Lessons learned from the Bristol heart scandal and the 2001 Kennedy Inquiry – Part 1

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Part 1 of a 2-part article

'*All changed, changed utterly*' said Richard Smith in the BMJ in 1998 in the aftermath of the 90s Bristol heart children scandal, borrowing from the line in W.B Yeats' Easter 1916. Writing after the GMC had found the surgeons Wisheart and Dhasmana and former chief executive Roylance guilty of serious professional misconduct but before the Public Inquiry, Smith predicted that the culture of British medicine would be transformed by the "*once in a lifetime*" drama of Bristol.

But did it? The families caught up in the scandal who fought so hard for the Public Inquiry certainly hoped so. Sadly, the litany of high-profile medical scandals that have followed one another relentlessly in the decades since Bristol - from Mid Staffs and Morecambe Bay, disgraced breast surgeon Ian Paterson and his involvement in NHS and private surgery , through to Shrewsbury and Telford (emerging as the biggest maternity scandal in the history of the NHS) and most recently East Kent with reports of more than 130 cases of babies suffering brain damage due to oxygen deprivation at birth over a 4 year period - show that this did not prove to be the case.

Professor Sir Ian Kennedy's 2001 Inquiry report with its 198 recommendations definitely did bring about major improvements in audit, governance, publication of surgical outcomes, and accountability within the medical profession. Self-evidently though, looking at all of these terrible scandals, Bristol did not succeed in bringing about the desired sea-change in the wider culture of the NHS. Nor did it produce what was going to be a root-and-branch reorganization of pediatric child surgery in this country which could have formed the basis of a blueprint for future reconstruction so that expertise and services can be concentrated in centers whose data demonstrated that they produce the best outcomes. So comprehensive and all-embracing were the Kennedy recommendations that it was hoped this, the largest and most expensive Public Inquiry in the history of the NHS, following in the wake of the longest ever GMC disciplinary hearing, would be definitive and would avoid the need for further Inquiries.

Disturbingly but presciently, Kennedy admitted on publication of his report that in spite of the abundance of NHS bodies and frameworks that had been created since the scandal broke he could not be confident that it would be possible to prevent another Bristol.

These are some of my personal reflections after representing the families as joint solicitor at the Public Inquiry and handling the claims of parents of children who died or survived but suffered brain damage and other serious injury in operations performed at the unit in Bristol by the two surgeons in the 90s. This has given me an insight into the world of heart surgery and paediatric cardiac surgery in particular with its own unique features and implications for the availability of data, and the development of the law of consent and the duty candour.

This quote from one of the nurses who accompanied many of the parents as they took their children to the operating theatre sums up the Bristol situation at that time. This nurse who later gave evidence to the Public Inquiry told the BBC in an interview before the GMC decision how she had wanted to voice her concerns about the surgeons operating at the unit: but

"There was a sense amongst the nurses generally that 'we've let the baby down' - there were times when I wanted to pick up the baby and just run out of the operating theatre, bundle it into the car with the parents and take them anywhere else."

What an indictment. A key member of staff who felt unable to raise her concerns who was placed in an intolerable position. Many within and outside the Trust in Bristol were aware of the danger to which already very poorly children were exposed but failed or were unable to act.

The background

The story was played out in the GMC hearings, Public Inquiry and the national media, casting huge scrutiny on the hospital in Bristol and those who had put the lives of children born with congenital heart defects at additional risk. Equally a picture emerged of the difficulties faced by those who sought to expose the failings at Bristol. From 1991 Dr Steve Bolsin attempted to raise concerns with his superiors at the Trust, including fellow clinicians and managers, over the alarming surgical mortality rates he had noticed after his arrival from the Royal Brompton in 1988. Dr. Bolsin - later described as the 'gnawing conscience' of the NHS - did his best to escalate those concerns through all levels of authority up to the top of the NHS, Department of Health and the Royal Colleges. All refused to heed his warnings and children continued to die at an alarming rate or survive but sustain neurological injuries leaving them with often severe disabilities.

