

The BRI inquiry into paediatric cardiac surgery in Bristol (1984-1995)

Name	Mrs K ARMSTRONG
Address	c/o Theatres Bristol Royal Hospital for Sick Children St Michael's Hill Bristol BS2 8BJ
Occupation	Cardiac Sister

Introduction

1. This statement is made in response to the Inquiry's request for my comments on Issue N. It supplements my earlier statements concerning "Block 4" evidence, and Issues B and H. I use the word "concern" in its ordinary meaning, not as meaning "unacceptably poor" outcomes.

Issue N: The Expression of Concerns**Issue N1: The parents' perceptions, both positive and negative, of the treatment and care received by their children, including:**

- a. the nature and form of any concerns that may have been expressed;**
- b. the persons to whom they were conveyed; and**
- c. the responses to any such concerns**

2. The only time I saw parents was when they accompanied their child to the anaesthetic room and, on occasion, briefly when the child was handed back to ICU on Ward 5. When parents are with their child pre-operatively in the anaesthetic room, concern is naturally always for the child. I have no recollection of any such views or concerns as are the subject of this Inquiry being expressed by parents at that time. The general concern parents felt arose out of the situation and impending surgery on their child, just as for any operative procedure, for any patient.

Issue N2: The concerns expressed about the quality or adequacy of paediatric cardiac surgical services by Dr Stephen Bolsin; the nature of those concerns; to whom they were expressed, and when

3. As a theatre nurse at the BRI during the relevant period, I was concerned by each child who failed to survive the complex paediatric cardiac surgery performed by the two consultants at the time, Mr Dhasmana and Mr Wisheart. My “concern” was a human response to the death of each child. It was extremely difficult scrubbing for a surgical procedure where a child was involved when, by virtue of the complexity of the cardiac surgery, the child’s chances of survival might be poor and yet we had to try to operate successfully. It was very depressing to work in an environment where children were dying. You always hope that every patient will survive and recover from every procedure. It was my job to work in that environment, and I accepted it. I simply got on with my job, unaware that there was any particular significance in the number of poor outcomes for paediatric cardiac surgery. My “concern” at that stage was a sense of regret that these children did not survive.
4. The first memory I have of any concern being raised about the poor outcomes on the paediatric cardiac surgery at the BRI came from Dr Stephen Bolsin. As noted in my “Block 4” statement at paragraph 3, I worked with Dr Bolsin. He often discussed informally in the anaesthetic room different issues that interested him. For example, if he had seen an article in the BMJ, or information about any work that he was doing. Informal discussions of this nature happened all the time with Dr Bolsin. They would often take place after Dr Bolsin had set up the anaesthetics for an operation in theatre, whilst I readied the anaesthetic room for the next patient to be prepared for surgery. My mind would be concentrating on the task in hand, as well as listening to the comments that Dr Bolsin was making.
5. At some time in 1992 (I do not recall the specific time) Dr Bolsin began to comment on the difference between the outcomes of paediatric cardiac surgery at the BRI, and outcomes at other units. He showed me results of the switch operations and also

AV canal repairs from several units. I believe this research also looked into Fallots Tetralogy, but at this stage I cannot be sure of this. As Dr Bolsin had previously worked in London, I believed the data had been gathered from the London hospitals (i.e the Brompton and Great Ormond Street Hospital). Dr Bolsin told me that the research data showed that the outcomes of procedures carried out at the BRI fell below the results of the other centres in the study. Dr Bolsin also showed me results and data he had collected concerning the AV canal procedure. I cannot now recall what the findings showed.

6. From 1992, I was aware that Dr Bolsin raised his concerns about outcomes informally with nurses, anaesthetists and other clinical staff. This was by way of sharing data "in passing", as well as making informal and general comments in the coffee room near the cardiac theatres. In the early stages I had the impression that these comments and results were passed on to us out of interest, rather than specifically wanting us to do something about them, or to look further into the situation. All "concerns" at this stage were raised whilst working in theatre. It is difficult now to be precise about dates or the details mentioned by Dr Bolsin. I recall that Dr Bolsin spoke to me quite often, as he did with everyone.
7. I have clearer memories of conversations around the time when Mr Martin Elliott came from London to look at the paediatric surgical Professor's position. Following this Professor Angelini took an adult cardiac surgery post instead. I am advised that this occurred towards the end of 1992, but I was unable to recall the date.
8. As I recall, the nature of Dr Bolsin's concerns were that too many children had died following complex paediatric cardiac surgery, and that this was related to the length of time the surgery was taking, time on bypass, and the difficulty this caused with then getting the child off bypass successfully.
9. As previously mentioned I had had "concerns" about each child who did not survive paediatric cardiac surgery, but until Dr Bolsin raised the suggestion that this may

have been due to something other than simply the condition of the child, I had no knowledge or suspicion that these outcomes might be in any way unacceptably poor.

