists were allowed some independent practice but deferred to the cardiac surgeons; senior management was accountable to no one.

c) There was loyalty within staff groupings and also between staff groupings. The paediatric cardiologists would have identified more closely with the paediatric cardiac surgeons then with the paediatric cardiac anaesthetists. The nurses probably identified more strongly with the paediatric cardiac surgeons than with other groups and there were historical and command issues related to this. The managers were employed in the associate directorate of cardiac surgery and therefore were primarily responsible to the cardiac surgeons. There was no managerial assistance to the Department of Anaesthesia so it was difficult to seed concerns over paediatric cardiac surgery into a managerial stream through the directorate of Anaesthesia.

d) Leadership was not a key feature of the Bristol Royal Infirmary or the UBHT. Teams were formed in the operating theatre on an ad hoc basis depending on the workload of the day. I formed an effective research team, which worked in cardiac theatre and provided scientific papers and interest for the other professionals in the operating theatre. As an attempt to improve the poor morale in the cardiac operating theatre suite I created a clinical directorate of fun, which was

unbudgeted, with no resources but allowed professionals working with me to achieve a high standard of practice in a reasonable environment. On the days that I was working in cardiac theatre nurses, perfusionists, and theatre porters would express the desire to be working in my operating theatre were the atmosphere and mood were much better than in the other cardiac theatre. Communication between members of staff on the day-to-day matters were reasonably good and certainly the professional management of individual cases was effected by adequate communication. However communication about the core problems of the unit was difficult to achieve and I raised these problems on only a few occasions with surgical colleagues. However I did continuously and very effectively raise the issues with two Directors of Anaesthesia and the other people referred to above. I also communicated my concerns to the following surgeons:-
Mr Roger Baird (senior vascular surgeon BRI)
Mr Patrick Smith (senior urological surgeon BRI)
Mr John Hutter (cardiac surgeon BRI).

e) The responses to poor performance by different members of staff varied. The nursing staff were largely unable to contribute any thing other than a sympathetic response but felt powerless to achieve any constructive change. Surgical staff may or may not have approached Mr Wisheart; the evidence suggests that many did but that he was capable of thwarting any attempts at review. Anaesthetic staff agreed that change was required but disagreed over the pace of change and two clinical directors agreed to deal with the issue with Mr Wisheart.

f) I did not receive or hear of many complaints of poor service or care from patients during this period.

g) The response to Gianni and me was essentially a very hostile one. Apart from the threats issued (detailed above) my Consultant job programme was altered in order to reduce contact between myself and the two paediatric cardiac surgeons. Only when I complained that as a national cardiac surgeon I needed to maintain my cardiac surgical practice was I able to restore my original job programme but with altered days of practice. This led to considerable hostility from Dhe director of Anaesthesia (Chris Monk) and I was forced to contact of the BMA concerning the issues involved. I was also told to engage in a counselling process details of which are given above.
I was also advised by surgeons in the Bristol area that at least one member of the UBHT board had asked a surgeon not to refer private practice patients to me. I believe that this demonstrates the level to which the UBHT was prepared to go in order to marginalise me as an individual Consultant and make my life as unpleasant as possible.

B13
In general the structures and attitudes within this organisation were out moded and archaic. The absolute belief in the priority of the surgical process and the fact that results were above review represent attitudes that have been largely replaced in all professions and by most organisations dealing with the general public on a day-to-day basis.

Issue H1.
It is undoubtedly true that for some of the patients operated on at the BRI the existence of a split site contributed to a reduce quality of care. For many of the patients the existence of the split site did not significantly impact on the quality of care. Caring for children in hospital in wards with both children and adults is not considered to be ideal. All the children in the BRI cardiac surgery unit were operated on under these circumstances although concessions were made where possible

in the form of nurseries and play room areas. The intensive care unit and high dependency unit could not be modified in this way.

The lack of availability of paediatric cardiologists in the management of patients following paediatric cardiac surgery was a major issue for those patients in a critical condition after surgery. The availability of be applicable opinion is, paediatric advice and angiography would undoubtedly have improved the outcome for some of the patients but was not required on a routine basis. One aspect of the split site which I believe is very important was that the paediatric cardiologists were not confronted on a day-to-day basis would be failures and "near misses" of the paediatric cardiac surgical service. Effectively this prevented a quantitative day-to-day audit from occurring in practice for these clinicians. The geographical separation of the referring physicians from the consequences of their referrals provided a degree of installation from reality which contributed to the preservation of a fatally flawed service.

H2

there was very little communication collaboration between the intensive care unit at the BRI and the children's hospital. The anaesthetists managing the intensive care unit at the children's hospital did not undertake operating lists at the BR I although they were part of the same directorate of Anaesthesia. Children were transferred between the two sites in certain circumstances. Children requiring open-heart surgery at the BRI but admitted to the children's hospital on the intensive care unit would be transferred by ambulance on the day of surgery. Children recovering from paediatric cardiac surgery at the BRI would be transferred by ambulance to the children's hospital when their condition was stable. This was inevitably decided by the surgeons in conjunction with the children's hospital intensive care unit.

H3.

The response of the clinicians to the problem of split site was to play down the disadvantages caused by such an arrangement. The management believed that the cost of integrating the two sites would be too great to contemplate in the near future and were not given any reasons to urgently reorganised paediatric cardiac surgical services. One of the reasons given by Mr Martin Elliot in not accepting the chair of paediatric cardiac surgery in Bristol was the lack of commitment of management to a split site for paediatric cardiac surgical services.
Satement ends

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