Joshua Loveday

The death of Joshua Loveday who underwent an arterial switch operation at Bristol in January 1995 at the age of 16 months became the pivotal event in the Bristol story and the catalyst for the GMC hearings and Public Inquiry into surgery carried out at the unit over the previous 10 years.

Mandy Evans, Joshua's mother, last saw her son alive on 12 January 1995, just after 7am. The surgeon assigned to carry out this complex operation was Janardan Dhasmana, the second of the two surgeons carrying out adult as well as the paediatric surgery at Bristol. Unbeknown to Mandy and Joshua's father Bert Loveday Dhasmana's survival rate for these operations was well below the national average – so far below that, on the evening before Joshua's operation, a secret eleventh-hour crisis meeting was held at the hospital. Despite concerns raised by Dr Bolsin it was decided that the operation must go ahead.

By the following afternoon Joshua was dead, after eight hours on the operating table. When later describing this meeting, at which he pleaded with his colleagues not to allow the operation to be carried out, Bolsin said he was overruled: he had been in a minority of one and his colleagues insisted that it must proceed. Professor of General Surgery Gianni Angelini had contacted the Department of Health and asked it to intervene and stop the surgery. Officials contacted the Trust's chief executive Dr Roylance who said this was a clinical matter in which he had no right to intervene. The Department of Health said it had no legal power to halt the operation.

Supra-regional status and the "learning curve"

The two surgeons Wisheart and Dhasmana were keen to keep Bristol at the forefront as a leading paediatric cardiac surgery unit, for which it received additional funding at that time as a supra-regional centre. Seemingly blinded to the unfolding dynamics, Joshua's surgeon Dhasmana appeared unaware that there was a problem. In his evidence to the Public Inquiry, he said he was shocked to learn of the severity of the situation, and why people had been so concerned about his '*learning curve*.' This proved to be a controversial issue for the Inquiry: is it acceptable for surgeons to have a learning curve and if so ,should patients be warned that the surgeon is still gaining experience? In fact, Dhasmana had never performed the 'switch' procedure himself but had assisted another surgeon on one occasion, five years previously. Dhasmana conceded that, when starting a new procedure, he did anticipate some infant fatalities as he improved his skills. In his words:

'*Nobody exactly knew what a learning curve was except for saying that, whenever you start any new operation, you are bound to have unfortunately high mortality . . . I do not think any surgeon wants to be seen as in a way practising with his patients, but that is the definition of "learning curve"*

Joshua's parents knew nothing of Bolsin's eleventh-hour attempts to stop the operation going ahead, or of Bristol's record for child heart surgery, or Dhasmana's inexperience in the arterial switch.

GMC disciplinary hearings

The GMC disciplinary proceedings in 1998, against surgeons Wisheart and Dhasmana and the Trust's former Chief Executive Dr John Roylance, focused on the unit's mortality rates for the arterial switch and atrioventricular (AV Canal) operations. It wasn't ideal to convene a GMC disciplinary hearing and decide who would be charged and what those charges would be before a wider public inquiry. The GMC hearings lasted 63 days and resulted in findings of serious professional misconduct against all three. Wisheart was struck off. Dhasmana was suspended from carrying out paediatric cardiac surgery for three years but cleared to continue adult cardiac surgery (conclusions arrived at without any analysis of his adult surgical outcomes, hence the "*would you let him operate on you?*" question put by Jeremy Paxman to the Health Minister Frank Dobson on that evening's BBC Newsnight – to which Dobson replied without hesitation "*No*"). Both surgeons had lacked insight into their shortcomings and

had failed to call a halt to their operations in the face of clear evidence that they were achieving unacceptably high mortality rates.