10. There was a period between 1992 and 1994 when, with Dr Bolsin's concerns gathering momentum, I became increasingly worried about the surgery being performed. I dreaded seeing complex paediatric cardiac surgery scheduled when I was due to scrub. Theatre staff had been told for some time that a paediatric cardiac surgeon was to be recruited, and that the children's services would move to the Bristol Children's Hospital. The combined effect of these two aims meant that we were reassured that our concerns would be only in the short term, and that whatever concerns we did have, clinicians and management were endeavouring to sort things out through those two developments. I certainly felt that matters were in hand to resolve general concerns over the paediatric cardiac surgery service. There was little else to be done from a nursing perspective.
11. I understand now that Dr Bolsin continued to express his concerns to others after 1994. I was not aware of the details, although Dr Bolsin became less vocal about his concerns after this. I assumed that this was because the situation was then being investigated.
12. The reassurance began to wain when the prospect of a paediatric cardiac surgeon being recruited seemed further away after Professor Angelini came instead of a paediatric cardiac surgeon. The move to the Bristol Children's Hospital also seemed quite distant. As time passed, theatre staff felt that something more positive had to be done to address the concerns about the service. As a result, in the middle of 1994, myself and other theatre nurse colleagues stopped scrubbing for complex paediatric cardiac surgery cases. Out of approximately 9 members of staff, only 2 nurses, Alison Reed and Onyx Berwin, would scrub for children's cardiac theatre. At that time I felt very let down as, at some point during 1994, both Mr Wisheart and Mr Dhasmana had been stopped from performing complex heart surgery. The theatre staff thought this meant all children but yet more children appeared on the

operating schedule. I later found out that they had only been stopped from operating on neonates.

13. One particular case, that of Joshua Loveday, did cause grave concern. It was, I believe, the turning point for the paediatric cardiac surgery work at the BRI.
14. At the time when Joshua Loveday was due for a switch operation, I was training to be a surgeon's assistant, an extended role from my usual grade. Mona Herborn, another sister in the department, came to me a few weeks before Joshua was due to have his operation, confirming that this switch operation was listed. We discussed what we should do about it. In our view we were not supposed to be dealing with any more complex paediatric cardiac surgery cases such as this. We spoke to Dr Bolsin about the operation. He seemed surprised that it was on the list. Dr Bolsin reassured us that it would not take place.
15. Shortly before the operation, Mona Herborn and myself asked Mr Dhasmana why, if he had been stopped from carrying out complex paediatric cardiac surgery, was Joshua's operation still listed. Mr Dhasmana replied that Joshua was not a neonate and that that was the category that he had been told not to operate on. Mona and I said nothing else and left.
16. Approximately 1 week before the operation was due, we noticed it was still on the list. Although we understood Dr Bolsin was trying to ensure that the operation did not take place, in the meantime we had to consider what theatre staff would be available for the operation. Mona Herborn was the only appropriate nurse on duty to scrub. She said that she would not do it. I also confirmed that I did not want to scrub for that operation. A few days before the procedure, Alison Reed had her day off changed, so that a scrub nurse was then available for the procedure. This left us short of an anaesthetic nurse. I was the only theatre nurse experienced as a paediatric anaesthetic assistant on duty that day. Right up until the evening of the operation, Dr Bolsin was reassuring the theatre staff that the operation would not go

ahead. Therefore, even though I was rostered to be the anaesthetic nurse for the operation, I did not believe it would go ahead.

17. On the morning of the operation I was horrified to find Joshua still on the list, but by then I thought it was too late to do anything about it and I prepared for the operation. Joshua did not survive. I believe it was after this that investigations into the paediatric cardiac services at the Bristol Royal Infirmary began in earnest. After the operation, Dr Underwood told me that there would be no more which I understood to mean that she would no longer be willing anaesthetise another child in these circumstances.

Issue N3: The nature, scope and methodology of the “confidential audit” carried out by Dr Bolsin (with the assistance of others such as Dr Black), e.g. the procedures examined; the data used, and the reasons why such sources were selected; the dates when the results were compiled, and by whom; the persons who were or were not informed that the data was being collected, and why; to whom, by what means, and when, the results were made available; and the merits of the methods adopted

18. Dr Bolsin showed his work openly to other people in the department, but I do not know who saw his work or when they may have seen it. I also do not recall when he completed his work. As far as I can remember Dr Bolsin’s main area of research related to three procedures, the switch procedure, AV canal repair and Fallot’s Tetralogy.