The statistical analysis carried out for the public inquiry found that measured on the basis of 30 day mortality Bristol was "an outlier, and not merely 'bottom of the league'" and that a "*divergence in performance of this size could not be explained by "statistical variation, systematic bias in data collection, case mix or data quality*"

Roylance, as a qualified doctor, fell under the GMC's jurisdiction and was struck off for failing to heed warnings and allowing the surgical failures to continue. It was hoped this would stand as a warning in the future for NHS managers who ignore concerns brought to their attention by whistle-blowers.

The aftermath of the revelations

I met Joshua's parents during the GMC hearings. Haunted by his son's death, Bert Loveday became progressively more depressed and disoriented; he had never been in any kind of trouble before but was persuaded to take part, keeping watch, in an armed robbery. He was sentenced to three years in prison and, unable to cope, was found hanging in his cell at Winson Green Prison, Birmingham, a month into his sentence. He was one of three, possibly four, Bristol parents from the 90s tragically caught in the eye of this developing storm to commit suicide.

Feeling quite wrongly and unfairly that they had let their children down, parents punished themselves for not asking probing questions and allowing incompetent surgeons to operate on their children. Unique in my experience was having clients say they hoped our experts would be unable to find negligence: in effect, wanting to lose their cases.

This was an inevitable consequence, repeated in subsequent large-scale scandals, of staff who knew of the failings at the unit on the one hand turning a blind eye and allowing the situation to get out of control or, on the other, like the nurse mentioned earlier, fearing reprisals if they were to raise concerns. h

Steve Bolsin's position became untenable after the Joshua Loveday operation and he had to emigrate with his family in 1995, to take up a position in Geelong, Australia. where he was soon elevated to Professor. Feted in Australia for his role in the Bristol scandal and his subsequent work in the development of governance and clinical audit Professor Bolsin was belatedly awarded the Royal College of Anaesthetists' Medal in Cardiff in 2013 in recognition for all he had done for patient safety. Interviewed in 1998 Bolsin said that to avoid a repeat of this kind of disaster we must 'never lose sight of the patient'

Media reports: the "Killing Fields" and the "Departure Lounge"

The lack of action over Bristol in the face of all the media reports had been extraordinary. Dr Phil Hammond, '*MD*' in Private Eye, first exposed the problems at the unit under the '*Killing Fields*' and '*Departure Lounge*' headlines in 1992, nine years before the publication of the Kennedy report. There were then no significant reports in the media until three years later, with Matthew Hill's BBC Close-Up West regional news programme in April 1995 and the Daily Telegraph's '*hospital took 6 years to act over baby deaths*' report of 1 May 1995. These were followed by the seminal Channel 4 Dispatches documentary of 28 March 1996, and the Times 1 April 1996 article: 'Why did they allow so many to die?'

It was hard to believe that heart surgery had been allowed to continue at the unit in spite of the lurid headlines in the media and the concerns expressed at senior consultant level - and that it took so long for anything to be done. Apart from suspicions or sixth senses confirmed in hindsight, no parent at the time of the operations had any inkling of the problems at the unit. Wisheart retired in 1995 with the highest grade A Merit Consultant Award, payments from the Department of Health worth a reported additional £40,000 a year. As well as his being senior of the two surgeons, performing adult as well as paediatric cardiac surgery, he held the position of Medical Director of the Trust. His replacement as surgeon heading the unit Ash Pawade who arrived from Melbourne in 1996 was achieving close to zero mortality when he gave evidence to the GMC in 1998. Dhasmana was dismissed by the Trust in 1998 after parents were unwilling to let him operate on their children and he had "*lost the trust and confidence of his colleagues*." He later lost his claim for unfair dismissal and breach of contract in which he had argued that he had been treated unfairly and made a scapegoat for the wider failings of the unit.

What occurred amounted to a betrayal of trust – not only by the surgeons but also by all those at Bristol and elsewhere who knew of the appalling death rates achieved by the unit. Parents of sick children in need of life-saving surgery had to cope with the cards they had been dealt. Bristol offered hope but, in so many cases, delivered despair.

Part 2 of this article will be published in the June edition of the Lawyers' Service Newsletter.