Issue N4: The response to any expression of concern made by Dr Bolsin (whether as a result of the audit data collected, or at any other time), from:

- a. **colleagues (whether anaesthetists, cardiologists, cardiac surgeons, nurses or others);**
- b. **the hospital or Trust management (or shadow management, prior to April 1991);**
- c. **the Department of Health (see further below);**

d. any others made aware of Dr Bolsin's views;

19. I remember over-hearing conversations between anaesthetists about Dr Bolsin's research and findings. I formed the opinion that there were 1 or 2 anaesthetists who did not accept what Dr Bolsin said, whilst the rest quietly agreed but did nothing about it.
20. I was not aware of any comment from the anaesthetists, except Dr Ian Davies who seemed to support Dr Bolsin's concerns. I believe that at some stage Dr Davies stopped taking part in complex paediatric cardiac surgery cases. Other anaesthetists stopped eventually. I cannot recall the exact details of when this decision was taken by the anaesthetists. I had no particular contact with the cardiologists and cannot comment on their responses to Dr Bolsin's concerns. I was not aware of the response from the cardiac surgeons, as they would not have spoken about Dr Bolsin in front of nursing staff.
21. I was aware, because Dr Bolsin told me, that when he first raised his concerns about our results there was confrontation between him and Mr Wisheart, which is perhaps not surprising given the concerns that Dr Bolsin had. Dr Bolsin was subdued for a while after this. Although operations were always carried out in a professional manner, there was a frostiness between them both in theatre and there was not the usual "chit chat" that they would sometimes engage in.
22. The only feedback of any sort that I specifically recall was Mr Dhasmana talking to me after I asked after his well-being, saying that he would have liked to go away for a period of re-training but could not be spared and also very much wanted the children's services to be taken to the Children's Hospital. This was around the same time that Martin Elliott came to look at the paediatric surgical Professor's position.
23. Mr Dhasmana later went to Birmingham for 2 days re-training. I do not believe that this was an adequate length of time. The only alterations I could see were that a

peritoneal catheter was routinely inserted and the scrub nurse moved to stand opposite the surgeon. I do not recall any change in surgical technique being pointed out to me, but that is not to say he was doing something differently that I was not aware of.

24. When Professor Angelini was appointed I was aware, again because Dr Bolsin told me, that Professor Angelini supported him.
25. Amongst my colleagues, Mona Herborn and I discussed Dr Bolsin's concerns a great deal. In the early stages this was purely coffee room gossip, which was generally the level at which much of the information was passed on. I cannot recall specifically when that level increased.
26. I am not aware of the response made by the hospital or Trust management, Department of Health, or any other people who might have been made aware of Dr Bolsin's views.

Issue N5: Whether such responses (or the lack of them) was adequate and appropriate; and, if not, the nature and importance of any inadequacies or deficiencies

27. I am not able to comment on the adequacy or appropriateness of any responses, except to confirm that at the time I did not expect anything to be said by the clinicians in front of the nursing staff. In that era there was very much an ethos of "closed ranks". Everybody talked within their own circles, to their own professional group, but not across the circles. I was aware from overhearing their conversations that the anaesthetists may have been divided into those who supported Dr Bolsin, and those who did not. Apart from Dr Ian Davies, I am unsure into which "camp" the other anaesthetists fell. In many ways Dr Bolsin broke the mould by talking about his concerns to the nurses.

Issue N6: If the response was inadequate or inappropriate, the reasons for these inadequacies or deficiencies

28. I am unable to comment.

Issue N7: Whether other personnel employed within, or associated with, the BRI expressed concerns upon the performance of the paediatric cardiac surgery unit; and if so, to whom; as a result of what event or events; in what terms; and when

29. The only other person at the BRI who I recall commented on the outcomes of paediatric cardiac surgery was Helen Stratton. She found it difficult to reassure parents about their children when she herself was aware that children undergoing these procedures were not doing well. I recall that she voiced her distress at some of the outcomes. She would voice her concerns to me or to whoever was the more senior theatre assistant available when she came to theatre to check on the progress of an operation and found that it was not going too well.

Issue N8: The response to any concern expressed by any staff employed within, or associated with, the BRI, from:

- a. colleagues;
- b. the Regional or District Health Authorities;
- c. the hospital or Trust management (or shadow management, prior to April 1991);
- d. the Department of Health (see further below);
- e. professional or statutory bodies (e.g. the Royal Colleges);

to the extent that any of these bodies were contacted or approached

30. I have no knowledge of this issue.

Issue N9: Whether such responses (or the lack of them were adequate and appropriate; and, if not, the nature and importance of any inadequacies or deficiencies

31. I cannot offer any comment on this.

Issue N10: If the responses were inadequate or inappropriate, the reasons for these inadequacies or faults

32. I cannot offer any comment on this.

Issue N11: The nature of the concerns about paediatric cardiac surgery at the BRI (if any) related to:

- a. the Hospital Audit Committee;**
- b. the Hospital Medical Committee;**
- c. the Chief Executive of the Trust;**
- d. the Trust Board**

33. This information is not within my knowledge.

Issue N12: The other sources of information to which these bodies had access (e.g. audit data, newspaper or magazine articles), that might reasonably have suggested cause for either concern about, or investigation of, paediatric cardiac surgical services

34. This information is not within my knowledge.

Issue N13: The extent to which these potential sources of information were in fact considered

35. This information is not within my knowledge.

Issue N14: How (if at all) the bodies described at 11(a)-(d) reacted to any concerns expressed to them

36. I was not aware of the details which passed between the bodies described at 11(a)-(d) and the Bristol Royal Infirmary. From sometime in 1994, we were stopped performing complex cases on children. I assumed that somewhere decisions were being taken about the concerns which had been raised. I have no idea how, why, or where such decisions were being taken.

Issue N15: Whether such responses (or the lack of them) were appropriate

37. I am unable to comment on this.

Issue N16: The formal or informal managerial, disciplinary, or regulatory structures existing within the BRI, through which issues of the adequacy of paediatric cardiac surgical services and/or issues of professional inadequacies or incompetence could have been raised and addressed; and the strengths and weaknesses of these systems

38. The only structures which identify professional incompetence arise from the auditing process. This did not start until quite a long time after I started working at the BRI. I cannot recall exactly when this started. Feedback to theatre nurses about a patient's progress was generally via the consultant who had performed the surgery.

Issue N17: Whether any of these mechanisms or structures were invoked; and, if not, why not

39. I have no information on this issue.

Issue N18: Whether any of these mechanisms or structures should have been invoked

40. I have no further information on this issue.

Issue N19: The concerns about paediatric cardiac surgery at the BRI (if any) related to the DOH and the Supra-Regional Services Advisory Group; the nature of those concerns, and the dates at which they were expressed

41. I understood that about a week before Joshua Loveday was operated on, Dr Bolsin told me that he was going to speak to Peter Durie to stop the operation. However, I have been advised that it was more likely to be Peter Doyle at the Department of Health. The passage of time may have clouded my recollection. I have no other knowledge of the extent of the concerns relayed to the Department of Health or any other group.

Issue N20: The other sources of information to which these bodies had access (e.g. contractual performance data, newspaper or magazine articles, DOH statistical data), that might reasonably have suggested cause for either concern about, or investigation of, paediatric cardiac surgical services

42. I have no information on this.

Issue N21: The reaction of the DOH and/or the Supra-Regional Services Advisory Group to any such expression of concern; and whether it was adequate or appropriate

43. I am aware that the Department of Health did not stop Joshua Loveday's operation. I thought their response was not appropriate. We all knew that Mr Pawade had been appointed and was shortly to start. As Joshua's operation was not an emergency, I believe that the Department of Health should have intervened and instructed that Joshua's operation should be delayed until Mr Pawade arrived.

Issue N22: The existence of any suggestion, prior to the decision to de-designate all centres in April 1994, that the BRI's neonatal and infant cardiac surgical services should be de-designated because of concerns that the centre no longer met the criteria for designation; and, if so, the grounds for consideration of such de-designation

44. I have no knowledge of de-designation.

Issue N23: Whether in 1984-1995 the district or regional health authorities were, or should have been concerned, about the performance of the paediatric cardiac surgical unit at the BRI, as a result of the information held by such bodies and/or their powers and responsibilities

45. I have no knowledge of this.

Issue N24: Whether in 1984-1995, healthcare professionals in other hospitals or healthcare organisations had expressed concerns about paediatric cardiac services at the BRI; and, if so, to whom had such concerns been expressed and with what results (if any)

46. I have no knowledge of this.

Issue N25: Whether in 1984-1995 other professional associations (such as the Royal Colleges) or statutory bodies, were, or should have been concerned, about the performance of the paediatric cardiac surgical unit at the BRI, as a result of the information held by such bodies and/or their powers and responsibilities

47. I have no knowledge of this.

SIGNED : *Kay F. Armstrong*
Mrs Kay ARMSTRONG

DATED : *6/10/99*

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06.10.99